UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS - PART 1 MEETING

Wednesday 11 March 2026

09:30 – 12:30

Training Room 1 and 2, Yeomans House, Bournemouth and via Microsoft Teams

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

University Hospitals Dorset NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 9:30 on Wednesday 11 March 2026 in **Yeomans House**, Yeomans Industrial Park, Yeomans Way, Bournemouth BH8 0BJ and via Microsoft Teams.

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

Judy Gillow
Interim Trust Chair

AGENDA – PART 1 PUBLIC MEETING

Time	Item		Method	Purpose	Lead
09:30	**1**	Welcome, Introductions, Apologies and Quorum	**Verbal**		**Chair**
09:32	**2**	Declarations of Interest	**Verbal**	**Review**	**Chair**
09:35	**3**	Staff Story – Chaplain and team	**Verbal**	**Receive**	**CPO**
09:55	**4**	Notification of any Urgent Business	**Verbal**	**Review**	**Chair**
09:57	**5**	Minutes of the meeting held on 14 January 2026	**Paper**	**Agree**	**Chair**
09:58	**6**	Action List and Matters Arising	**Paper**	**Review**	**Chair**
	7	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
10:00	**7.1**	Trust Chair's Update	**Verbal**	**Note**	**Chair**
10:05	**7.2**	Chief Executive Officer's Report	**Paper**	**Note**	**CEO**
	8	**PATIENT FIRST STRATEGY** *Population and Systems, Our People, Patient Experience, Quality Outcomes and Safety, and Sustainable Services*			
10:25	**8.1**	Maternity and Neonatal Quality and Safety Report	**Paper**	**Assure**	**DoM**
10:35	**8.2**	Accountability Framework	**Paper**	**Approve**	**COO**
10:45		**15 MINUTE BREAK 10:45 to 11:00**			
	9	**RISK AND PERFORMANCE**			
11:00	**9.1**	Risk Management Strategy (and Risk Appetite Statement) • Corporate Risk Register	**Paper** **Paper**	**Approve** **Note**	**CNO/ Execs**
11:20	**9.2**	Committee Chairs' Assurance Reports ➢ Quality Committee (3 Feb, 3 Mar)	**Paper**	**Note**	**Committee Chairs**

		➢ Finance and Performance Committee (2&10 Feb, 2 Mar) ➢ People and Culture Committee (2 Mar) ➢ Charitable Funds Committee (16 Feb) ➢ Transforming Care Together Group (2 Feb)			
11:40	**9.3**	Integrated Quality, Performance, Workforce, Finance and Informatics Escalation Report	**Paper**	**Note**	**Execs**
	10	**CORPORATE GOVERNANCE**			
12:05	**10.1**	Board Committees Terms of Reference	**Paper**	**Approve**	**Chair**
	11	**ASSURANCE REPORTS TO NOTE**			
12:10	**11.1**	• Resident Doctor Plan • Antimicrobial resistance: call to action for NHS leaders • Maternity Safer Staffing Review • Patient Safety Event Report • Guardian of Safe Working Hours Report • Gender Pay Gap Report • National Cancer Plan	**Paper**	**Note**	**Chair**
12:20	**12**	Reflections on the Board Meeting	**Verbal**	**Discuss**	**Chair**
12:25	**13**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on Friday 6 March 2026 to: uhd.company.secretary-team@nhs.net			
	14	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 13 May 2026 at 9:30.			
	15	**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.			
12:30	**16**	**Close** (30-minute break - Part 2 to start at 13:00)	**Verbal**		**Chair**

* Late paper
[R] Associated item in Reading Room

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Items for Next Board Part 1 Agenda

Standing Reports

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

Quarterly/Bi-annual/Annual Reports

- Mortality Report
- Quality Impact Assessment Overview Report
- Maternity and Neonatal Quality and Safety Report
- Guardian of Safe Working Hours Report
- Board Assurance Framework
- 7 Day Services Board Assurance Framework
- Freedom to Speak Up Guardian Report
- Annual Security Report
- Annual Equality Diversity and Inclusion Report
- Going Concern Statement
- Key Areas of Judgment and Estimation within the Annual Accounts
- Code of Governance
- Register of Compliance with Licence Conditions
- Independence of Non-Executive Directors
- Seal of Documents Register
- Register of Directors' Interests
- Annual Certificates: availability of resources; training of governors

University Hospitals Dorset
NHS Foundation Trust

AGENDA – PART 2 PRIVATE MEETING

13:00 on Wednesday 11 March 2026

Time	Item		Method	Purpose	Lead
13:00	**17**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	18	Declarations of Interest	**Verbal**	**Note**	**Chair**
	19	Notification of Urgent Business or Confidential Escalations	**Verbal**	**Review**	**Chair**
	20	**MINUTES AND ACTIONS**			
13:01	**20.1**	Minutes of the Board Part 2 Meetings held on 4 and 10 February 2026	**Paper**	**Agree**	**Chair**
	20.2	Action List and Matters Arising	**Paper**	**Review**	**Chair**
	21	**CHIEF EXECUTIVE OFFICER'S UPDATE**			
13:02	**21.1**	Chief Executive Officer's Update	**Verbal**	**Note**	**CEO**
	22	**PATIENT FIRST STRATEGY** *Population and Systems, Our People, Patient Experience, Quality Outcomes and Safety, and Sustainable Services*			
13:45	**22.1**	Staff Survey	**Paper**	**Review**	**CPO**
13:55	**22.2**	Clinical Strategy	**Paper**	**Review**	**CSTO**
	23	**GOVERNANCE**			
14:05	**23.1**	GGi Well-Led Report and Action Plan	**Paper**	**Review**	**CNO**
	24	**ITEMS FOR APPROVAL**			
14:15	**24.1**	EPIC Contract and Inter-trust agreements	**Paper**	**Approve**	**CFO**
14:30	**24.2**	Discharge lounge business case	**Paper**	**Approve**	**CSTO**
14:40	**24.3**	3rd Surgical Robot business case	**Paper**	**Approve**	**CFO/ COO**
	24.4	Return to Wellbeing business case	**Paper**	**Approve**	**CFO**
14:45	**25**	Reflections on the Board Meeting	**Verbal**	**Discuss**	**Chair**

Date and Time of Next Standing Board of Directors Part 2 Meeting: Board of Directors Part 2 Meeting on Wednesday 15 April 2026 at 9:30.

University Hospitals Dorset
NHS Foundation Trust

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Items for Next Standing Board Part 2 Agenda

Standing Reports

- Chief Executive's Update
- Recommendation Reports for approval

Annual Report

- Annual Governance Statement

List of abbreviations:

Officer titles

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

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 14 January 2026 at 9:30 in Boardroom 1, Poole Hospital and via Microsoft Teams.

Present:	Judy Gillow	Trust Chair *(Chair)*
	Siobhan Harrington	Chief Executive Officer
	Beverley Bryant	Chief Digital Officer
	Sarah Herbert	Chief Nursing Officer
	Femi Macaulay	Non-Executive Director
	Michael Marsh	Non-Executive Director
	Mark Mould	Chief Operating Officer
	Pete Papworth	Chief Finance Officer
	Sharath Ranjan	Non-Executive Director
	Richard Renaut	Chief Strategy and Transformation Officer
	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
	Dr Deniz Cetinkaya	Public Governor
	Sharon Collett	Public Governor
	Andrew Doe	Associate Non-Executive Director
	Rob Flux	Staff Governor
	Mel Hartley	Patient Experience and Engagement Lead (003/26)
	Prof Alison Honour	Associate Non-Executive Director
	Rosie Martin	Public Governor
	Keith Mitchell	Public Governor
	Truda Scriven	Interim Company Secretary
	Diane Smelt	Public Governor
	Carrie Stone	Public Governor
	Lorraine Tonge	Director of Midwifery
	Kani Trehorn	Staff Governor
	Michele Whitehurst	Public Governor
	Katherine Brereton	Corporate Governance Manager
	(Three members of the public in attendance)	

BoD001/26	**Welcome, Introductions, Apologies and Quorum** The Chair opened the public meeting and extended New Year greetings to all members, colleagues and observers. She confirmed that the meeting was quorate and outlined participation arrangements for those joining remotely. She welcomed the attending governors and confirmed that the patient story would precede formal Board business. Apologies had been received from Helena McKeown, Tracie Langley and Alastair Matthews.
BoD002/26	**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.
BoD003/26	**Patient Story** Sarah Herbert, Chief Nursing Officer, introduced Mike, a 44 year-old policeman with a young family. Mike and his wife were invited to present their story. Mike explained that he had been diagnosed in May 2023 with stage 4 ALK-positive lung cancer following a period of respiratory symptoms and reduced exercise tolerance, which initially had been attributed to asthma. He described the trajectory from primary care through to imaging and specialist evaluation, noting that diagnostic CT scanning identified a large lung tumour and that subsequent investigations revealed spinal, hip and brain metastases. He reflected that early in his admission he received high-dose steroids and that, crucially, a liquid biopsy was expedited and sent with special funding for genomic analysis, enabling rapid access to a targeted therapy regimen that had since stabilised the disease. He described coordinated care across providers, including timely radiotherapy at Dorchester and neurosurgical review in Southampton, and he highlighted the quality of multidisciplinary communication and planning between UHD and tertiary partners. He paid particular tribute to the lung cancer specialist nursing team, emphasising their accessibility, continuity, and practical support from the point of diagnosis onward. In discussing areas for improvement, Mike described recurring challenges with the scheduling of surveillance CT and MRI scans prior to oncology clinic reviews. He explained that imaging appointments frequently occurred too close to follow-up consultations to allow for reporting, resulting in uncertainty, delays to decision-making and additional anxiety for him and his family. He said that when he had attempted to contact booking teams, the process offered little scope for coordinated re-scheduling and that he had occasionally felt obliged to insist on changes to avoid missing neurosurgical multidisciplinary discussion timelines. Sarah Herbert acknowledged the issue and confirmed that the next cycle of Mike's imaging had been secured as an immediate action, while stressing that a broader operational fix was being pursued so that other patients would benefit from reliable sequencing of scans and results ahead of clinics. She confirmed that the cancer leadership team would work with imaging and booking services to improve coordination, and that the patient's permission would be sought to share the story across relevant teams to reinforce positive practice and highlight areas requiring change. **Action:** Regarding the diagnostics scheduling for oncology follow up the COO/CNO would look to implement a standard ensuring CT/MRI were completed and reported in time for clinics; improve patient communications and escalation options when appointments clashed. Assurance would be provided via Quality Committee. The Chair thanked Mike and his wife for their candour, confirmed that the learning would be taken forward, and invited the Board to sustain focus on communication, timeliness and research access in cancer care.
BoD004/26	**Notification of any Urgent Business** No items of urgent business had been notified.

BoD005/26	**Minutes of the Board of Directors Meeting held on 5 November 2025** The minutes of the Part 1 meeting of the Board of Directors held on 5 November 2025 were AGREED as an accurate record subject to one correction in the maternity section regarding the status of the baby tagging system review following relocation to the BEACH building.
BoD006/26	**Matters Arising – Action List** There were no outstanding actions due. There were no matters arising.
BoD007/26	**Lead Governor Update** Michele Whitehurst, Lead Governor, addressed the Board and conveyed the Council of Governors' appreciation to staff across UHD for their commitment during a year of significant change. She confirmed that governor induction had taken place the previous week, noted the forthcoming Council meeting and assured the Board that governors would continue to gather feedback from members and communities, and support the organisation throughout the next stages of transformation. The Chair thanked the Lead Governor for the update and acknowledged the close working relationship between the Board and Council leadership. The Lead Governor's update was NOTED.
BoD008/26	**Trust Chair's Update** Judy Gillow delivered her report and recorded the Board's appreciation to staff for their exceptional dedication during the festive period and into January. She described joint Christmas Day visits to both sites, undertaken with the Chief Executive and other executive directors, and reflected on the professionalism and warmth encountered in clinical and non-clinical areas. She noted the contribution of Salvation Army musicians to patient and staff morale. Judy Gillow congratulated Dr Michael Marsh, non-executive director on receiving an MBE in the New Year Honours List for his contribution to healthcare and public service. It was confirmed that the date of the investiture would be shared with the Board in due course. Judy Gillow informed the Board that NHS Providers had been commissioned to support a national review of NHS Foundation Trust governors' roles and that she and the Lead Governor were engaged with relevant reference groups, promising to update the Board as the work progressed. She concluded by reiterating that 2026 would be a pivotal year as the Trust moved towards the planned separation of emergency and planned care in July, and she committed to sustaining Board focus on safety, staff well-being and stakeholder communication throughout the transformation programme. The Chair's update was NOTED.
BoD009/26	**Chief Executive Officer's Report** Siobhan Harrington presented her Chief Executive's update. Siobhan Harrington emphasised that, while the report referred to November performance, the position had evolved materially in early January due to extreme operational pressure. She confirmed that the Trust had entered a period of business continuity escalation for eight days and, on the preceding Tuesday, had declared a critical incident due to the inability to maintain safe flow across the Trust. She explained that a structured assessment across ten critical services had been undertaken and that, although UHD had continued to accept emergency patients, the scale of congestion necessitated incident declaration. She reported that the Trust had worked intensively with system partners to unlock additional capacity and accelerate discharges and that UHD had achieved a 20% day-on-day increase in

	discharges following escalation and actions across the Trust and system. However, Siobhan Harrington said the criteria for standing down the incident had not yet been met and further improvement from partners was required. She confirmed that achieving safe flow would remain the overriding priority over the coming days. Siobhan Harrington highlighted a positive elective milestone that UHD had achieved at the end of December, namely that there were no patients waiting more than 65 weeks, and she thanked teams for sustaining elective recovery despite winter pressures. She said the financial position remained broadly on plan but was at risk from premium staffing costs associated with incident response. She noted that national funding for industrial action costs had been confirmed the previous week, partially mitigating risk to financial outturn. Siobhan Harrington described ongoing Dorset-wide strategic work with Vista Health to shape future clinical models and confirmed that Board updates would follow on completion of the current phase. Siobhan Harrington welcomed the Board's forthcoming consideration of the Our Dorset Digital Strategy and noted the significance of the EHR programme for both Dorset and Somerset, adding that the full business case for UHD would come to the Board in an extraordinary session on 23 January 2026. She closed by recognising the embargoed status of early staff survey results and indicating that, despite a year of substantial change, overall scores appeared broadly stable, with detailed analysis and actions to be discussed in due course. The Board discussed the operational situation. Non-executive directors sought assurance on the risk assessment supporting incident declaration, the protection of critical services and the expected trajectory for de-escalation. Mark Mould, Chief Operating Officer, described the internal framework used to assess critical services, confirmed the daily review cadence and reiterated that the Emergency Department remained the principal pressure point. Peter Wilson, Chief Medical Officer, emphasised that the Trust would continue to avoid normalising corridor care, underlining that deconditioning and falls risk for patients with no criteria to reside (NCTR) were significant quality concerns. The Board discussed progress on reducing NCTR numbers, noting that although the monthly target position for January was fewer than 190 patients, the actual number on the day was approximately 240, with the majority awaiting Pathway 2 or 3 packages and/or social work assessment rather than UHD controlled actions. Mark Mould nevertheless cited internal improvement, including a reduction in older people's length of stay from around eleven days to just under eight, improved early escalation and validation processes, and tighter internal tracking with clear daily discharge expectations. Mark Mould said the ICB and regional partners had increasingly recognised the need to support UHD to achieve the target NCTR position required for the July 2026 reconfiguration. The Chair and Chief Executive confirmed that they would continue these discussions at system level later that day and that the Board would be updated on next steps. Members were pleased to see the Staff Excellence Awards. It was suggested that visibility be enhanced through internal promotion (eg site boards, intranet) in order that teams and leaders could recognise awardees in real time. For future reporting it was agreed that a fuller description of their award be included in the CEO's report. The CEO's report was NOTED.
BoD010/26	**UHD NHS Charity Annual Report and Accounts** Pete Papworth, Director of Finance, reported an unqualified external audit opinion with no issues raised and highlighted strong in-year performance, including circa £6 million raised at a cost of approximately 14 pence per pound and £3.3 million invested in patient and staff welfare and service enhancement. He noted a closing fund balance just under £18 million and said that, although this provided a robust

	platform, the Charitable Funds Committee's priority would be to convert balances to impact through strategic projects with demonstrable patient benefit and longevity, such as the proposed Maggie's Centre partnership. The Board discussed the importance of aligning charity funding with organisational priorities, including the Maggie Centre and practice educator roles. The Board endorsed the Charitable Funds Committee's approach. The Board considered and APPROVED the UHD NHS Charity Annual Report and Accounts for submission to the Charity Commission by 31 January 2026.
BoD011/26	**Our Dorset Digital Strategy** Beverley Bryant, Chief Digital Officer, then presented the Dorset Digital Strategy for Board approval. She set the context of historically variable digital maturity across providers and the imperative for an integrated, pragmatic strategy that connected mental health, community, primary care and acute services. Beverley Bryant explained that development had begun in March 2025 and had involved IT leaders, Chief Clinical Information Officers and wider clinical engagement across organisations to ensure co-ownership. She confirmed that while the EHR was a major pillar, the strategy also prioritised infrastructure alignment, rationalisation of legacy systems, workforce digital skills, pateint facing offers, data and analytics capability, and scaled deployment of proven innovations such as ambient voice technology where appropriate. Beverley Bryant emphasised that technology was an enabler and that benefits would be realised through changes in practice and robust training, with a parallel focus on information governance and public assurance about data use. Non-executive directors welcomed the strategy's clarity and asked that the subsequent delivery plan quantify benefits, including time to care and productivity improvements, and set out KPIs with trajectories for short and long-term benefit release. The Board discussed the importance of aligning role profiles and training to anticipated digital practice, ensuring communications for staff and patients, and integrating the strategy fully into clinical transformation and outpatient improvement programmes. Board members discussed the importance of patient enablement, seamless care across organisational boundaries, and releasing staff time to care. Beverley Bryant confirmed that the strategy prioritised training, digital skills, and the transformation of administrative processes, with plans to quantify productivity and efficiency gains in the operational delivery plan. The Board APPROVED the strategy and agreed that the delivery plan, target operating model, KPI framework and investment roadmap would return to the Board in April/May, following a Dorset delivery workshop scheduled for late January.
BoD012/26	**Maternity Incentive Scheme** Lorraine Tonge, Director of Midwifery, presented the Maternity Incentive Scheme (MIS) Year 7 compliance paper. She confirmed that all ten safety actions had been met and that UHD's evidence had undergone internal verification by clinical leads and the LMS lead midwife, together with independent review by BDO, aligning with the assurance received at Audit Committee. She requested Board agreement to enable the Chief Executive's formal declaration by 3 March 2026. The Chief Executive sought confirmation that no criteria were expected to change before submission; the Director of Midwifery confirmed that the evidence file was complete and that LMS sign off would occur in mid-February. The Board recorded appreciation for the sustained work undertaken during a year of substantial service change and approved the MIS declaration. The Director of Finance observed that achieving MIS standards also supported Trust finances through the CNST rebate mechanism.

	The Maternity Incentive Scheme compliance was APPROVED and the CEO was authorised to make the declaration.
BoD013/26	**Corporate Risk Register** Sarah Herbert, Chief Nursing Officer, reported that the newly established Risk Oversight Committee had begun to improve the quality and consistency of risks, with reductions in duplication and clearer articulation of mitigations. She noted that the emergency department risk and the linked four-hour performance risk required full refresh to reflect the current position, planned mitigations and triangulated harm data; a deep dive on care in non-clinical areas was scheduled for the Quality Committee in February, and the four-hour recovery plan would be reframed within a Trust-wide flow programme. It was confirmed that an updated Risk Management Strategy incorporating refined risk appetite and risk tolerance would move through the Audit Committee before coming to the Board. Risk ratings would be incorporated into the Board Assurance Framework from the new financial year to allow tracking of improvement and deterioration over time. There would be a refresh of risks associated with corridor care and Emergency Department crowding and the 4-hour standard with current mitigations, evidence and targets. There would be a Quality Committee deep dive on non-clinical area care in February. The Board would receive outcomes.
BoD014/26	**Integrated Quality, Performance, Workforce, Finance and Informatics Escalation Report and Committee Chairs' Assurance Reports** The Board received non-executive committee chairs' assurance reports which highlighted service reviews, workforce wellbeing, and ongoing challenges in areas such as radiology, cancer therapies, and staff psychological support. Dr Michael Marsh, Quality Committee chair, summarised recent activities of the committee meetings held on 25 November, 16 December and 6 January. This had included scrutiny of medicine for older people, reiterating strong leadership and innovation in a highly pressured area and highlighting system factors driving No Criteria To Reside numbers and end-of-life admissions from care homes. He confirmed that the Committee had reviewed delayed diagnostics, neonatal admissions metrics, access to second obstetric theatre capacity and systemic anti-cancer therapy pressures and had requested targeted assurance and improvement plans where required. Sarah Herbert highlighted patient safety themes including VTE prophylaxis prescribing and confirmed that refreshed metrics and targeted improvement work were being taken through the Quality Committee and into the IPR. Sharath Ranjan, People and Culture Committee chair, reported from the meeting held on 5 January on appraisals performance, workforce planning, Guardian of Safe Working updates and the Improving Working Lives ten-point plan for doctors. He noted active engagement through the Resident Doctor Forum and progress on rota resilience, bank utilisation and exception reporting oversight. Assurance was provided regarding the availability of occupational psychology and clinical counselling services, noting that the Trust offered extensive support compared to other organisations. The Board agreed to maintain a focus on staff well-being, particularly during periods of transformation. Melanie Whitfield, Chief People Officer, reported that she would bring an enhanced plan to the People and Culture Committee with trajectories set to Trust target. The Board would receive assurance through committee escalation. Femi Macaulay, Charitable Funds Committee chair, reported that the meeting on 10 November had been presented with strong fundraising performance to mid-year, approved investments including clinical lasers, and initiated work with the People directorate on a strategic approach to funding practice educator posts through baseline budgets rather than piecemeal charitable applications.

	Judy Gillow, Transforming Care Together Steering Group chair, reported that the meeting held on 15 December had seen progress made, however, several work streams remained behind plan and would be subject to closer programme level oversight. The assurance reports from the Finance and Performance Committee meetings held on 24 November, 15 December and 5 January were taken as read. The Board then reviewed the Integrated Performance Report by exception covering updates on financial performance, critical incident status, and system pressures, including the impact of industrial action, escalation costs, and the need for system-wide accountability in reducing delayed discharges and improving patient flow. Mark Mould reiterated the emergency care pressures described earlier and the need to reduce No Criteria To Reside numbers to enable safe Emergency Department flow and corridor elimination. He detailed the efforts to reduce the number of patients with NCTR, including improved internal processes and collaboration with system partners. The Board discussed the need to distinguish between organisational and system-level responsibilities, with ongoing work to address commissioning gaps and improve patient flow. Pete Papworth, Director of Finance, summarised the month 9 financial position. He advised that year-end break-even remained achievable but was contingent on reducing escalation and premium staffing costs as critical incident actions took effect. It was confirmed that funding for industrial action costs had been notified the previous week, reducing financial risk, and that UHD was working with national and regional teams to secure capital re-profiling aligned to reconfiguration timelines, with an update to be provided at the next meeting. The Board recognised the challenging revenue position, driven by operational pressures and industrial action, but noted that additional funding for industrial action costs had been secured. The Board discussed the importance of reducing escalation costs and delivering efficiency targets to achieve break-even. Melanie Whitfield reflected on the triangulation between operational demand, financial constraint, and workforce supply, observing that overall vacancy levels were modest but that sustained operational efficiency and digital enablement were essential to balancing the establishment safely and productively. The Board was updated on the transition to electronic-only pathology orders, noting successful pilot feedback but highlighting equipment issues, specifically the need for label printers, which would be addressed through standard capital processes. It was stated that pathology would no longer accept paper orders, with all requests to be made electronically. The pilot implementation in selected areas received positive feedback, with users reporting that the system functioned well and no significant issues were identified, aside from equipment needs. Before closing, the Board returned briefly to cancer services. Peter Wilson, Chief Medical Officer, reiterated the importance of clinical trials access as highlighted by the patient story and confirmed that the oncology teams were actively pursuing opportunities aligned to the Trust's research strategy. The Board asked that research alignment and trial participation metrics be included in forthcoming reports on the cancer programme, together with progress on imaging to clinic sequencing improvements. The Chair thanked Board members and executives for their contributions. The IPR and Committee Chairs' Assurance Reports were NOTED.
BoD015/26	**Assurance Reports** The 2025/26 Annual In-Patient Establishment Review

	The Board received the statutory annual Workforce and Staffing Establishment Review, which outlined the methodology used, the associated financial implications, and the identified requirements for strengthening senior oversight and weekend cover. The review was based on acuity data, triangulated with safety metrics, national benchmarks, and professional judgement. The findings indicated a need for enhanced senior presence in high-activity areas, particularly at weekends, rather than increases in overall headcount. An investment of £215,000 was proposed to address these gaps. It was confirmed that this requirement would be incorporated into next year's financial plan and offset by reductions elsewhere. The methodology and conclusions had been externally reviewed and found to be robust and aligned with national expectations. Sarah Herbert noted the ongoing need to develop Band 7 capability in roster management and workforce planning, supported by national staffing resources and a commitment to continuous improvement. The 2025/26 Annual In-Patient Establishment Review was NOTED and the investment of £215,000 was APPROVED. <u>The Quality Impact Assessment Overview was NOTED</u> <u>Patient Safety Event Report</u> Peter Wilson raised the declaration of a historic patient safety event, the rationale for its timing, and ongoing improvements in theatre standardisation and quality, with continued oversight of theatre improvements and patient safety by the Quality Committee. The Patient Safety Event Report was NOTED. <u>Guardian of Safe Working Hours Report / 10 Point Plan</u> Peter Wilson would submit the detailed update to the People and Culture Committee, then a summarised version to Board, including regional solutions for carry over leave and agreed local priorities from the Resident Doctor Forum. The Guardian of Safe Working Hours Report was NOTED,
BoD016/26	**Reflections on the Board Meeting** It was accepted that by having the committee assurance reports ahead of the IPR narrative improved the Board meeting's effectiveness and encouraged more responsive engagement. This was AGREED to continue in the future.
BoD017/26	Questions from the Council of Governors and Public arising from the agenda. A question had been raised by Diane Smelt, Public Governor: *"The NHS has announced the nine common conditions that will be the first to be treated using the new proposed NHS online hospital to be launched in 2027. Some of the services are ones which UHD currently provided so how does the Trust propose to ensure that our patients continue to receive a fair and equitable service and be eligible to access face to face specialist in-patient care when this proposal becomes operative in 12-months' time".* In response Mark Mould stated that the Trust recognised the NHS proposal to introduce an Online Hospital and noted that a number of the initial conditions identified for inclusion align with services currently delivered by UHD. At this stage, the Online Hospital was intended to complement, rather than replace, existing local provision. UHD remained committed to ensuring that all patients continued to receive fair, equitable and clinically appropriate care. Patients whose needs required face-to-face assessment, specialist intervention, or in-patient treatment would continue to

	be identified through established clinical triage and referral pathways and would retain access to local services where this was clinically indicated. The Trust would work closely with NHS England, and system partners to ensure that eligibility criteria, referral processes and digital pathways do not disadvantage patients who were unable to access or were unsuitable for online models of care. Equality impact assessments and patient experience data would inform implementation to ensure that vulnerable groups were not adversely affected. As further detail on the scope, timelines and operational arrangements of the Online Hospital became available, UHD would review its service models accordingly and provide assurance that patient safety, quality of care and access to specialist and in-patient services remained paramount.
BoD018/26	A question had been raised by Keith Mitchell, Public Governor: *"RBH Emergency Department was particularly busy over the weekend, and while I was volunteering on both Saturday and Sunday, two senior members of staff asked to speak to me about the pressures they were experiencing.* *They were aware of my role as a governor and were clear that they were not asking me to become involved in day-to-day management. However, they did ask whether I could pass their concerns on to the board, as they felt they had previously escalated these issues through management routes without seeing any improvement.* *At times, all areas were full, including corridors. RATS was particularly busy with all cubicles occupied and two additional rows of trolleys placed down the centre of the unit. Patients and relatives in this area were becoming increasingly frustrated by waiting times and were directing complaints towards staff.* *I was also concerned to observe patients having to use bedpans in corridors, which is clearly undignified and does not feel consistent with patient-first principles.* *Given this context, I would like to ask whether the non-executive directors are confident that there is a clear and effective strategic plan in place to address these pressures, both in the immediate term and as part of wider capacity planning".* The Chair thanked the governor for raising concerns and for supporting staff as a volunteer. NEDs acknowledged that the issues described: corridor care, pressure within Rapid Assessment and Treatment, lack of cubicle capacity, and the resulting impact on patient dignity and experience, were deeply concerning and confirmed that the Board took these matters extremely seriously. NEDs reiterated that such levels of corridor care were not acceptable for patients or staff and emphasised the importance of strengthening strategic oversight, ensuring that improvement was both visible and sustained. NEDs committed to seeking more regular and detailed reporting on Emergency Department flow, staff safety, patient dignity concerns and the effectiveness of previously escalated actions, while ensuring that staff felt heard where internal escalation had not produced improvement. Peter Wilson, Chief Medical Officer, added that the governor's observations reflected the significant and sustained pressures experienced by frontline teams and highlighted the clinical risks associated with overcrowding, including delayed assessments, potential harm and the impact on staff morale. The CMO reaffirmed ongoing improvement work, including the ED improvement plan, daily senior reviews and rapid actions through the improvement board, and committed to strengthening clinical engagement and increasing visibility of progress. The CMO also confirmed that several challenges required system-wide action, involving ambulance, community and social care partners. In closing, the Chair confirmed that the question, and concerns would be formally recorded, and set out that an enhanced ED performance and safety update should be included in the next Integrated Performance Report, with clearer milestones,

	continued escalation of system-wide pressures with partners; and close monitoring through Board and committee reporting cycles.
BoD019/26	**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 Chair thanked all those present and the meeting was closed.
	The next meeting of the Board of Directors Part 1 would be held on Wednesday 11 March 2026 at 9:30

Board Part 1 Action List - March 2026						
Meeting Date	**Minute No.**	**Matter Arising / Action**	**Lead**	**Due Date**	**Progress**	**Status**
14/01/2026	**BoD003/26**	Regarding the diagnostics scheduling for oncology follow up the COO/CNO would look to implement a standard ensuring CT/MRI were completed and reported in time for clinics; improve patient communications and escalation options when appointments clashed. Assurance would be provided via Quality Committee.	**CNO/COO**	Mar-26	**Jan26:** Assurance would be provided via Quality Committee.	**In Progress**

MARCH 2026 TRUST BOARD
CHIEF EXECUTIVE UPDATE

1 INTRODUCTION

As March arrives, the shift into spring brings a lift to us all after a challenging winter. Many of us feel the benefits of brighter mornings. As has become a tradition at UHD, we shared daffodils with staff across all sites during the first week of March — a simple gesture to mark the season and bring some joy to our working spaces.

Thank you to all our teams for the continued support you show one another and the consistent care you provide for our patients. The past few months have brought sustained pressure, yet colleagues across our sites have focused on delivery of safe patient care and supporting colleagues.

As we enter the final month of the financial year, I have been reflecting on the significant service moves completed during 2025–26. These include the relocation of Maternity and Neonatal services into the BEACH Building, alongside the moves of Surgical Same Day Emergency Care, the Surgical Admissions Unit and Oncology inpatient services. Each of these transitions has required careful planning and exceptional teamwork, and they represent major milestones in creating modern, purpose-built environments that support the future model of care across Dorset.

This month we were pleased to welcome members of the NHS England Board to Dorset and they visited UHD at our Bournemouth and Poole hospitals as well as Dorset County Hospital, St. Ann's Hospital and teams in Weymouth & Portland. Their feedback highlighted strong engagement, motivated clinical and operational teams, and impressive new facilities, with clear pride in patient care. Colleagues also noted that, as the Trust continues to evolve, there remain opportunities to build on this progress and further enhance how we work together across the system.

We marked International Women's Day on 5 March. The UHD Women's Network organised a full programme in the RBH lecture theatre, and colleagues were invited to share their time and contribute to the sessions throughout the day. My thanks go to everyone working to shape the programme and ensure staff were given opportunities to take part.

2 NATIONAL UPDATES

2.1 Impact Statement: 10-Year Health Plan for England

The Impact Statement for the 10 Year Health Plan for England, published on 12 January 2026, sets out the overarching implications of the Government's intention to shift the NHS towards a more preventative, community-based, and digitally enabled model of care. It confirms three strategic system shifts—moving activity from hospitals into neighbourhood and community settings, accelerating digital transformation, and prioritising prevention—to relieve pressure on acute services, improve patient experience, and support earlier intervention. These changes signal a fundamental reshaping of service delivery and workforce models across the NHS over the next decade. [gov.uk], [lincslmc.co.uk]

The statement notes that while the direction of travel is clear, many proposals remain at formative stages, with detailed costings and implementation decisions expected to be taken locally. It highlights key risks to delivery, including workforce capacity, digital infrastructure readiness, and the scale of cultural and operational change required across organisations. Overall, the plan sets a clear trajectory for modernising the NHS—anchored in prevention,

digital innovation, and community-based care—to ensure the service is fit for the future and able to respond sustainably to rising demand.

2.2 National Cancer Plan – Published 3 – 4 February 2026

NHS England and DHSC have now launched the new National Cancer Plan, setting a decade-long programme to modernise cancer care. It commits the NHS to ensuring that by 2035, three in four people diagnosed with cancer will be cancer-free or living well after five years. The Plan includes major expansion of diagnostics, wider use of robotics and AI, faster approval routes for modern radiotherapy techniques, and preparatory work for multi-cancer early detection testing.

These national commitments will shape future expectations for early diagnosis and treatment productivity.

2.3 Actions to Deliver Agenda for Change Uplift and a Fairer Deal for Nurses – Published 12 February

The Government has now confirmed a 3.3% consolidated uplift for all Agenda for Change staff, effective 1 April 2026. The award will be paid on time in April salaries, and further discussions with unions will consider structural improvements to the pay framework.

This represents the first on-time pay settlement in six years.

NHS nurses are set to receive a career boost, as the Government and the Royal College of Nursing (RCN) have agreed a major package to properly recognise the vital work they do. Wes Streeting, the Secretary of State for Health and Social Care has set out a package of new commitments to nursing staff in England announced in February, including:

- prioritising increasing graduate pay
- reviewing the roles and pay bands of every band 5 nurse
- establishing a single national nursing preceptorship to create a national framework to support newly qualified nurses

2.4 National Supply Incident – Heraeus Medical Bone Cement products - Published 18 February

Following the recent national announcement of disruption to orthopaedic bone cement supplies used in some joint surgery that is impacting across the NHS, we are working closely with NHS England and Dorset ICB to assess the impact of this disruption. The cement is used mostly in knee replacements, but also in some hip and shoulder replacements. All NHS hospitals have been asked to prioritise trauma and urgent care for people who have suffered broken joints until supplies return to normal. While we are making every effort to minimise the impact, this has resulted in a small number of planned joint replacements being postponed to ensure there is sufficient cement available for trauma emergencies

3 DORSET UPDATES

3.1 ICB Cluster

Across Dorset, work continues to progress within the newly established Integrated Care Board (ICB) cluster, which brings together NHS Dorset, NHS Somerset, and Bath and Northeast

Somerset, Swindon and Wiltshire (BSW). The cluster has moved fully into its operational phase, with cross-ICB development sessions and leadership forums now underway.

I attended the Cluster Board Development session on 12 February 2026, where we discussed moving towards place and cluster-based working, with a focus on local autonomy, outcome-focused commissioning, and stronger partnerships.

3.2 Digital

The HealthSet Electronic Health Record (EHR) Programme Full Business Case has gained approval from all Boards in Dorset, by the NHS England EPR Investment Board and DHSC Joint Investment Committee during January and February. We have now received formal ministerial approval.

We are now finalising the EPIC contract and expect to sign contracts before the end of March 2026. This is a major achievement for Dorset and Somerset and brings us closer to achieving our vision for joined-up, integrated care across our clinical pathways.

We are now mobilising teams and expect the main implementation efforts to start in late summer to take us to a big-bang go-live in April 2028.

Alongside this, the target operating model for the Digital Services has been agreed across Dorset. Deputy Chief Digital Officers are now in post, and the team are beginning to consider the next level of digital leadership, including clinical digital leadership across Dorset.

4 UNIVERSITY HOSPITALS DORSET

4.1 Performance Headlines

Urgent & Emergency Care and Elective Care

January has been a challenging month across the organisation with high occupancy impacting UEC pathways including the outflow from the Emergency Department. In response we declared several Business Continuity incidents and a Critical Incident to manage recovery.

We recognise the challenging operational environment that winter brings for both patients and staff and have a winter plan guided by our Trust strategic deployment reviews: we remain confident that our focused actions and continued prioritisation will ensure we deliver against our key objectives for winter.

The UEC Getting It Right First Time team visited UHD at the end of February. Over two days they reviewed our acute medicine, UEC and care of the elderly pathways for patients. It was an invaluable visit and we await their written report.

Discharge and Flow

Work continues with our system partners in agreeing and deploying recovery actions to reduce the number of patients who no longer need an acute bed and are awaiting discharge, which remains above the agreed improvement trajectory.

4-hour organisational safety standard

Our performance against the 4-hour organisational safety standard did deteriorate in January at 63%, falling short of the planned trajectory of 72.5%. We continue to focus on recovery actions across the UEC pathway and planning is underway as part of a national ‘sprint,’ to improve performance against the 4-hour standard.

Ambulance handover times have remained consistent and tracking favourably as compared to previous winters helping to ensure our ambulance partners are able to meet emergency

demand. We have also sustained the number of patients referred to our Same Day Emergency Services, which continues to out-perform the planned trajectory and the number of occupied bed days (OBDs) used continues to track favourably as compared to previous years.

Elective Care

With regards to elective activity, we have continued to deliver an increase in planned operations, procedures and appointments for patients compared to the 2019/20 baseline period. Year to date the Trust has increased elective activity to 115.4% of the activity delivered in 2019/20 for the same period, exceeding the Trust's operational plan trajectory of 108.6%. We also continue to see a reduction in the length of waits for patients on an elective list, with waits over 65 weeks eliminated for the second consecutive month in January and the percentage of waits over 52 weeks reducing to 2.3% of patients on an RTT waiting list. Almost three quarters of patients will receive a first OPA or diagnostic test within 18 weeks of referral, meaning that we are achieving earlier identification of whether they can be discharged or require treatment.

Diagnostics

Although we saw a lengthening of some diagnostic waits over December due to reduced capacity over the Christmas period, we maintain a strong overall performance against the national diagnostic standard (DMO1), achieving only 5.7% of waits exceeding 6 weeks.

Cancer Pathways

We have also improved pathways for cancer patients by achieving the Trust's performance trajectories across all three national cancer waiting times standards in December (latest reported data) – Faster diagnostic standard, 31 day and 62-day standards.

5 FINANCE

At the end of January, the Trust has reported a year-to-date deficit of £3.1 million being £38,000 favourable to budget. This reflects a continued improvement consistent with the forecast recovery plan. The Trust continues to forecast delivery of the full year break-even plan. Within this position, efficiency savings are forecast to be £15.4 million lower than budgeted, however financial mitigations have been identified to offset this shortfall.

The Trust continues to benchmark well, with implied productivity growth of 3.6% (Month 6 outturn) against the regional average of 2.6% and national average of 2.4%.

Medium Term Planning

The Trust submitted its Medium-Term Plan on 12 February following board approval. This reflects an incredibly stretching financial plan for the year ahead (2026/27), requiring £68.5 million of efficiency savings (6.8%) in order to achieve a balanced budget. Savings of 7% are expected to be required in year 2, reducing to 4.8% in year three.

The Trust has set out plans to deliver all key operational performance standards except for the percentage children's community waiting list within 18 weeks, due to specific capacity challenges.

The workforce plan sets out the continued improvements in the reliance upon agency and bank staff, together with the impact of productivity and efficiency programmes. Strategic developments relating to the acute reconfiguration in July and developments within Community Diagnostics have similarly been reflected. Overall, the Trusts workforce is expected to remain stable with a marginal increase due to local hosting arrangements.

6 STRATEGY & TRANSFORMATION

Key service moves into brand new facilities at Royal Bournemouth Hospital, have successfully completed for:

Surgical Same Day Emergency Care (SDEC) and the Surgical Admissions Unit (SAU).

Oncology inpatient services

These were complex changes involving multiple teams and patient moves. Thank you for everyone involved in safely and swiftly achieving making the changes. Patients and staff will now benefit from new facilities, including more single rooms and better layouts for modern care.

Work at Poole continues on the new Endoscopy unit and will shortly start on the additional MRI and CT scanners.

Clinical Strategy

Development of our Trust-wide clinical strategy continues to progress well. Many specialty teams have now drafted their contributions, which have been consolidated in preparation for the forthcoming broader engagement phase. This work remains closely aligned with the wider Dorset health and care strategy and builds on recent public engagement undertaken as part of the NHS Long Term Plan.

A report outlining current progress and proposed next steps has also been submitted to the BCP Health and Adult Social Care Overview and Scrutiny Committee for their meeting on 2nd March, where it will be reviewed and considered. Our ambition remains clear: to make Dorset the healthiest place to live in the UK.

Way finding at RBH

Changes to make it easier to find your way around our largest site are now being rolled out. Change, especially for those of us who know the site well, will take a little adjusting to. By using the best evidence and experience from hospital across the country, as well as talking to our hospital users, we now have a new system that is much simpler and more consistent. This is a huge task and it will take several months to bed in, including for appointment letters. To help there is a period of “double running.” In future we will also be looking at digital wayfinding, for visitors who have mobile phones. A special thanks to all our volunteers on the main entrances who continue every day to help our thousands of patients and visitors and provide a welcoming smile. Wayfinding

7 OUR PEOPLE

Staff Survey

Colleagues are aware publication is anticipated mid-March, and to prepare the Organisational Development People Team have shared information packs with each of our clinical care groups and corporate teams for managers to plan their approach for local listening into action.

Further analysis and insights are underway with consideration to staff experience across all the Protected Characteristics Data.

New People Pulse Pack (January) is ready for circulation, sadly we note a reduction in completion rates, 625 to 953 last quarter and considerably lower than the national average of 2968 – we are building action plans to raise awareness and completion, noting what a good “bellweather” the pulse survey could be for how our staff are feeling.

- building on the OD team staff engagement have been leading:

- bespoke team development sessions to support teams facing transformation (including Dermatology, Pathology, MatNeo SLT and ED)
- training over 50 team leaders to implement the TED (Team Engagement and Development) toolkit and network of leaders are being created and 60 delegates have taken part or booked onto the Building Readiness for Change workshops
- I with, Melanie CPO met the People and Culture Champions and heard about staff feedback on rest spaces
- 22 new reverse mentors and mentees trained using our in-house resources for delegates from the Florence Nightingale programme to support a more inclusive culture within our workplace.

Staff Network Events

We have agreed a calendar of events for 2026, noting the many challenges on people's time and our ongoing commitment to build both a Team UHD and a sense of belonging through the multiple service configurations.

Workforce operational plan

Monitoring for M10 and M12 continues to show an adverse variance for both total and substantive WTE. Bank and agency usage reduced in M10 with a favourable variance both in month and year end. But colleagues are aware overall, there has been an increased reliance on temporary staffing over the winter period which continues to present a risk to delivery of the 2025/26 workforce plan, driven by increased operational pressures including patient flow, no criteria to reside patients, escalation beds and the winter ward.

Former Colleague on Trial for Fraud

All members of the Board are aware most recently both by internal brief and national press Leanne Underhill, a former colleague in our People Directorate, was on trial in Poole Magistrates' Court in February for fraud by false representation following an investigation UHD instigated with TIAA, our counter fraud specialist. She worked at the trust as an interim associate director from December 2023 to June 2024. She was paid sick time/compassionate leave for her mother's death, but her mother was still alive. The outcome was that the judge ordered full repayment of the salary overpayment and the investigation costs. I am pleased that this case was resolved with the money being paid back to support patient care and thank all colleagues and TIAA for their work in this very difficult case.

UHD Staff Awards 2026

Nominations for the UHD Staff Awards are now open, with all staff, volunteers, and members of the public invited to put forward individuals or teams for recognition. Categories cover a wide range of roles and include a new Partnership Award for collaborative work with external partners, as well as the Patient Choice Award, which is nominated by patients and the public. Anyone can nominate and anyone can be nominated.

Nominations close at noon on Friday 3 April. Winners will be selected by a panel representing different staff groups and announced at a ceremony in Bournemouth in June, supported by UHD Charity. Full details and nomination forms are available on the UHD website and intranet.

8 TRUST MANAGEMENT GROUP (TMG) UPDATE

TMG approved a suite of governance documents that together shape how oversight and decision-making will operate across the organisation. These included the Terms of Reference for the Patient First Steering Group and the final Terms of Reference for TMG, confirming the remit and responsibilities of both bodies. TMG also approved the Final Governance Map for Tier 2 and Tier 3 groups, which sets out the structure of subordinate committees and their

reporting routes, and the Executive Governance Cycle, confirming the annual rhythm for papers, assurance, and decision-making. Each of these approvals ensures that the Trust's governance arrangements for 2026/27 are clearly defined and consistently aligned.

Alongside these decisions, TMG reviewed a number of specific items:

- Staff Survey
- ICE results
- Annual In-Patient Establishment Review
- Future Allocation of Space
- Well-Led Review (GGI) update
- Joint Private Patients Presentation
- Governance arrangements were also reviewed and approved.
- Wessex Pathology Full Business Case was approved.

8.1 Monthly Staff Excellence Awards

I was pleased to present Excellence Awards to one team and two individuals since my last report and have included below the nomination background for each of this month's winners.

Orthopaedics Admission Team, Bournemouth

The Orthopaedic Admissions Team at Royal Bournemouth Hospital is recognised for their exceptional response during the ten days following a major fire incident. They effectively managed the needs of 95 patients, including rescheduling 51 procedures, while maintaining clear communication and supporting patients through unavoidable changes.

The team ensured continuity of care for all clinically urgent and longest-waiting patients, demonstrating strong coordination and a willingness to go above and beyond to keep services safe and responsive during significant operational pressure.

Abigail Brelsford, Clinical Site Management Team, Bournemouth

Abigail Brelsford is recognised for her exemplary professionalism and leadership during an emergency evacuation on Derwent Ward on 4 November. Despite fire alarms, smoke and understandable concern among staff, she remained calm and communicated clearly and respectfully throughout.

Working closely with the fire service and clinical teams, Abigail coordinated the evacuation effectively, identified key priorities, and supported staff to maintain patient safety at every stage. Her actions reflect a level of commitment and responsiveness that exceeded the expectations of her role, ensuring a safe and well-managed response during a highly pressured real-time incident.

Leah Galbraith, Acute Inpatient Therapy Team, Bournemouth

Leah Galbraith, Band 6 Occupational Therapist, is recognised for her exceptional work in coordinating the complex discharge of a patient with learning disabilities who had been an inpatient for seven months. She ensured his best interests remained central, maintained oversight across multiple teams and prevented delays in care.

Leah contributed 54 hours of targeted therapy within two months and took on responsibilities that went beyond the usual scope of her role to progress the case safely and effectively. Her

leadership, persistence and professional judgement were key to achieving a successful and well-planned transition back into the community.

9 INTEGRATED CARE BOARD 13 NOVEMBER 2025

I attended the NHS Dorset ICB Board Meeting on 15 January 2026. The minutes of the meeting held on 13 November 2025 were ratified at this meeting. I attach a copy of the minutes of the meeting at Appendix A.

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 13 November 2025 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) (virtual)	ICB Non-Executive Member
	Siobhan Harrington (SH) (virtual)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Chris Hearn (CH)	Joint Chief Finance Officer (DCHFT/DHC) – nominated deputy
	Alison Henly (AH)	ICB Interim Chief Finance Officer
	Karl Hoods (KH)	ICB Non-Executive Member
	Paul Johnson (PJ)	ICB Chief Medical Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW)	GP Alliance Chair, Primary Care Partner Member
	Adrian White (AW)	ICB Non-Executive Member
	Dan Worsley (DW)	ICB Non-Executive Member
Invited Participants Present:		
	Louise Bate (LBa) (virtual) (part)	Manager, Dorset Healthwatch
	Paula Bennetts (PB) (virtual)	Programme Director, Dorset VCSA
	Aidan Dunn (AD)	Chief Executive, BCP Council
	David Freeman (DF)	ICB Deputy Chief Executive Officer
	Catherine Howe (CH)	Chief Executive, Dorset Council
	Andrew Rosser (AR) (virtual)	Chief Finance Officer, SWASFT
	Ben Sharland (BS) (virtual)	Primary Care participant
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Liz Beardsall (LB)	ICB Head of Corporate Governance
	Jane Ellis (JE)	ICB Chief of Staff
	Steph Lower (SL) (minutes)	ICB Deputy Head of Corporate Governance
	Clare Mechen (CM) (for item ICBB25/155)	GP Alliance Lead Nurse
	Rachel Pearce (RPe) (virtual)	Managing Director (System Commissioning Development), NHS England South West
Public:		
	4 members of the public were present. The meeting was also available via livestream.	
Apologies:		
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member
	Rob Carroll (RC)	Director of Public Health, BCP Council
	Sam Crowe (SC)	Director of Public Health, Dorset Council
	Millie Earl (ME)	Leader of BCP Council
	Dawn Harvey (DH)	ICB Chief People Officer
	Jonathan Higman (JH)	Cluster Chief Executive Officer

	Ken Heap (KH)	Acting Chair of the Governance Board, Dorset VCSA
	Nick Ireland (NI)	Leader Dorset Council and ICB Local Authority Partner Member
	Pam O'Shea (POS)	Interim ICB Chief Nursing Officer

ICBB25/151 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from Matthew Bryant, Rob Carroll, Sam Crowe, Millie Earl, Dawn Harvey, Ken Heap, Jonathan Higman, Nick Ireland and Pam O'Shea.

ICBB25/152 Conflicts of Interest

There were no conflicts of interest declared.

ICBB25/153 Minutes of the Part One meeting held on 11 September 2025

The minutes of the Part One meeting held on 11 September 2025 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 11 September 2025 were approved.

ICBB25/154 Action Log from the Part 1 meeting held on 11 September 2025

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

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

Standing Items

ICBB25/155 Primary Care Board Story

The Chair of the GP Alliance presented the Primary Care Board Story video which illustrated the breadth of primary care services in Dorset, highlighting the multi-disciplinary approach and the success of the Leg Club model - a registered charity 'owned' by the local community which had transformed community wound care through collaboration, compassion and connection.

A patient story was shared which demonstrated the Leg Club's impact on both physical healing, social reintegration and empowering individuals to take responsibility for their own care. The model had enabled significant cost savings compared to traditional care.

A Rosser joined the meeting

The Board considered how prevention could be supported through the commissioning intentions, neighbourhood working and contractual arrangements.

The video would be shared to help promote care outside of hospitals.

ACTION: Corporate Governance

Resolved: the Board noted the Primary Care Board Story.

ICBB25/156 Chair's Update

The Chair provided the following updates:-

- Dorset HealthCare had been announced as one of eight trusts nationally to pilot Advanced Foundation Trust status. There had been significant partnership working to enable this and it was hoped to serve as a system asset for integrated neighbourhood health.
- Following Treasury approval, NHS England had launched a model Voluntary Redundancy Scheme. The Board recognised how difficult the changing parameters around the transition were for ICB staff.
- All three Boards within the ICB cluster were operating well and Dorset ICB was essentially on target in terms of the operating plan and financial position.
- It was noted there were likely to be difficult decisions taken in terms of public spending within the budget announcement due on 26 November.

Resolved: the Board noted the Chair's update.

ICBB25/157 Chief Executive Officer's Report

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

Key points included:-

- The Board noted the publication of the Medium Term Planning Framework which marked a shift from short-term operational cycles to a longer-term locally led approach to improvement, aligned to the ambitions of the 10-year Health Plan. Initial submissions were required in December 2025 with final versions due in January 2026.
- NHS England had published its Strategic Commissioning Framework. This had significant implications in terms of NHSE's expectations from ICBs in the strategic commissioner role and what ICBs and providers could expect from NHSE.
- The Board reiterated its commitment to tackling racism and fostering an inclusive, respectful and professional environment.
- A further strike for resident doctors would take place from 14-19 November 2025. All partners were working together to mitigate the impact as far as possible. Patients should attend planned appointments unless told otherwise and to access other services in the normal way.
- The Dorset NHS system partners had met with NHS England to conduct Dorset's mid-year review. The meeting had been constructive with strong challenge and support. There was focus on meeting operational and financial targets and the need for continued effort to deliver on agreed plans.
- Dorset had been successful in a bid to join the first wave of the National Neighbourhood Health implementation programme and there was a commitment to share the learning across Dorset.

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

ICBB25/158 Board Assurance Framework

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

The Board had agreed to maintain the local BAF during the transition period with ongoing monthly reviews and reporting into the committees. The BAF would be re-set once the new strategy and governance were established.

Following a query regarding the status of the digital maturity risk, it was clarified that digital maturity was currently out of tolerance but expected to move within tolerance once the digital strategy was approved.

The Board discussed the importance of capturing transition-related risks. The strategic risk of the safe and coherent transition was captured in the cluster Transition Committee risk register (which was accountable to the three ICB Boards) but not captured explicitly in the BAF. This would be taken away in terms of cross referencing accordingly.

ACTION: DF

Resolved: the Board approved the Board Assurance Framework.

ICBB25/159 Committee Escalation Reports

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

Finance and Planning Committee:

- Discussion regarding the transition to a financial recovery plan due to the significant year-end forecast variation. Monthly trajectory monitoring was agreed as some variation was expected.
- Discussion regarding the ongoing risks and actions related to the independent sector over-plan spend. Despite the actions being taken, this remained a risk to the overall plan delivery.
- Routine updates including medium term planning and contracts going out for tender.

The Board discussed the workforce trajectories which had been revised and would focus on more deliverable targets for the remainder of the year.

Agency usage had reduced with stronger controls implemented across providers. Bank staffing remained an area of overspend. This was a key focus with robust controls in place and ongoing review through internal committees.

The Board noted the potential adverse impact of the resident doctor industrial action and the need to factor these into the planning.

The Board discussed the importance of shared impact assessments to ensure any unintended consequences were understood.

Outcomes Committee:

- Agreed to continue the ongoing discussions on the Our Dorset Digital Strategy as it continued to develop.
- Welcomed the update on the New Hospitals Programme with a focus on neighbourhood health which underpinned the programme.

The Board discussed the need for an updated Out of Hospital Estates Strategy to support neighbourhood health, emphasising the need for alignment with local government plans, clear governance routes to facilitate decision-making and delivery across health and local authority partners and capital allocation principles. It was agreed that this be brought to the Board as a future item.

ACTION: Corporate Governance

People Committee:

- Agreed to retain sight of the Freedom to Speak Up data.
- Acknowledged the ongoing staff uncertainty and noted the support/signposting available.
- Noted the two People Committee risks were on the Transition Committee risk register with clear actions to mitigate the risks.

Quality and Commissioning Committee:

- Discussion regarding the ongoing local impact of the closure of Jhoots pharmacies (which was a national issue), particularly in Lyme Regis and Shaftesbury. This was a significant risk however mitigations were in place with assurance that other pharmacies were providing services across the county. Evidence of any harm events would be checked through the national scheme.

The ICB would link with Dorset Council to provide an overview of the mitigation plans, particularly regarding transport issues.

ACTION : PJ/SC

- The committee sought assurance in relation to the importance of carers involvement in out-of-hospital care design and recognising the impact on carers when developing other approaches.
- The committee further developed its understanding of strategic commissioning under the new framework.
- The Committee asked the Outcomes Committee to look further at planned care health inequalities.

Resolved: the Board noted the Committee Escalation Reports.

ICBB25/160 System Integrated Performance Report

The Chief Operating Officer introduced the System Integrated Performance Report.

Key points included:-

- The good performance against the national operational standards, particularly in elective care.
- The challenges in relation to the 62 day cancer standard, urgent and emergency care standards and no criteria to reside.

Ambulance response times had improved following implementation of a 45 minute handover protocol across the trusts however further progress was needed to meet targets.

Access targets for children and young people's mental health services continued to slip. A recovery plan was in place to address. A further update on the trajectory position would be provided in the next report.

ACTION: DSp

Paragraph 3 under Workforce Summary (page 76) relating to substantive staffing would be amended to read DHC rather than DCH.

ACTION: DSp

Workforce controls to ensure delivery on the plan had been reviewed and strengthened, including more stringent vacancy control processes.

Regarding no criteria to reside, a number of substantive appointments had been made, and a reduction was being seen in the patient pathway timeline.

Resolved: the Board noted the System Integrated Performance Report.

Items for Decision

ICBB25/161 Committee Workplans

The Chair introduced the Committee Workplans report which set out the updated workplans based on each committee's objectives within their revised Terms of Reference and, where applicable, agendas from the previous committee over the past year. The respective proposed workplans had been reviewed by each committee and were recommended to the ICB Board for approval.

Resolved: the Board approved the Committee Workplans.

ICBB25/162 Commissioning Intentions 2026-27

The Chief Operating Officer introduced the Commissioning Intentions 2026-27 report.

The Commissioning Intentions had been developed collaboratively with system partners and aligned with the three shifts in the 10-Year Health Plan. Assurance had been taken through the recent ICB Quality and Commissioning Committee.

Alignment discussions had taken place across the BSW, Dorset and Somerset cluster to ensure consistency of approach and to identify any shared 'golden threads'.

The Board discussed market shaping, payment mechanisms, quantifying the intentions, lead model provider, fragility of the voluntary and community sector, capital plans and workforce upskilling.

L Bate left the meeting

Further collaborative work was underway to develop detailed timelines, implementation plans including measurable outcomes to support effective delivery and alignment with strategic priorities.

A draft 5-year plan was planned to be brought to the next Board meeting.

Resolved: the Board approved the Commissioning Intentions 2026-27.

Items for Noting/Assurance/Discussion

ICBB25/163 Medium-Term Planning

The Chief Operating Officer introduced the Medium-Term Planning update.

NHS England had published the medium term planning framework which introduced a shift away from short-term operational focus towards long term, locally-led improvement across the NHS, underpinning the ambitions of the 10-Year Health Plan and long-term NHS sustainability.

A fundamental part of the planning this year was the move from a system plan to organisational plans.

Systems were required to develop three-year operational, workforce and financial plans and five-year commissioning and provider delivery plans.

15 national success measures would underpin performance monitoring through the NHS Oversight Framework.

Initial submissions were due on 17 December 2025 with final versions due to be submitted in January 2026.

Concern was raised that having lots of separate plans could cause confusion within communities and that it would be helpful to have an over-arching plan that pulled everything together.

Resolved: the Board noted the Medium Term Planning update.

Items for Consent

ICBB25/164 There were no items for consent.

ICBB25/165 Questions from the Public

A question had been received from a member of the public as follows:-

Question

On 9 November 2025 the Department of Health and Social Care issued a press release stating that a major new programme, backed by £1.8 million, will see NHS staff receive training to identify patients with Armed Forces backgrounds and provide more targeted, personalised care. How will this be implemented by NHS Dorset?

Response

NHS Dorset is proud that we work with the Veterans Covenant Healthcare Alliance (VCHA) and Royal College of General Practice Veterans Friendly Practice Accreditation Scheme with a 100% of our Practices and Hospital and Community Trusts now accredited. This investment directly supports our staff as the National Armed Forces healthcare training and education programme is being delivered across England, with a dedicated VCHA trainer for each region.

This programme is now in place to support NHS Dorset, and their partners receive the appropriate training and education required to ensure they can develop a **skilled**, **educated**, and **inclusive NHS primary, community and secondary care workforce**, to meet the evolving needs of the Armed Forces community.

VCHA regional trainers and educators will work with and across NHS Dorset, so we are better able to respond and manage care for the Armed Forces community, assisting in the development of delivery of local population health. This Programme will ensure that our veterans and wider Armed Forces Community can continue to access additional support through Op Courage and Op Restore for those impacted by both mental and physical health.

The work of Grove Medical Centre, and other Practices across Dorset who have embraced the General Practice Veterans Friendly Practice Accreditation Scheme connecting our Armed Forces Community and signposting them to other Community Assets to support their wellbeing, reinforces our commitment as a Board to support our Armed Forces Community during this week of Remembrance.

ICBB25/166 Any Other Business

Live inspections were underway in Bournemouth, Christchurch and Poole Council in relation to adult social care and special educational needs. The inspections would involve both local authority and Dorset-wide partners and thanks were extended to colleagues for their partnership efforts.

ICBB25/167 Key Messages and review of the Part 1 meeting

Key messages included:-

- Welcomed the Primary Care Board story which helped frame the later discussion on commissioning intentions.
- Welcomed Dorset Healthcare being announced as one of eight trusts nationally to pilot Advanced Foundation Trust status.
- The suggestion of an Out of Hospital Estates Strategy which could be beneficial for the system.
- The collaborative approach to the development of the Dorset ICB Five Year Commissioning Intentions which included discussion on market shaping, payment mechanisms, quantifying the intentions and workforce upskilling.

ICBB25/168 Date and Time of Next Meeting

The next formal meeting of the ICB Board would be held on Thursday 15 January 2026 at 10.15am in committee room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ.

ICBB25/169 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: 15/01/26

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: 8.1

Subject:	Maternity and Neonatal quality and safety report Quarter 3, October -December 2025 data.
Prepared by:	Lorraine Tonge, director of Midwifery and Neonatal services.
Presented by:	Lorraine Tonge, director of Midwifery and Neonatal services.

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) and Board of Directors of present and/or emerging safety concerns. The report follows the reporting requirement to Trust Boards to meet the Maternity incentive scheme in year 7. It triangulates intelligence from the maternity safety champions reports, maternity quadrumvirate and safety champions, safety champions listening and walkabout events in conjunction with IPR dashboard slides attached to give the board a summary of the key areas of focus for maternity. UHD have an overall continual improvement plan which has been developed to align all national and local improvement drivers into encompassing Ockendon 2022, the 3-year single delivery plan 2023, Saving Babies Lives Care Bundle v3, report , CQC maternity patient survey 2025 , MSSP sustainability criteria and locally identified safety priorities, MIS year 7 maternity self-assessment, Score culture and staff survey improvements. The Trust will continue to report to the LMNS for assurance of progress and on continual improvement in the Mat Neo improvement plan **Areas which demonstrate continuous improvement** • There were no MNSI cases nor any babies having Hypoxic ischemic encephalopathy (HIE).

- Saving babies V3 (new version April 2025) assessment showed that 93% of all safety measures have been implemented

- Mandatory maternity training and overall compliance improvement are seen for all staff groups.

- ATAIN was < 5% this quarter was lower than Regional and National targets sustained improvement

.

- Time to respond to complaints has much improved with the MNVP monitoring the quality of our responses.

- Stable CQC patient survey 2025 with improvements seen from 2024

Areas for continued focus

Stillbirth review

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

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

  The review showed incidental learning re Carbon dioxide monitoring. The review provided assurance that the care was safe, appropriate and in alignment to national standards. Rates have now stabilized in this quarter.

Workforce

- The move to the BEACH building has been extremely positive for patient satisfaction overall. However, the safety champions have met staff members in quarters 2 and 3 who expressed challenges into settling into the new building.

There are four main action plan workstreams put in place:

1. Building and estates defects or alterations required,
2. Patient flow throughout the service,
3. Workforce and new ways of working,
4. Communication with all staff groups.

Support has been given by the patient's first team to have full team involvement. And progress is monitored by the care group.

There has been good progress made in quarter 3 with the completion of estates works, and supporting staff on returning from sickness and with taking breaks during shifts.

	The introduction of patients first huddles with has improved staff engagement in making changes and improvements in their wards Ongoing work continues with patient flow and staff engagement. A Culture plan for 2026 will continue. Intelligence from walkabouts and listening to events suggests that staff are starting to settle into the new unit and enjoy celebrating the first Christmas in the new building.
Background:	The purpose of the Maternity and Neonatal Safety Report is for the Board Level Safety Champion to share emerging guidance for maternity services, provide updates from reviews of published national and local inspection reports, include feedback from women and their families, support quality improvement and escalate locally identified safety issues in Maternity.
Key Recommendations:	To note reports and evidence in trust Board minutes.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☒ Operational Performance ☒ People (inc. Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Maternity quadrumvirate	16/01/2026	Noted and approved through Governance processes.
Safety champions meeting	23/01/2026	Noted and approved through Governance processes safety champions reports
Directorate meeting	20/01/2026	Noted and approved through Governance processes safety champion reports
Care Group Board	23/01/2026	Noted and approved through Governance processes safety champions reports
Quality Committee	03/02/2026	The Committee was assured by 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

MATERNITY AND NEONATAL SAFETY REPORT

QUARTER 3 (OCTOBER –DECEMBER)

Author: Lorraine Tonge

Director of Midwifery and Neonatal Services

REPORT OVERVIEW

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

1.0 PERINATAL MORTALITY RATE

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

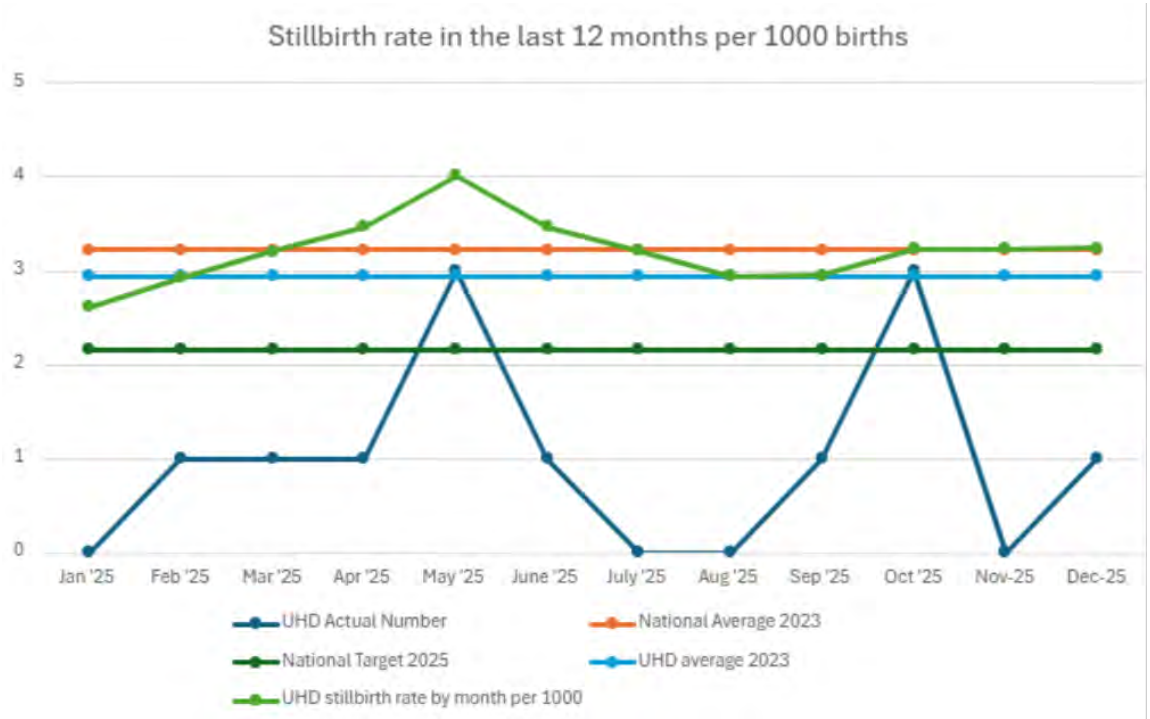


Table 1: UHD NHS Trust stillbirth rate per 1000 births over the last 12 months

Due to an increase identified by UHD of our perinatal mortality cases from December 2024 to June 2025, a thematic review including ethnicity and areas of deprivation has been completed by one of the Consultant Midwives. This review showed no themes identified, with some incidental learning regarding monitoring of CO readings. This learning has been disseminated. The review also provided assurance that the care was safe, appropriate, and in alignment with national standards. There were no cases where a difference in care could have affected the outcome. The outcome of this review was shared at Mat Neo safety champions meeting in November. From July, UHD's stillbirth rate has stabilized and met the national average rate per 1000 births this quarter.

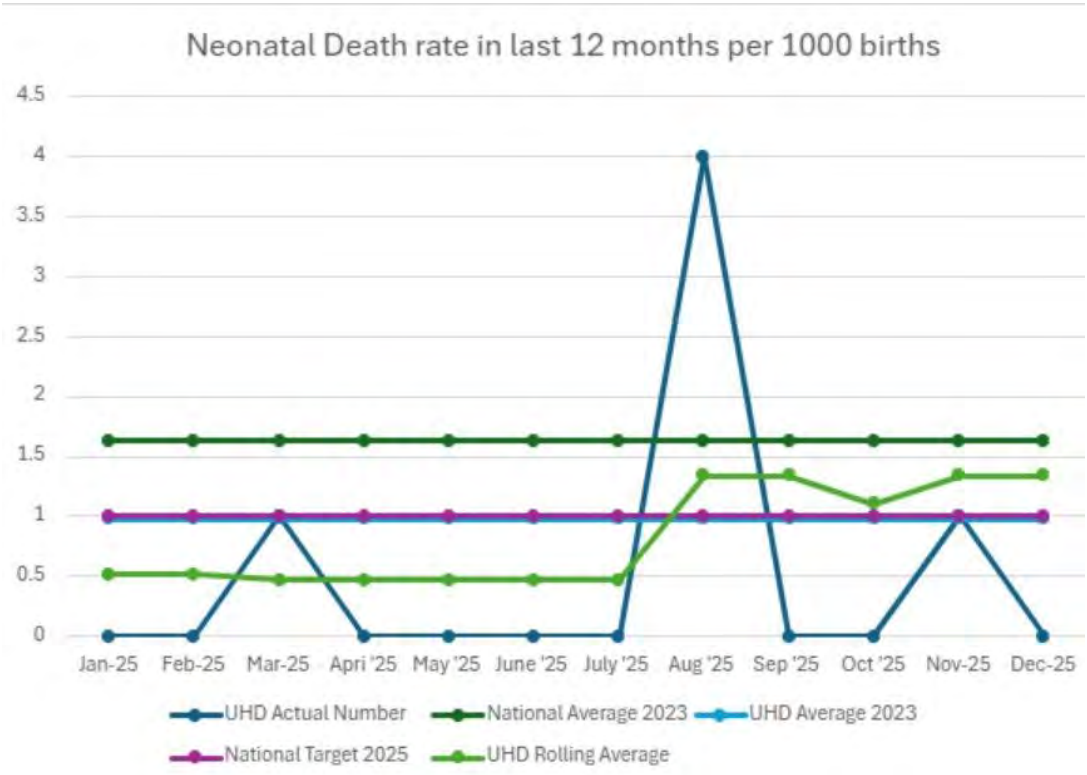


Table 2: UHD NHS Trust Neonatal Death rate per 1000 births over the last 12 months

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

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

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

In Q3 there were four MBRRACE-UK reportable cases; three antenatal stillbirths and one neonatal death (know fetal anomaly and parents opted for comfort care) which met criteria for PMRT review. No cases were eligible for referral to the Maternity and Newborn Safety Investigation program (MNSI). No cases required escalation through PSIRF.

Month	Late fetal loss	Stillbirth	Neonatal death
October 2025	0	2	0
November 2025	0	0	1
December 2025	0	1	0
TOTAL reported to MBRRACE meeting PMRT criteria	**0**	**3**	**1**

Table 3: UHD's cases reported to MBRRACE meeting PMRT criteria Q3 2025/26

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

Of the 4 PMRT reportable cases for Q3:

- 2x White British ethnicity- IMD quintiles 2
- 1x Romanian ethnicity- IMD quintile 3
- 1x Any other background- IMD 1

*All four mothers spoke English.

2.0 PERINATAL MORTALITY REVIEW TOOL (PMRT)

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

All four cases were notified by the Trust to MBRRACE-UK within seven working days. All four families have been or will be informed of the PMRT process and review, and their feedback has, or will be sought. At the time of this report, all four reviews have commenced and are set to be reviewed at the next monthly PMRT review meeting: all meeting the recommended time frame standards.

MBRRACE Case ID	Date of Delivery	Standard a) All eligible perinatal deaths from 1 December 2024 onwards are notified to MBRRACE-UK within seven working days	Standard b) For at least 95% of all deaths of babies who died in UHD from 1 December 2024, parents' informed and perspectives of their care and any questions they have sought	Standard c) Following the death of babies:			Standard d) Quarterly reports should be discussed with the Trust Maternity Safety and Board level Safety Champions
				Standard c) 95% of reviews have been started within 2 months	Standard c) 75% of all reports completed and published within 6 months	Standard c) 50% to include and document the presence of an external member at MDT PMRT review panel	
96374	05/12/2024	Met	Met	01/01/25 Met	05/06/25 Met	Met	Met
96413	08/12/2024	Met	Met	01/01/25 Met	08/06/25 Met	Met	Met
97371	17/02/2025	Met	Met	16/03/25 Met	9/7/25 Met	Met	Met
97727	03/03/2025	Met	Met	12/04/25 Met	29/05/25 Met 1st draft completed & published, awaiting clinical investigation results	Met	Met
98047	02/04/2025	Met	Met	15/04/25 Met	31/10/25 Met	Met	Met
98416	04/05/2025	Met	Met	13/05/25 Met	12/06/25 Met 1st draft completed & published, awaiting 2nd discussion following postmortem	Met	Met
98476	07/05/2025	Met	Met	29/05/25 Met	9/7/25 Met	Met	Met
98683	20/05/2025	Met	Met	28/05/25 Met	31/10/2025 1st draft completed & published, awaiting clinical investigation results	Met	Met
99103	21/06/2025	Met	Met	09/07/25 Met	31/10/25 Met	Met	Met
99186	28/06/2025	Met	Met	29/07/25 Met	31/10/25 Met 1st draft completed & published, awaiting clinical investigation results	Met	Met
99187	26/06/2025	Met	Met	29/06/25 Met	29/10/25 Met	Met	Met
99663/1	01/08/2025	Met	Met	06/08/25 Met	In progress Publish by 01/02/26	Met	Met
99663/2	01/08/2025	Met	Met	14/08/25 Met	In progress Publish by 01/02/26	Met	Met
100116	09/08/25	Met	Met	03/09/25 Met	In progress Publish by 09/02/26	Review panel not taken place yet	Met
100033	28/08/2025	Met	Met	Baby born in different trust so n/a Met	Baby born in different trust so n/a Interim report has been published 19/11/25 whilst waiting for Coroner and SWAST PSII	Baby born in different trust so n/a Met	Baby born in different trust so n/a
100464	27/09/2025	Met	Met	02/10/25 Met	In progress Publish by 27/03/26	Review panel not taken place yet	Met
100716 / MAT-000-178	11/10/2025	Met	Met	31/10/25 Met	In progress Publish by 11/04/26	Review panel not taken place yet	Not yet met- Q3
100955 / MAT-000-364	29/10/2025	Met	Met	Met 3/11/2025	In progress Publish by 29/04/26	Review panel not taken place yet	Not yet met - Q3
101279/ MAT-000-721	21/11/2025	Met	Met	Met 1/12/2025	In progress Publish by 21/5/2026	Review panel not taken place yet	Not yet met - Q3

Table 4: PMRT eligible cases, MIS/CNST period Year 7 (01/12/2024 to 30/11/2025)

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

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

Statutory Duty of candor has been completed in all cases. In cases where feedback from families of their care was received, this was incorporated into the PMRT reviews. All families receive a follow-up postnatal appointment with a consultant to discuss the outcome of their review.

2.1 LEARNING FROM PMRT REVIEWS IN Q3

2.1.1 Summary of PMRT cases reviewed in Q3.

Three PMRT meetings were held in Q3 between UHD and Dorset County Hospital (DCH). A total of seven cases were reviewed, four first reviews (awaiting postmortem and placental histology investigation reports) and three second reviews.

PMRT Meeting	UHD Cases Reviewed
15/10/25	**1: Antenatal Stillbirth diagnosed and delivered 32+2 weeks.** **Case: April 2025 case (Second review).** • Confirmed grading of care: B and A • Cause of death: uteroplacental insufficiency • No family feedback is received. • Actions: Misoprostol given 2 hours early during the induction process, learning shared with team. Drug errors are managed appropriately. • Case closed **2: Antenatal Stillbirth diagnosed and delivered 28+2 weeks.** **Case: June 2025 (Second review).** • Confirmed grading of care: A and A • Cause of death: Trisomy 21 and hypo coiled cord

	• Family feedback not received • Actions: Nil
12/11/25	**1: Neonatal Death 5 hours concealed pregnancy estimated gestation 33-35 weeks.** **Case: August 2025 (first review).** • Initial grading of care: unable to grade care due to complexity of case • Cause of death: To be confirmed • No family feedback has been received • Case ongoing - SWAST have commissioned a Patient Safety Incident Investigation (PSII) to review the aspects of out of hospital care and resuscitation
10/12/25	**1: Antenatal Stillbirth diagnosed and delivered 31+2 weeks.** **Case: October 2025 (first review).** • Initial grading of care: A and A • Cause of death: to be confirmed following receipt of investigations • No family feedback has been received • Case ongoing **2. Antenatal Stillbirth diagnosed and delivered 34+4 weeks.** **Case: September 2025 (First review).** Initial grading of care: B and A • Cause of death: to be confirmed following receipt of investigations • Family feedback has been received • Case ongoing

	3. Neonatal death delivered twins at 22+4 weeks. **Case: August 2025 (First review)** • Initial grading of care: C, A and A • Cause of death: extreme prematurity • Case closed. All antenatal care took place in an External Trust; the external Trust graded the antenatal care as C due to not following National Guidance for Twin cervical lengths. They are in the process of adding this to their policies. **4. Antenatal Stillbirth diagnosed and delivered at 31+6 weeks.** **Case: May 2025 (Second review)** • Grading of care: A, B. Grading changed from initial review (A, A) following receipt of parental feedback which showed a delay in initial prescribing of Mifepristone. • Case of death: maternal vascular malperfusion. • Case closed.

Table PMRT cases reviewed in Q3

It has been agreed locally that any case where care factors were thought to have contributed to the outcome (C or D grading), will be escalated through the Trusts Risk and Governance processes for consideration of further escalation and investigation as part of the Patient Safety Incident Response Framework (PSIRF). Cases meeting MNSI criteria are referred for a separate investigation, alongside the PMRT. No UHD cases reviewed in Q3 met the criteria for further escalation of investigation.

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

Table 6: PMRT grading of care

2.1.2 Saving babies lives V3.2

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

PMRT and Saving Babies Lives V3.2 [4]	Q3
Element 2: Fetal growth – risk assessment, surveillance, and management • 2c: Percentage of perinatal mortality cases annually where the identification and management of fetal growth restriction (FGR) was a relevant issue.	0 out of 4 0%
Element 3: Raising awareness of reduced fetal movements • 3c: Percentage of stillbirths which had issues associated with RFM management	0 out of 4 0%
Element 4: Effective fetal monitoring in labour • 4d: The percentage of intrapartum stillbirths and early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	0 out of 4 0%
Element 5: Reducing preterm births and optimizing perinatal care • 5k: Percentage of perinatal mortality cases annually where the prevention, prediction, preparation, or perinatal optimization of preterm birth was a relevant issue.	0 out of 4 0 %

Table 7: SBLs V3.2 for Q3

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

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

2.1.3 Learning and Actions from PMRT Cases

From April 1st, 2021, all actions generated by the PMRT review process and any additional reviews such as MNSI or PSII, are added to the LERN/Datix system for completion and monitoring. A PMRT Action Tracker has been reinstated since December 2022 for all learning and actions arising from PMRT Cases. All completed actions are archived

Learning/actions from PMRT reviews in Q3:

- Processes for the unwell baby transfer from community to UHD - work in progress.
- The Diabetic team are reviewing the process around obtaining prescriptions of metformin from GPs
- Learning shared through Risky Business: if there are any signs of spontaneous rupture of membranes (SROM), refer to Triage.
- To ensure that Mifepristone prescriptions are prescribed as soon as the patient arrives at the unit, to prevent any delays in administration.
- Misoprostol administration error has been managed appropriately, and learning has been disseminated.

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

3.1 BACKGROUND

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

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

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

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

3.2 INVESTIGATION PROGRESS UPDATE

There were no new incidents which met MNSI criteria in Q3.
There were no ongoing MNSI investigations in Q3.

3.3 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) INVESTIGATIONS

There were was 1 incident escalated for an additional learning response through Care Group Insight group in Quarter 3.

- 6.2L Major Obstetric Haemorrhage (MOH) following a Category 2 emergency cesarean section (EMCS) and hysterectomy in theatre, followed by a transfer to ITU. An After Action Review (AAR) was commenced, which has been further escalated to a Patient Safety Incident Investigation (PSII). This has been commenced with family feedback at the center of the investigation.

There were no ongoing incident investigations (MNSI, AARs,PSIIs) or final reports at the close of Q3.

3.4 LITIGATION

Summary of Litigation Claims in Maternity in Q3

1. **CURRENT POSITION**

- 31 open claims
- 1 further linked claim (primary speciality-Radiology)
- 5 open ENS matters
- 4 open inquest files (2 Maternity and 2 Neonatal)
- 0 open Healthcare Regulatory Matters

2. **ACTIVITY**

The following is a summary of activity in Q3:

- 1 new claim received
- 1 claim settled
- 0 new ENS matters reported

- 0 ENS matters settled
- 0 ENS matter closed
- 0 new Inquest investigations opened
- 0 Healthcare Law Matters received

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

NEW CLAIMS RECEIVED

Description	Cause	NHSR Injury
Alleged failure to correctly suture rectus sheath of caesarean wound leading to dehiscence of the wound.	Operator error	Additional/ unnecessary operation Unnecessary pain

Table 8: New claims

Settled Claims in Q3:

There was 1 claim for women's health that resolved with damages being agreed in Q3.

Description	Damages
This claim related to the alleged mismanagement of ectopic pregnancy which led to rupture of the right Fallopian tube, removal of the right Fallopian tube and psychological harm.	£20,000

Table 9: Litigation Claim resolved with damages being agreed in Q3

CLAIMS CLOSED

No claims were closed in Q3.

EARLY NOTIFICATION SCHEME MATTERS

Summary of the 5 ongoing ENS matters:

- 1 matter opened in 2017, has proceeded to a claim and will be settled in due course.
- 1 matter responded to previously has now become a formal claim, expert reports have been obtained.
- 1 matter responded to previously has now become a formal claim, expert reports have been obtained, and liability has been denied.
- 1 matter- a summit has been held. An outcome letter is in the process of being drafted to the Claimant's mother.
- 1 matter is awaiting a case conference with experts and staff involved.

INQUESTS

There have been no new Inquests for Q3

3.5 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable

4.0 OCKENDEN UPDATE

4.1 OCKENDEN FINAL REPORT UPDATE – Q2 July to September

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

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

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

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

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

Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups is required to be above 90% to fulfil the requirements set out within the MIS. The service is also committed to working towards ‘stretch targets’ as outlined within the CCFv2 which is considered a measure of high functioning organisations

Standard		Expected compliance	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Fetal Monitoring (Module 2)	Obstetric consultants	90%	94.12%	94.44%	94.44	93.33%	100%	100.00%	100%	100%	100%	100%	100%	100%
	All other obstetric doctors contributing to the obstetric rota	90%	95.65%	100%	100%	100%	94.74%	94.74%	100%	100%	100%	85.71%	93.75%	93.33%
	Midwives	90%	97.67%	99.23%	98.73%	98.80%	99.17%	99.22%	99.22%	99.59%	99.66%	99.62%	98.05%	95.61%
PROMPT (Module 3)	Obstetric Consultants	90%	89.47%	94.73%	[illegible]	100%	100%	100%	100%	100%	93.75%	93.75%	100%	100%
	All other obstetric doctors contributing to the obstetric rota (commenced prior to 1 July 2025)	90%	97.14%	[illegible]	82.35%	[illegible]	[illegible]	96.87%	100%	100%	100%	[illegible]	100%	100%
	Obstetric rotational medical staff that commenced work after 1 July 2025	a lower threshold						n/a	n/a	0%	100%	76%	100%	100%
	Midwives	90%	93.79%	85.65%	91.01%	94.44%	94.42%	95.71%	98.78%	98.36%	98.29%	97.52%	98.38%	96.41%
	Maternity Support Workers	90%	90.24%	[illegible]	84.88%	94.87%	83.52%	94.20%	94.18%	90.12%	95%	93.97%	96.42%	96.35%
	Anaesthetic consultants and autonomously practising anaesthetists	90%	92.00%	96%	96%	96%	80.90%	85.71	95%	95%	94.73%	94.73%	100%	100%
	to the obstetric rota (commenced prior to 1st July 2025)	90%	100%	90%	85%	90%	[illegible]	[illegible]	82.75%	82.75%	100%	100%	90.00%	90.47%
	Anaesthetic rotational medical staff that commenced work after 1 July 2025	a lower threshold						n/a	n/a	0%	50.0%	33.33%	75.00%	75%
	Can you demonstrate that at least one emergency scenario is conducted in the clinical area?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area?	Yes	93.36%	92.56%	98.63%	90.13%	96%	96%	96.74%	93.64%	96.36%	93.39%	97.42%	96.28%
Neonatal Basic Life Support (Module 6)	Neonatal consultants or paediatric consultants covering neonatal units	90%	100%	86%	100%	100%	83%	100%	100%	83%	83%	100%	100%	100%
	Neonatal junior doctors (who attend any births) Clinical fellows	90%	100%	100%	100%	100%	100%	94%	100%	50%	50%	100%	100%	100%
	Neonatal nurses (band 5 and above who attend any births)	90%	100%	100%	100%	97%	97%	100%	100%	97%	97%	91%	91%	91%
	ANNPs	90%	100%	94%	100%	100%	100%	100%	100%	100%	93.75%	82.00%	100%	100%
	Midwives	90%	90.31%	81.39%	80.07%	84.90%	92.82%	92.99%	90.68%	91.39%	94.04%	92.97%	95.54%	98.80%
	Nursery Nurses	90%	[illegible]	[illegible]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	All trusts must have an agreed plan in place including timescales for registered RC-trained instructors to deliver the in house basic neonatal life support annual updates and their local NLS courses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Midwife Update Day	Midwives	90%	95.34%	97.67%	98.82%	97.61%	97.21%	96.49%	97.98%	97.54%	97.44%	95.45%	96.40%	91.63%

Table 10: Maternity Training MIS year 7 standards for Fetal Monitoring, Prompt, Neonatal basic life support and Midwife update training compliance.

Compliance

In December Q3 the table above demonstrates that all staff groups were above the 90% requirement as per MIS requirements except for the sub sections as defined by MIS.

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

An Action plan was shared with the Trust Board in Q2 report and currently 75% are trained and on target to meet the plan.

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

Table 11: (Agreed action plan for anaesthetist starting after the 1st of July)

Training Category by Least to Most Compliant

Category	Competence Compliance
Oliver McGowan	51.19%
Safeguarding Adults	52.61%
Safeguarding Children	78.03%
Information Governance	86.03%
Infection Control	87.13%
Prevent (WRAP)	88.18%
Resus	89.22%
Fire Safety	92.28%
Moving & Handling	92.35%
Health Safety & Welfare	92.65%
Equality Diversity & Human Rights	93.38%
Conflict Resolution	94.23%
Patient Safety	95.96%
Total	**82.49%**

Table 12: Cosmos 14/1/26 Mat Neo - Trust core skills and National core skills

There are 3 areas of focus in quarter 4:

1. **Oliver McGowan training** requirement was updated in 2025 with an additional face to face session level 2 for all maternity staff. Due to this additional need staff have found it difficult to obtain a place on training as the Trust demand is high.

Additional sessions are in place for 2026, and it is anticipated the compliance level will improve however expected to take place over the next six months.

2. **Safeguarding adults** training was an additional recorded requirement in 2025, and staff are booking onto sessions.

3. **Safeguarding level 3** is below the expected standard and will be a focus with all teams for improvement in quarter 4 and blended session is incorporated into the maternity update day sessions for 2026.

6.0 BOARD LEVEL SAFETY CHAMPIONS

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

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

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

Challenges range from:

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

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

Actions have that have been taken are

- Senior trust leadership support
- A weekly estates and transformation meeting to address all issues.

- Patient flow MDT working party to address concerns
- Midwifery workforce template reviewed
- Weekly feedback and communication through Quad messages
- Daily walkabouts on the unit by all maternity and neonatal leadership team listening to staff to understand their concerns and feedback actions taken.
- Monitoring of progress will be through Care Group and executive oversight.

Many actions were completed in this quarter with estates and workforce and staff fed back to safety champions more positively in December and celebrated the first Christmas in the new unit.

Patient first improvements boards are now in all areas and huddles each week enabled staff to feel involved in changes in their place of work. The team are currently working on their drivers for 2026

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

7.0 NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q1 2025/26

The service was able to declare full compliance with all 10 Safety Actions MIs year 6 and year 7 in January 2026 as detailed in the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme

	Maternity incentive scheme -safety action detail	Submission MIS year 5	Submission MIS year 6	Submission MIS year 7
1	Are you using the National PMRT to review perinatal deaths to the required standard?			
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
3	Can you demonstrate that you have transitional care services in place to minimize separation of mothers and their babies?			
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?			
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			

6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users			
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			
10	Have you reported 100% of qualifying cases to the Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme.			

Table 13: Declaration for compliance with MIS Year 5 and MIS year 6 and 7

An Assessment with auditors and LMNS in November supported the verification of the evidence provided to declare MIS compliance in year 7.

Full Trust Board reported submitted to complete MIS process for declaration in March.

We will continue to work on all standards and strive to meet MIS year 8 safety standards which are expected to be released in April 2026.

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

SBLv3.2 Progress Summary

Trust: University Hospitals Dorset NHS Foundation Trust

ICB: NHS Dorset

NHSE Region: NHSE South West

% of interventions fully implemented (LMNS Validated)

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

Table 14: UHD Maternity position for implementation of Saving Babies Lives Care Bundle v3 – Q2 was assessed in Q3.

Saving Babies Lives Care Bundle Version 3 implementation was assessed externally by the LMNS using the national implementation tool on NHS Futures. UHD evidenced position in Q2 is reported in table is 93% complete.

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

Due to updated version with the additional standards this quarter overall showed good progress and 93% achievement and working towards 100% embedded standards.

Key areas to focus for improvements outlined in quarter 2 were:

Saving Babies' Lives (Version 3.2) Board Report

Dorset Local Maternity and Neonatal System

Our Dorset

NHS Dorset

Trust	University Hospitals Dorset
Date of review meeting	13/11/2025
Review period	Quarter 2, 2025/26
ICB accountable officer	Pam O'Shea (Interim ICB Chief Nursing Officer)
Trust accountable officer	Peter Wilson (Chief Medical Officer)
LMNS peer assessor name(s)	Vicky Garner (LMNS Lead Midwife)

Executive summary:

- In accordance with the Maternity Incentive Scheme Year 7 requirements for Safety Action 6.3, sufficient progress has been made towards implementing SBLv3.2, in line with the improvement trajectory agreed with the ICB.
- Q3 2025/26 priorities, alongside sustaining improvements, include:
  - Improving exception reporting for intervention 2.19
  - Meeting preterm optimisation targets, ensuring performance and areas of non-compliance are addressed through MDT improvement meetings.
  - Evidence of either significant progress or completion of action plan to meet the requirements of intervention 6.2

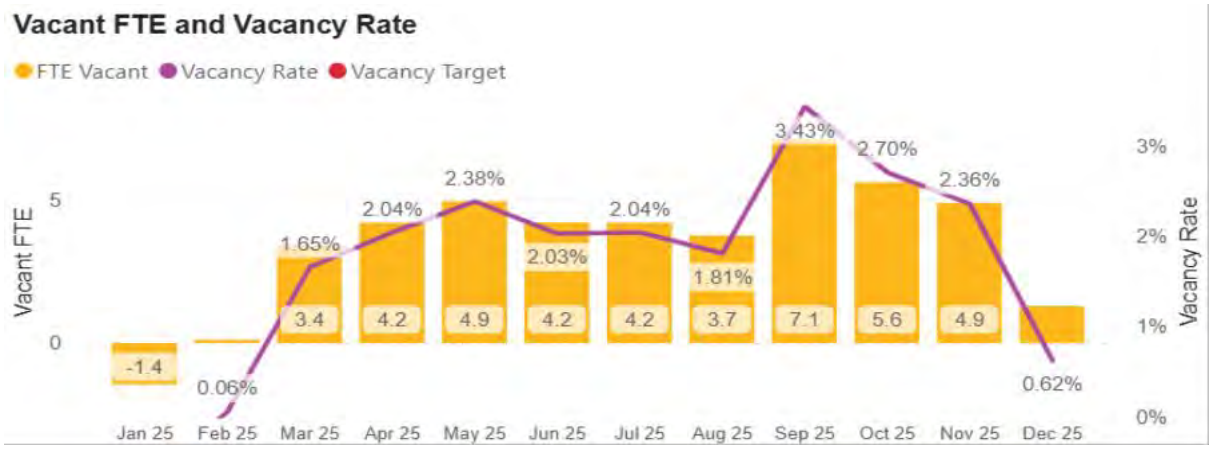
% of interventions fully implemented (LMNS Validated)	Q1	Q2	Q3	Q4
Element 1 Smoking in pregnancy:	90%	90%		
Element 2 Fetal growth restriction:	80%	95%		
Element 3 Reduced fetal movements:	100%	100%		
Element 4 Fetal monitoring in labour:	100%	100%		
Element 5 Preterm birth:	88%	92%		
Element 6 Diabetes:	83%	83%		
Total implementation (all elements):	87%	93%		

Agreed Improvement Activity and Shared Learning

Element 1	• The Q2 target for smokers setting a quit date (Intervention 1.6, Process Indicator 1c) was not achieved, having exceeded the stretch target in Q1. Recommend review exceptions and identify recurring themes to provide context and guide improvement efforts.
Element 2	• Compliance with uterine artery Doppler assessment (Intervention 2.7) reached 94%, reflecting a significant achievement and demonstrating the impact of quality improvement efforts, particularly given previous challenges with this intervention. • Improvement is required in reviewing exceptions for antenatal detection of small-for-gestational-age babies (Intervention 2.19) to provide assurance of processes, learning and identification of any associated harm.
Element 3	• 100% compliance for four consecutive quarters to be celebrated. • Next working day ultrasound compliance (intervention 3.2, process indicator 3b) continues to exceed the minimum target, demonstrating the benefits of the quality improvement efforts.
Element 4	• Element 4 has maintained 100% compliance for four consecutive quarters – a notable achievement deserving recognition. • Quality checks introduced by the Lead Midwife, following updated SBL v3.2 audit requirements, provides additional assurance of fetal monitoring processes.
Element 5	• Evidence received confirming job planning for the preterm birth neonatal consultant and the establishment of improvement meetings. • Targets for optimal cord clamping (Intervention 5.22) and maternal breastmilk (Intervention 5.24) not met. Minimum targets must be achieved in Q3. Any non-compliance with preterm optimisation metrics must be addressed through MDT improvement meetings
Element 6	• An action plan to meet the new requirements of Intervention 6.2 has been received, demonstrating sufficient progress for Q2. Delivery of this intervention depends on updates to clinical guidance and development of SOPs. A progress update is required in Q3, with at minimum, draft guidelines or SOPs submitted as evidence if governance approval is still pending.

9.0 SAFE MATERNITY AND NEONATAL STAFFING

9.1 MIDWIFERY STAFFING



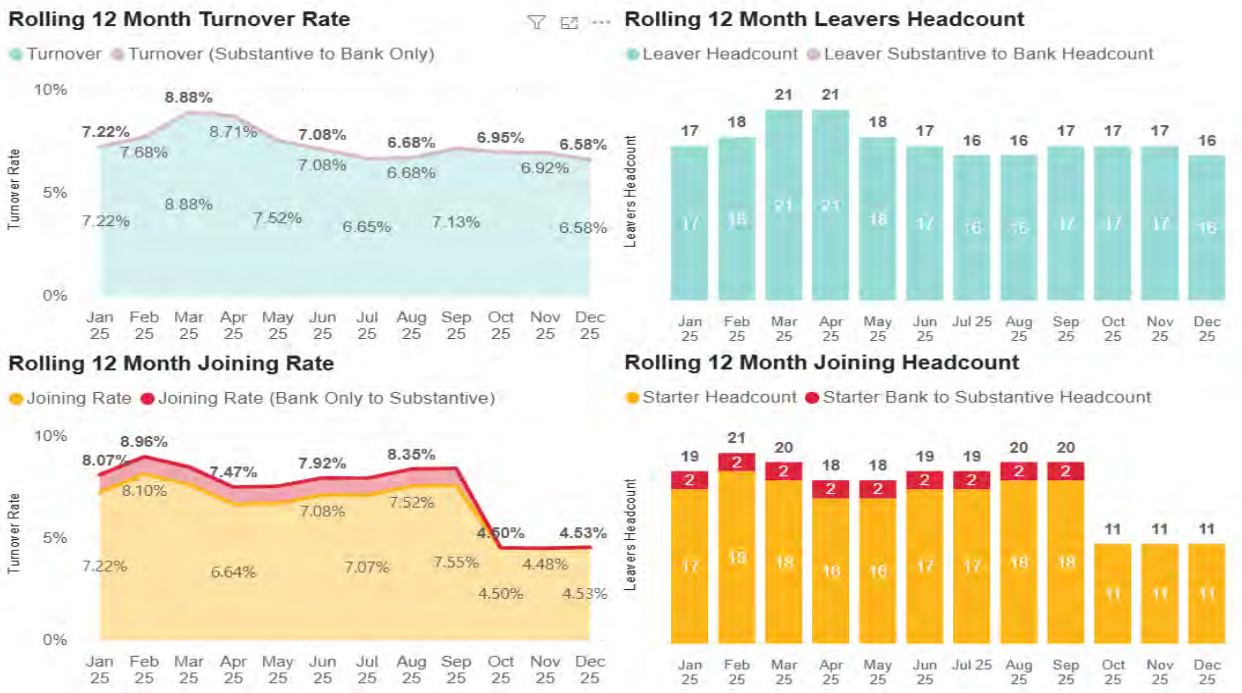


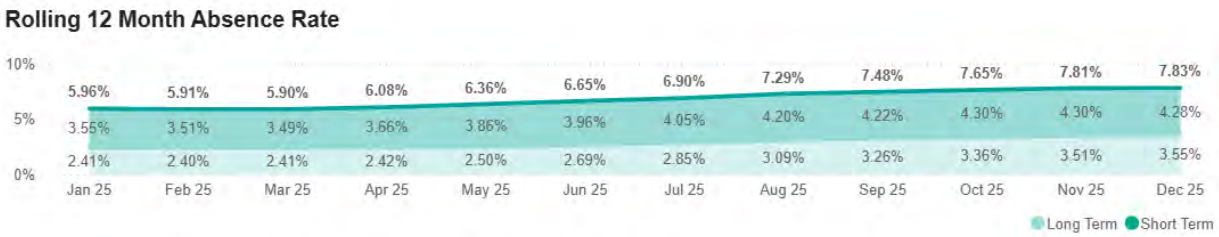
Table 15: Midwifery rolling vacancy and turnover rate -data source COSMOS 8th January 2026

From our data on cosmos, (and data verified through workforce reviews), there has been a reduction in vacancy rates within this quarter. The national average vacancy rate for midwifery in the UK for 2025 was 4% and regionally 4.1%, UHD have remained below this level even when the peak in September occurred – UHD are still able to fill vacancies in a timely manner and have recently recruited from neighbouring hospitals- indicating people are keen to work at UHD.

A paper was presented to the board following concerns raised by staff at listening events, they told us there was gaps in rotas due to sickness and maternity leave (On average 10WTE midwives are on maternity leave.) which causes significant pressures on the workforce. The paper was supported by the safety champions and executive team and 10 WTE posts were approved for one-year fix term contracts. This enabled the appointment of all UHD student midwives who had qualified and expressed an interest to work at UHD.

In this quarter the rolling turnover for midwives has remained similar to the previous quarter but has reduced since early 2025 - the previous high turnover was linked to some staff deciding not to move to the BEACH building at the end of March 2025. The UHD average turnover this quarter is 6.81%, the national average turnover rate for midwifery in the UK for 2025 was 6.2% and regionally 6.4%. One of the improvement drivers within the Mat Neo department is to aim to reduce turnover to 6.2% in 2026.

There is currently a low uptake in staff completing electronic exit forms, but our data shows that staff recently mainly left due to retirement, relocation or fixed term contracts ending. No midwives have left UHD to work for a neighbouring maternity unit within the same role. Nationally the main reason for midwives leaving their post is for retirement.



In Month Sickness Absence Rate by Division

Division	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
⊞ 153 WCCSS Care Group	9.69%	5.90%	5.70%	6.83%	7.69%	6.69%	8.09%	8.99%	8.59%	8.85%	8.33%	8.39%
Total	**9.69%**	**5.90%**	**5.70%**	**6.83%**	**7.69%**	**6.69%**	**8.09%**	**8.99%**	**8.59%**	**8.85%**	**8.33%**	**8.39%**

Table 16: Midwifery absence rate - data source Cosmos portal 14/1/26

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

From the data we can see overall rise in the absence rolling rate in the last 3 months – with a consistent >8% absence rate.

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

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

Absence management is in place and additional support and training by the human resources team is occurring to update line managers skills to support staff in returning to work.

Midwife to birth ratio- safe staffing

Measure	Aim	October	November	December
Midwife to funded birth ratio BR plus	1:23.5	1:23.5	1:23.5	1:23.5
Midwife to actual birth ratio	1:23.5	1:20.9	1:18.9	1:19.8
Supernumerary labour coordinator at start of shift	100%	100%	100%	100%
1:1 care in labour provided	100%	100%	100%	100%

Table 17: Midwifery staffing safety measures

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

9.2 OBSTETRIC STAFFING

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

Table 18: Obstetric staffing safety measures

The recommended Consultant presence on the labour ward at UHD meets the criteria set for units with births less than 4000 as per RCOG guidance 2009 however in addition to this there is an expectation through the Ockenden immediate essential actions that consultants do twice daily ward rounds. To meet this standard the consultants are rostered 12 hours presence Monday to Friday and 5 hours Saturday and Sunday to complete twice daily ward rounds and 100% compliance was achieved in Q3

There are minor gaps in rotas for consultant presence on labour ward, however this is mitigated through the employment of locum consultants. Should there be a gap due to unexpected sickness there is a system in place for escalation, and the consultant team will step into the vacant position. An additional Obstetric consultant is currently in the process to be appointed with interviews booked in the coming weeks. This will ensure the labour ward obstetric rota will be complete.
The resident middle grade doctor rota has 3.6 WTE vacancies. To mitigate the risk of multiple gaps on the out-of-our rota, we are moving from a 1:8 to a 1:7 rota for our middle grade doctors. This may impact training for residents' doctors and GMC feedback in 2026. We will move back to a 1:8 rota when staffing improves.

GMC feedback 2025 showed significant improvements from 2024 for all areas. Excellent for supportive environment, training and supervision. Areas to improve included rotas and time to train.

Compensatory rest is monitored through rosters and continued to be rostered in Quarter 3. Not currently fully compliant and clinical Director looking at long term solutions. Compliance not required in MIS year 7 however standard to work towards for all units.

Alongside these measures in year MIS year 7 additional standards have been set for continuous monitoring to ensure compliance of short term and long-term locums are

meeting the required standard set by the RCOG. This a continuous standard measured and presented through maternity governance for full compliance.

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

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

The Trust is compliant with monitoring of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'.
An audit showing 94% compliance was presented by Consultant Obstetrician Directorate quality and risk meeting in quarter 2. Discussions and learning were shared with the team and the importance of safety reinforced. A further audit will be completed in quarter 4 to ensure standards are being upheld.

Obstetric Consultant job planning and service review has been completed. Obstetric staffing remains on this risk register. This is due minor gaps within the Consultant rotas and 3.6 WTE middle grade posts been vacant. Mitigation are in place and Consultant gaps are covered internally, and middle grade gaps are advertised as Locum.

With the service review there is the requirement for further appointments to address clinical need. Areas identified were the mental health service and increase in planned LSCS. A business cases will be presented at SSG in January 2026 for consideration of extended LSCS lists.

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

9.3 NEONATAL NURSING STAFFING

Neonatal Nursing

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

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

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

As per MIS safety action 4, the Neonatal Matron with the Southwest ODN conducted a review in Q2 using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification

in Speciality (QIS). Compliance with BAPM standards for neonatal nursing is a detailed requirement of MIS safety action 4.

There is currently just 1.72 WTE vacancies in registered nurses within the neonatal unit. It was identified that the current compliance with (Qualified in Specialty) QIS Registered Nurse workforce is 69.6% (against standard requirement of 70%) this has been due to the recruitment of junior (non-QIS) band 5 nurses. 2 nurses are resubmitting assignments for the course. We currently have 2 band 5 nurses currently undertaking the QIS course, with a further 4 nurses starting in February 2026. With these nurses moving to QIS, the QIS registered Nurse workforce will be 83.9% by 2027.

Recent audit of compliance with BAPM standard for neonatal nursing shows that 93.75% of shifts are staffed to BAPM standards. This illustrates the unit's ability to safely admit unexpected babies following delivery and accept repatriations of ITU step downs from the regional tertiary provider as necessary. NNAP data plots UHD nurse staffing to above national average, within the middle 50% of units.

9.4 NEONATAL MEDICAL STAFFING

Measure	Aim	Oct	Nov	Dec
Tier 1 separate rota compliance 24/7 'At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7.'	**100%**	100%	100%	100%
Tier 1 The Rotas should meet European working time directive (EWTD) compliant and have a minimum of 8 Whole time Equivalent (WTE) staff who do not cover general Pediatrics	**100%**	100%	100%	100%
Tier 2 Separate rota compliance 12h per day 'Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day'	**100%**	100%	100%	100%
Tier 2 compliance: significant geographical separation between neonatal and paediatric units 'The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required' Since the 1st of April there has been no call cover from Pediatric service as this remains in Poole site.	**100%**	100%	100%	100%

Planned move in July 2026. Interim arrangement is two ANNPs are rostered to meet safety standards.				
Tier 3 daytime compliance All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year	**100%**	100%	100%	100%
A minimum of 7 WTE Consultants on the on-call Rota with expertise in neonatal care	**Compliant**	No	No	No

Table 19: Neonatal medical workforce standards

The neonatal medical workforce has been reviewed in alignment with the BAPM recommendations, and it was recognised that to achieve the standard, a 1:7 on call commitment from the neonatal Consultants was required. There are six neonatologists and therefore an additional consultant was required. With the support from the safety champions and the executive team, we have appointed the 7th Consultant.

This additional post has also given the opportunity to review job plans and strengthen the leadership roles with the neonatal team and meets the full BAPM standard of 1:7 on call rota in January.

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

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

	October	November	December
Complaints	5	2	1

Table 20: Complaints Q3 25/26

Compliments are received through a variety of sources from the MNVP monthly survey, thank you cards and through friends and family monthly feedback and articles of thanks in the echo. This feedback is given to the members of staff and their line manager to celebrate the good work within the team.

During Q3, 8 complaints were received with a continual decrease from 2024/2025

Themes from complaints identified which were communication, and understanding of clinical processes and delays in pain relief.

Triangulation of complaints with CQC national maternity patient feedback 2025 showed us that communication concerns and pain relief were the main factors affecting service user experience.

10.2 MATERNITY AND NEONATAL VOICES PARTNERSHIP (MNVP)

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

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

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

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

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

In October the **MNVP** and members of the public conducted the 15 steps in the Maternity and Neonatal unit. Positive feedback was given by the group, and the group was pleased to see that actions have been taken already in this new building from previous feedback.

Further suggestions will be added to the overall 15 steps action plan to continue improvements

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

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

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

10.3 CQC maternity (UHD patient feedback) survey 2025

The NHS patient survey programme (NPSP) is commissioned by the Care Quality Commission (CQC) to collect feedback from maternity patients.

The sampes of patients surveyed are those who had the birth of their baby in February. The questionnaires were sent out on and returned from April to July.

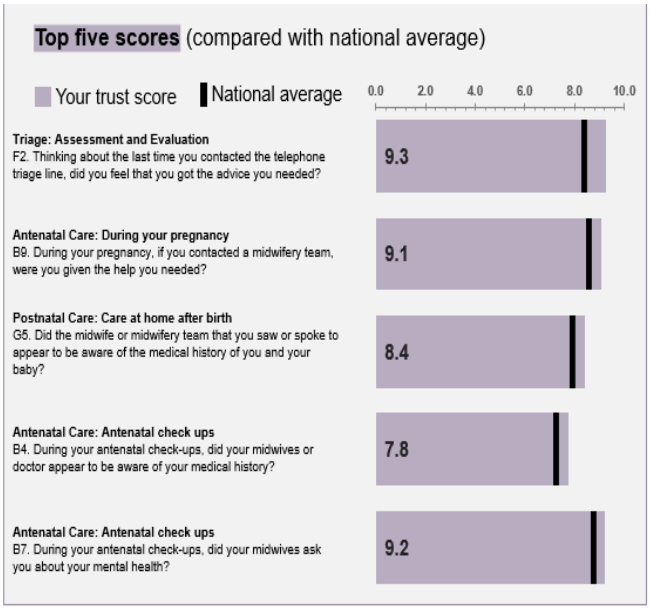
The survey provides an indicator and understanding of quality of services from service users and helps to inform us of the areas for improvement and celebration of good practice.

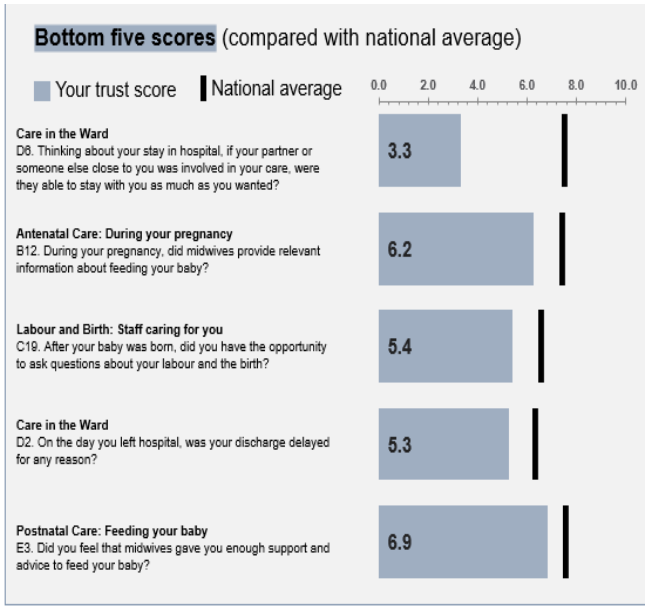
The women surveyed for UHD in 2025 received all their care from the maternity services in St Mary's Hospital Poole.

There was 300 women invited to the survey with 106 responses. (36% response rate UHD and 39% response rate for all Trusts)

The survey results are compared to other Trusts and rated

Best and worst performance relative to the national average





The bottom five areas will be our focus in 2026. However, it should also be noted that the comparable - worse than expected - related to partners not being able to stay in the unit. This is now resolved in the BEACH building, and a significant improvement will be seen in the next survey.

Areas of good practice were celebrated with the teams, and the maternity advice line was recognized for the excellent care they provide.

11.0 PERINATAL CULTURE AND LEADERSHIP PROGRAMME

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

The Quad triangulate the feedback and staff insights, and the focus continued this quarter was on:

Patient flow

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

Postnatal flow

One of the focus areas was readmission of babies <30 days to the maternity unit. A Quality improvement project of starting a wellbeing clinic, to enable an assessment prior to any admission was commenced in November. With the support of the community midwifery team this has had initial successes' significantly reducing admissions in November and December.

Other flow projects are underway postnatally with supporting women in their discharge and preventing delays. This element of pre planning discharges is also supported by our CQC maternity patient feedback.

Review of Stillbirths

The Consultant midwife presented the stillbirth review from the rise seen in quarter 1.

- The review was requested as this quarter showed a rise in stillbirths.
- This was a second review following the PMRT process and findings were discussed with the safety champions.
- The review found that the care provided was safe, appropriate and aligned with national standards.
- There were no themes identified and there were no cases where different care would likely have changed the outcome.
- Since this quarter rates have stabilised and will be continually monitored.

Post Partum Haemorrhage (PPH)> 1500 mls

The maternity team shared the work that is been done to improve the PPH rates. The impact of a PPH is impactful on women's lives and the experience of birth which can have long lasting effects. Each case is reviewed and all learning is extracted.

The team initially focused on wider learning and training which is now completed. However ongoing work with individuals and practice post reviews is now the focus to ensure staff are using all tools available to prevent blood loss.

The consultant midwife and matron for the labour ward with the obstetric lead will continue with this Quality Improvement incorporating theatre teams and trust portering in simulation sessions.

From this intense QI improvements could be seen at the end of this quarter. Ongoing monitoring by the safety champions will continue in quarter 4.

Increase in LSCS
Other areas the quad have focus on are the overall increase in Caesarean sections rate and capacity within theatres. Planned all day lists have commenced for 4- 5 out of 5 days, and business plan is progressing to find a long-term solution.

Psychological safety
Culture plan continued and in October the labour ward leads had a focused session with time away to work with the management team. A key factor from the day was communication and updates to the team. Whilst there was various system in place the clinical leads felt that it was difficult to keep abreast of all changes so a monthly session with HOM and DOM has commenced in November and the team have fed back that they have found this very helpful.

The culture plan for 2026 is being updated and work will continue with all teams.

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

12.1 THE NATIONAL AMBITION

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

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

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

12.2 WHY IT IS IMPORTANT

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

12.3 ATAIN DATA

There has been a focused QI on ATAIN and ATAIN data in Q3 was below both the Reginal Target of ≤ 5% and National target of ≤6%.

There was 43 term admission to NICU in Quarter 3. All cases have been reviewed with the multi-disciplinary team who fund 2 out of 43 cases as avoidable.

The two avoidable admissions were due to respiratory distress.

12.4 Themes identified were:

- Delays in continuing care following induction/augmentation on labour ward
- LSCS at 37 weeks
- Failure to check and set the flow on the recusitaires.

12.5 ATAIN QUALITY IMPROVEMENT

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

QI initiatives commenced in 2024-25
Project 1: Improving the immediate thermoregulation and nutritional management of term babies to reduce admissions to NICU.
This work includes improvements to birth environmental temperatures, skin to skin practices, first feeds and staff training.

QI initiatives commenced in 2025-26
Project 2: The neonatal team have commenced bedside CPAP for 1 hour for babies it may benefit.

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

Plans for 2026 include.

- Continuation of the Warm Bundle work to maintain temperature and blood glucose of newborns.

- Relaunch of Red Hat end of January – This initiative planned to enable staff to easily identify babies requiring additional monitoring post birth.
- We have updated the case review template to capture relevant details and to provide space to capture questions and learning at each stage of the babies' journey through pregnancy, birth and postnatal period.
- ANNP attendance at elective caesarean birth is being considered due to admission rates for these babies.
- Continued work with education of Fetal monitoring including uterine hyperstimulation.

To also reduce admissions of babies to Special care baby unit, during Q3, the Transitional Care service was facilitated 100% of the time with >50% of neonatal care

provision within a Transitional Care Pathway (TCP), providing neonatal care at the mother's bedside.

13.0 Maternity Neonatal Risk Register:

There are 10 Live combined Risks across maternity and neonatal services in Q3: These are all closely monitored. Actions towards closing the gaps have been identified within the individual risk assessments on Datix, and continued mitigation of risk, will be monitored through Specialty and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust Risk framework.

In Holding	ID	Title	Risk level current	Rating current	Increse decrease	
12/25	2183	High Risk Perinatal Mental Health Service	Moderate 8 - 12	8	↑	
12/25	2300	15-year-old Draeger ventilators in use on the neonatal unit	Moderate 8 - 12	12	N/A	
Date opened	**ID**	**Title**	**Risk level current**	**Rating current**	**Increse decrease**	**Review due by**
09/25	2246	Inability to Access a second obstetric theatre	High 15-25	15	⟺	26/01/2026
10/25	2258	Maternity Advice Line (MAL) Provision	Moderate 8 - 12	12	↓	26/01/2026
07/17	1202	Medical staffing women's health	Moderate 8 - 12	12	⟺	02/01/2026
08/24	2098	Elective caesarean capacity	Moderate 8 - 12	10	⟺	02/01/2026
08/24	2100	Maternity Drug Assay in-house testing	Low 4 - 6	6	⟺	23/03/2026
08/24	2097	Viewpoint 6 obstetric ultrasonography package	Low 4 - 6	6	⟺	30/01/2025
01/24	2018	Ventilator on Portable Incubator	Low 4 - 6	6	⟺	06/02/2026
11/23	1995	Baby Abduction systems and processes	Low 4 - 6	4	⟺	30/01/2026

08/21	1648	Neonatal Consultant Rota	Very low 1-3	3	⟺	16/04/2026
09/25	2247	Nursing Qualified in Speciality (QIS)	Very low 1-3	3	⟺	31/01/2026

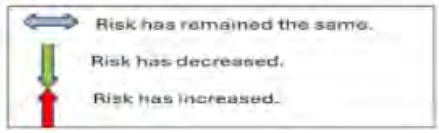


Table Maternity & Neonatal Risk Register

13.1 CLOSED RISKS IN Q3

There were 5 closed risks in Q3

- **Replacement of neonatal ventilators-** was closed in October following review at PSIRF Oversight meeting, as ventilators were still well within the service plan. This risk has been reinstated in December as a new risk.
- **Translation services in the maternity**- was closed as the risk met target grading following a reaudit.
- **Fetal monitoring at UHD**- was closed as the risk met target grading due to the consistent improvement in fetal monitoring compliance. This is continually being audited, monitored and reviewed.
- **24/7 service Labourline-** was closed as the risk is no longer current. This risk has been reinstated as a new risk.
- **Possible memory leak in Badger Net-** was closed as the risk met target grading due to no reported incidences and the risk being owned externally by Badger Net.

13.2 REDUCED RISKS IN Q3

During Q3 there was 1 reduced Risk whilst in the holding area:

- **Risk 2258 Maternity Advice Line (MAL) provision** was initially added to holding as High ‘15’, decreased to Moderate ‘12’ on 24/12/25 and approved as new mitigations in place: Agency in place - 1.8wte post is out to advert and MAL rota is being closely monitored.

13.3 INCREASED RISKS IN Q3:
During Q3 there was 1 increased Risk:

- **Risk 1202 Medical Staffing Women's Health** was increased from Moderate '8', to Moderate '12' was approved on 19/12/25 with mitigations of Rota management, locum cover and consultants cover gaps in registrar rotas.

13.4 NEW RISKS IN Q3

During Q3 there were:
3x new approved risk:

- **Risk 2247, Nursing Qualified in Speciality (QIS),** was a pre-existing risk that was closed briefly and reopened based on Maternity Incentive Scheme (MIS) standards.

- **Risk 2246, Inability to access a second obstetric theatre,** was approved on 25/11/25 as High '15': Mitigations-Protocol to risk assess and summon a second emergency obstetric team to theatres is in place.

- **Risk 2258 Maternity Advice Line (MAL) provision,** was approved on 24/12/25 Moderate '12' (refer to 13.2 above)

2 new risks added to the Risk Register in the holding area:

- **Risk 2183, High Risk Perinatal Mental Health Service, Moderate '8'.** This was a 'live' risk in Q2 but has increased from '6' in Q3 as there is now a gap in consultant cover. Risk mitigations are that there are good links with Perinatal Mental Health Service.1x specialist consultant obstetrician in perinatal mental health needs recruiting into post.

- **Risk 2300, 15-year-old Draeger ventilators in use on the neonatal unit,** Moderate '12'. UHD purchased replacement ventilators in 2024, but it was identified that these were not safe for use. As a mitigation, the old ventilators were repaired and reserviced and in use. This service agreement is due to expire in March.

14.0 RECOMMENDATION

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: 8.2

Subject:	Trust Accountability Framework (Updated)
Prepared by:	Judith May, Director of Operational Performance and Oversight, Truda Scriven, Interim Company Secretary, Claire Mills, Improvement Manager.
Presented by:	Mark Major, Deputy 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)	All
Purpose of paper:	Decision/Approval
Executive Summary:	Subsequent to the delivery of the Corporate Project – Organising for Success, a refresh of the Trust's Accountability Framework has been undertaken. The enclosed paper includes all tracked changes, however the notable changes are: 1. An update to the document with regards to progressing the maturity of the Trust's Patient First implementation 2. Insertion of the updated Patient First triangle on page 9 and breakthrough objectives on page 10 to reflect the revised format for 2026/27. 3. Updated and simplified text with regards to corporate governance – various sections. 4. Corporate Governance structures in Appendix 1 have been updated to align to the 2026/27 Corporate projects. 5. Corrected title for the Chief Digital Officer in the diagram on page 23. 6. Section 10.5 – Trust Management Group, updated in line with the Terms of Reference and to reflect that the Risk Oversight Group and Health and Safety Group reports into TMG. Table on page 44 now includes TMG.

	7. Executive responsibilities table (page 36) amended to remove reference to Health and Safety from CSTO and now soley under CPO.
Background:	The Trust Accountability Framework is critical in supporting the delivery of University Hospitals Dorset NHS Foundation Trust's Annual Operational Plan. It sets out the key enabling structures and processes to support the delivery and achievement of our vision, our strategic themes and objectives, and our key enabling programmes. The current update was jointly undertaken by Corporate Operations, Quality, Governance and Risk and the Corporate Governance team with oversight by Executive Directors.
Key Recommendations:	The Board is asked to approve the current document as the working Accountability Framework for the Trust.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Operational Performance ☒ People (inc Staff, Patients ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Trust Management Group	26/2/26	Approval to recommend to Board following adjustments 6 and 7 above.

Reason for submission to the Board in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐

University Hospitals Dorset
NHS Foundation Trust

ACCOUNTABILITY FRAMEWORK

Version:	Master Version v10
This version issued:	April 2026
Next Review date:	April 2027
Primary Authors:	Judith May, Director of Operational Performance and Oversight and Truda Scriven, Interim Company Secretary

CONTENTS

Appendices

Part A: Overview

1. Introduction

1.1 Effective governance is fundamental to the delivery of safe, sustainable, and high-quality care. Central to this governance is a framework of accountability and performance management, which enables the Board of Directors to fulfil its statutory and regulatory responsibilities and to ensure the Trust is managed efficiently and transparently.

1.2 The Accountability Framework is a key enabler in the delivery of University Hospitals Dorset NHS Foundation Trust's Annual Operational Plan. It establishes the structures, processes, and mechanisms necessary to support the achievement of the Trust's vision, strategic objectives, and priority programmes, ensuring alignment between leadership, operational management, and service delivery.

1.3 By providing clear guidance on roles, responsibilities, and decision-making, the framework supports leaders, managers, and staff in embedding a culture of continuous improvement. It underpins efforts to deliver consistently high-quality services and outcomes for patients, service users, and the local communities served by the Trust.

2. Accountability and Responsibility

A clear distinction between accountability and responsibility is fundamental to effective governance and operational management:

Accountability refers to the individual who is ultimately answerable for a decision, action, or outcome. The accountable person holds final authority, including decision-making powers such as approval or veto, and can be asked to explain and justify the results. Only one individual can be assigned accountability for any specific action or decision, ensuring clarity and transparency in governance.

Responsibility refers to the individual(s) tasked with carrying out or implementing the action. Responsibility can be shared among multiple people and relates to executing tasks to achieve the required outcome. The scope and degree of responsibility are defined and delegated by the accountable person, who retains overall oversight.

This distinction ensures that while multiple staff may contribute to the delivery of tasks, ultimate accountability remains clearly defined, supporting robust decision-making, risk management, and performance assurance across the organisation.

3. The Framework

3.1 The Accountability Framework has been developed in alignment with the NHS Oversight Framework 2025/26 (NHS England, June 2025) and the CQC Single Assessment Framework (SAF, 2025), which incorporates the Well-Led key question alongside Safe, Effective, Caring, and Responsive domains. The framework ensures the Trust optimises the use of NHS resources to deliver high-quality, sustainable, and safe care, while meeting evolving national

regulatory expectations and local system priorities.

3.2 Principles of Deployment

The Accountability Framework is implemented according to the following principles:

- Proportionate and consistent – expectations are applied fairly and uniformly across the organisation;
- Open and transparent – governance arrangements, roles, and reporting lines are clear and visible;
- Respectful and supportive – fostering a culture of learning, constructive challenge, and continuous improvement.

3.3 Objectives

This framework aims to provide timely, accurate, and actionable information to enable the Board of Directors and senior leaders to:

- Understand, monitor, and assess the Trust's performance and quality across clinical, operational, and governance domains;
- Identify early any deterioration in performance or compliance with regulatory standards;
- Recognise, reinforce, and celebrate improvement and innovation;
- Ensure accountability and transparency in decision-making across the Trust.

3.4 Monitoring, Assurance, and Improvement

The Trust's Accountability Framework provides a structured approach to ensure robust governance, transparent decision-making, and continuous improvement in line with the CQC Single Assessment Framework (SAF, 2025). It aligns leadership, operational performance, and quality oversight with the Well-Led quality statements, supporting the Board and senior leadership in fulfilling their statutory, regulatory, and organisational responsibilities.

The table below demonstrates how the framework:

- Links leadership and governance structures directly to key organisational objectives;
- Ensures clarity of accountability across roles, committees, and decision-making processes;
- Provides timely, accurate information for monitoring performance, identifying risks, and driving improvement;
- Promotes a culture of continuous learning and innovation, embedding quality

improvement across all services;

- Supports compliance with statutory and regulatory obligations, including the NHS Oversight Framework and CQC requirements;

- Engages staff, patients, and stakeholders in decision-making, promoting transparency, responsiveness, and trust.

This approach ensures that the Trust is able to proactively manage risk, celebrate improvement, and take early action where performance falls below expectations. The framework is regularly reviewed and updated to reflect evolving governance practices within the Trust and the wider Dorset health and care system, ensuring that it remains relevant, effective, and aligned with national best practice.

Well-Led Quality Statements	How the Accountability Framework will support the Well led Quality statement
We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.	• Our Vision, Values and Strategy have been developed using a structured planning process in collaboration with staff, people who use services and external partners. • By developing a realistic and robust strategy and plan this will inform how we ensure the future sustainability and quality of our services. • Strategic planning and monitoring through our monthly Strategic Deployment Reviews will guide decisions on how we will provide high quality, safe services and how we will allocate resources effectively for optimum benefit. • Effective structures, processes and systems of accountability are in place to support the delivery of the strategy, and these are regularly reviewed and improved.
We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively and do so with integrity, openness and honesty	• Staff at all levels are clear about their roles and they understand what they are accountable for and to whom. • Through our values and behaviours framework, leaders at all levels understand and demonstrate their responsibility to model positive behaviours through leading with integrity, compassion, openness, and honesty. They understand that successful leadership is not just about what they deliver as an organisation, but how it is delivered. • An essential part of leadership is monitoring the effectiveness of systems in place and supporting teams to learn and improve, which is being driven through our Patient First Programme.
We foster a positive culture where people feel that they can speak up and that their voice will be heard	• Staff and patient feedback is a standard agenda item for all governance meetings.
We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.	• Action is taken to address behaviour and performance that is inconsistent with the Vision and Values, and behavioural framework, regardless of seniority. • Staff and teams work collaboratively, share responsibility, and resolve conflict quickly and constructively. • Clear priorities for ensuring sustainable, compassionate, inclusive, and effective leadership are understood.

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate	• The Trust has clear governance, assurance, risk and accountability structures. These interact well with each other and support effective decision making. They provide robust assurance that risks are effectively and sustainably mitigated, and the quality of care is consistently sustained. Staff at all levels are clear about roles and responsibilities. • Accountabilities and responsibilities are clearly defined for individuals and enable effective delegation. • Leaders understand the challenges to quality and sustainability. • There are comprehensive assurance systems and performance issues are escalated appropriately through clear structures and processes. • There are processes to manage current and future performance. These are reviewed and improved. • There is a holistic understanding of performance, which covers and integrates people's views with information on quality, operations and finances. • There are clear and robust service performance measures which are reported and monitored.
We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement	• There are positive and collaborative relationships with external partners which build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs. • There is transparency and openness with all stakeholders about performance.
We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome, and quality of life for people. We actively contribute to safe, effective practice and research.	• Participation in and learning from internal and external reviews – learning is shared effectively and used to make improvements. • All staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes, and performance – this leads to improvements and innovation and is enabled through our Patient First Programme.
We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same.	• Environmental sustainability is recognised in our Patient First objectives and is therefore integrated into accountability and strategic deployment review frameworks.

4 Mission, Vision, Values and Strategic Priorities

4.1 The accountability framework provides a structured mechanism to support the delivery of the Trust's vision and strategic objectives. It defines the governance processes, roles, and responsibilities that enable the Board of Directors and other key personnel to understand, monitor, and assure themselves of the Trust's performance across quality, finance, workforce, and operational domains. The framework ensures that oversight is aligned with both national and local standards, promoting transparency, effective decision-making, and continuous improvement throughout the organisation.

4.2 The accountability framework operates within the broader strategic and organisational context of the Trust, ensuring alignment between governance, decision-making, and delivery of objectives. It is underpinned by:

Our Purpose – The Trust's mission statement, defining why we exist and the outcomes we seek to achieve for patients, staff, and the wider community.

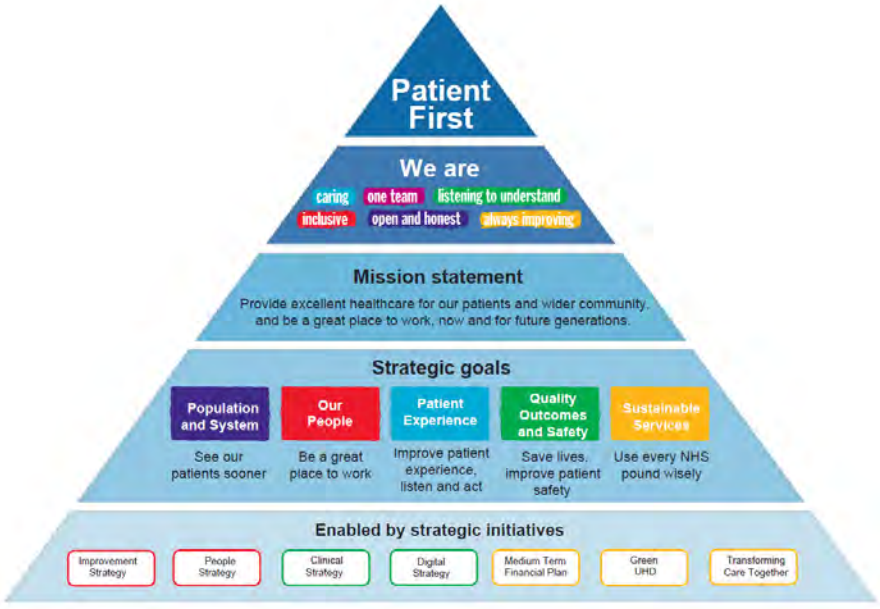
Our Principles – The Trust's values, which guide behaviour, decision-making, and organisational culture.

Our Ambition – The Trust's vision statement, setting out where we aspire to be in the short, medium, and long term.

Our Strategic Approach – The strategic themes, goals, breakthrough objectives, and enabling programmes that define how the Trust will deliver its vision and priorities.

Our Performance Oversight – The accountability framework, which specifies governance mechanisms, processes, and lines of accountability for strategy delivery, and provides the basis for monitoring and measuring progress through robust performance management systems.

This structure ensures that all levels of the organisation are clear about responsibilities, accountable for outcomes, and able to monitor progress towards achieving the Trust's strategic objectives in line with national and local standards.



4.3 Our Mission statement is:

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

This is supported by our vision statement, developed as part of the design phase of the culture programme:

"To positively transform our health and care services as part of the Dorset Integrated Care System"

4.4 Our strategic themes

There are 5 strategic themes:

- Population and System
- Our People
- Patient Experience
- Quality Outcomes and Safety
- Sustainable Services

4.5 Our strategic goals are at Trust level and focus on where we most want to see significant improvements delivered in a sustained way over the next three years. These fit within our Dorset-wide role in the health and care system. The Trust's strategic goals are aligned with the strategic themes, and each has its own long-term vision. Breakthrough objectives describe the short term (next 12months) objectives of the Trust. The annual breakthrough objectives for 2026-27 are summarized below.

Strategic Goal	Vision *LONG TERM:* 7-10 years	Strategic Goal *MEDIUM TERM: 3 - 5 YEARS*	Breakthrough Objective *SHORT TERM: ~1 YEAR*	Driver metrics AND TARGETS
POPULATION AND SYSTEM *Chief Operating Officer* "See our patients sooner"	Consistently delivering timely, appropriate, acces sible care as part of a wider integrated care system for our patients.	Meeting the patient national constitutional standards for Planned and Emergency care, reducing inequalities in outcome and access and improving productivity and value	• To achieve shorter waiting times and improved outcomes for patients as measured by achievement of access trajectories within the operational plan (Planned, UEC, Diagnostics and Cancer.	• 82% of *emergency department attendances admitted, transferred or discharged within four hours* • 7% improvement in *patients waiting 18 weeks or less for elective treatment (18-week RTT)* • 80% of *patients treated for cancer within 62 days of referral*
OUR PEOPLE *Chief People Officer* "Be a great place to work"	To be a great place to work, attracting and retaining the best talent, as measured by the Trust being in the upper quartile for all 7 elements of the People Promise.	• To develop a sustainable workforce measured against the 3 components of staff morale: improving retention, staff feeling supported with sufficient resources, and respected and trusted to do their work	• To improve permanent staff availability across all professions as measured by the reduction in temporary staffing spend.	• To have favourable *variance of WTE against the budgeted establishment* • To reduce *premium (bank) spend* by 15% against the 2025-26 baseline
PATIENT EXPERIENCE *Chief Nursing Officer* "Improve patient experience listen and act"	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	• Rated as Outstanding by CQC as Caring • Over 80% of our employees see patient care as a top priority for UHD • In the top 20% of NHS Acute Hospital Trusts on the 'overall experience' section in all CQC national surveys	• To understand the experience of our patients by actively listening to feedback and using it to inform change in the way we deliver care in a timely way.	• 90% of *total complaints to be closed within 35 days* • 95% for % *of good/very good recorded on FFT* for all areas
QUALITY OUTCOMES AND SAFETY *Chief Medical Officer* "Save lives, improve patient safety"	To be rated the safest Trust in the country and be seen by our staff as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).	• In the top 20% of trusts in country for Hospitalised Standard Mortality Ratios (HSMR) • Rated as Outstanding by CQC for Safety • Decrease severe/moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30% • Over 80% of employees believe the Trust promotes a safety culture • Digital integration across all clinical and operational workflows	• To improve mortality and morbidity across the trust as measured by a 5% reduction in hospitalised standardised mortality rate through an improvement in key morbidity metrics.	• 95% *compliance on VTE prescribing within 24 hours of admission* • To reduce the number of *hospital acquired e Coli infection* by 20% • *Uptake of ICE filing* – improved % sign off on a monthly rolling basis
SUSTAINABLE SERVICES *Chief Finance Officer* "Use every NHS pound wisely"	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	• Return to recurrent financial surplus from 2028/29 • Rated as Outstanding by the CQC for our Use of Resources • Achieve our Green UHD goals of sustainability for people and planet, and 80% carbon reduction by 2030	• To operate within the approved budget, including delivering the budgeted Efficiency Improvement Programme target, with at least 60% achieved recurrently.	• To have favourable *Forecast Outturn Variance to Budget* • To achieve 60% *Forecast EIP Recurrent Delivery*

5 Annual Operational Plan

5.1 The Trust has a high-level single Annual Operational Plan document, supported by a compelling strategic narrative that can be easily understood by patients, staff, regulators and members of the public that outlines our mission statement.

5.2 The strategy of the organisation reflects the wider strategy of the Dorset Integrated Care Partnership (ICP) 2022/23[1], which prioritises prevention and early help, thriving communities, and working better together. For the Trust, founded in October 2020, this involves the redesign of many of its services, the implementation of a complex capital programme and the introduction of a service model that requires the separation of emergency care from planned care. It also involves closer working with Dorset County Hospital to develop more networked services, along with more integrated working with Dorset Healthcare, primary care and local authority partners.

5.3 The Green Plan is the Trust's Sustainability Strategy and is a board approved document. This plan puts the Trust on a path to having 'Net Zero' carbon emissions by 2040, in line with NHS England's goal. It also commits the Trust to becoming a "Clean Air Hospital" by 2026, to deliver against all of the UN Sustainable Development Goals and attain a 100% score by 2030 under the NHS sustainable assessment framework.

6 Our Structure and People

6.1 The Trust manages three main hospital sites in East Dorset: Poole Hospital site, Royal Bournemouth Hospital site and Christchurch Hospital site. We also operate clinical services from the Outpatient Assessment Centre at Dorset Health Village, Poole. Clinical services across these sites are organised into care groups, and with corporate directorates, they are under the overall leadership of the Chief Executive. Each corporate directorate (see section 11.6) is headed by an Executive Director.

6.2 The operational management of the Trust is delivered through 3 Care Groups (Surgical Care Group, Medical Care Group and Women, Children, Cancer and Support Services Care Group) and an Operational Support Group (Clinical Site Management, Facilities, Partnerships, Integration and Discharge, Emergency Planning, Operational Performance and Delivery and Outpatients). Clinical directorates feed into the relevant care groups.

6.3 Equality, Diversity and Inclusion (ED&I) – As a major employer and health service provider, we are committed to building an inclusive workforce which is valued and whose diversity reflects the community we serve. An Equality, Diversity & Inclusion group (EDIG) meets quarterly and is chaired by an Executive Director. This is attended by representatives from across the Trust, including senior managers, union representatives and governors. An update report and tracker on key EDI deliverables are presented regularly to the People and Culture Committee. The responsibility of EDIG is to provide advice to the Chief Executive and Executive Directors on equality, diversity and inclusion matters. It will also monitor the delivery of the Trust's ED&I strategy, advising and agreeing any mitigating or corrective action and/or interventions as appropriate.

[1] Making Dorset the healthiest place to live Joint Forward Plan: 2023-2028

Part B: Corporate Governance

7 Policies, Procedures and Standing Orders

7.1 Governance Documents and Regulatory Framework

The Trust's governance framework is supported by a suite of core policies, procedures and statutory documents, which have been approved by the Board of Directors and define how the organisation operates within the statutory and regulatory environment. These documents establish the principles and obligations by which the Trust conducts its business, ensuring transparency, accountability, and effective control over clinical, financial, and operational activities.

These core governance documents should be read in conjunction with the Accountability Framework and are reviewed regularly to ensure continued relevance and compliance with statutory requirements, NHS England guidance and sector best practice.

The key governance documents include:

- Standing Orders - which set out the procedural rules for the conduct of the Board's business, including the regulation of meetings, quoracy, and decision-making authorities; standing orders are reviewed periodically to reflect legislative and governance developments.

- Scheme of Matters Reserved to the Board and Scheme of Delegation[4] - which clearly defines the responsibilities that are retained by the Board and those delegated to executive directors and officers, including financial limits and operational authority, ensuring clarity of accountability throughout the organisation.

- Code of Conduct - which sets out the standards of behaviour, ethical principles and professional expectations for all staff, supporting a culture of integrity, respect and accountability.

- Standing Financial Instructions (SFIs)[5] - which detail the financial responsibilities, controls and procedures required to ensure probity, accuracy, economy, efficiency and effectiveness in the use of public funds; these instructions are formally reviewed and updated at least annually or as required.

- Risk Management Strategy[6] - which outlines the Trust's approach to identifying, evaluating, managing and reporting risk, providing assurance that risks to quality, safety and performance are appropriately governed.

8 Board Assurance Framework (BAF)

8.1 The Board Assurance Framework (BAF) is the primary mechanism by which the Board of Directors identifies, assesses and manages the Trust's principal risks, those risks that could have a material impact on the achievement of the Trust's Strategic Objectives. It provides a structured link between strategic objectives, principal risks, key controls, sources of assurance and mitigating actions, in line with NHS England's Managing Risks and Issues guidance.

8.2 The BAF forms a core component of the Trust's governance, risk management and internal control arrangements. It supports the Board of Directors in maintaining oversight of the effectiveness of controls in place to manage principal risks, the quality and reliability of assurances received, and the identification of any gaps in control or assurance. The BAF enables the Board to monitor the implementation of agreed action plans and to seek additional assurance where required, thereby supporting informed decision-making and effective risk management.

8.3 Risk Register - The Trust maintains a comprehensive Risk Register to record and manage risks at operational, tactical and strategic levels. Risks are assessed and prioritised in accordance with the Trust's Risk Management Strategy. Risks that exceed the Board of Directors' agreed risk appetite, or which have the potential to become significant risks, are escalated through the appropriate governance structures for review by Executive Directors and Board Committees, and, where appropriate, inclusion on the Board Assurance Framework, in line with established governance and reporting arrangements.

9 Corporate Governance structure

9.1 The Trust has established a robust Corporate Governance Framework which defines the structures, processes and reporting arrangements through which assurance is obtained, and oversight is exercised from operational level through to the Board of Directors. The framework is designed to support effective decision-making, accountability and the delivery of the Trust's strategic objectives, in line with NHS England's governance requirements and the CQC Well-Led framework.

9.2 The Board of Directors is collectively responsible for setting the Trust's strategic direction, ensuring the effective stewardship of resources, and maintaining systems of governance, risk management and internal control. The matters reserved to the Board and those delegated to individual Directors and Board Committees are clearly defined and documented within the Trust's Scheme of Delegation, which is reviewed regularly to ensure it remains appropriate, effective and compliant with regulatory expectations.

9.3 The Trust operates in accordance with Standing Financial Instructions approved by the Board of Directors. These set out the financial responsibilities, controls and accountabilities required to ensure the proper stewardship of public funds, compliance with statutory and regulatory requirements, and the maintenance of effective financial governance.

9.4 The Board of Directors has established a number of Board Committees to support the discharge of its statutory and fiduciary responsibilities and to provide independent oversight and assurance in key areas of activity. Each Committee operates in accordance with approved terms of reference and reports regularly to the Board of Directors. The Trust's

governance structure, designed to ensure clear lines of accountability and effective oversight of business activities, is illustrated in Appendix 1.

10 Committees of the Board of Directors

10.1 The Board of Directors operates a well-established and effective committee structure to support the discharge of its statutory and fiduciary responsibilities. The committee framework is designed to strengthen the Board's oversight of quality, finance, workforce and organisational performance, and to provide structured assurance to the Board on the effectiveness of the Trust's systems of governance, risk management and internal control.

10.2 Each Board Committee operates in accordance with Terms of Reference approved by the Board of Directors and an agreed annual work programme aligned to the Trust's governance and assurance cycle. In support of openness, transparency and effective engagement, Governors may attend Board Committees as observers, with the exception of the Appointments and Remuneration Committee and the Transforming Care Together Group. This arrangement is formally documented within the relevant Committees' Terms of Reference.

10.3 All Board Committees are chaired by a Non-Executive Director and comprise a balanced membership of Executive and Non-Executive Directors, ensuring appropriate independence, challenge and expertise. In line with recognised standards of good corporate governance, the Audit Committee is comprised solely of Non-Executive Directors. The Chair of the Trust is not a member of the Audit Committee and does not normally attend its meetings, thereby preserving the Committee's independence and objectivity.

10.4 The Chairs of Board Committees provide regular reports to the Board of Directors at meetings held in public, summarising the assurance received, key matters considered, and any significant issues or risks requiring Board attention. These reports support transparency, collective accountability and informed decision-making by the Board.

Committee	Responsibility
Appointments and Remuneration Committee	• The Appointments and Remuneration Committee is responsible for overseeing the appointment of Executive Directors to the Board of Directors and for determining the remuneration, terms and conditions of service of the Trust's Chief Officers and those staff employed on Very Senior Manager (VSM) terms and conditions. The Committee ensures that appointment and remuneration decisions are made in a fair, transparent and objective manner, are aligned with the Trust's strategic objectives, and comply with national guidance, contractual requirements and principles of good corporate governance.
Audit Committee	• The Audit Committee meets at least four times in each financial year, and more frequently where required, to discharge its responsibilities effectively. The Committee operates in accordance with Terms of Reference approved by the Board of Directors, which are aligned with the principles and guidance set out in the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook and relevant national governance standards. • The Committee provides independent assurance to the Board of Directors on the adequacy and effectiveness of the Trust's systems of governance, risk

	management and internal control across all areas of activity, including clinical and non-clinical services. Its responsibilities include oversight of the internal audit function, consideration of the appointment, independence and performance of the external auditors, and review of the assurances provided in relation to the delivery of the Trust's strategic objectives and compliance with statutory and regulatory requirements.
Charitable Funds Committee	• The Charitable Funds Committee is formally established as a committee of the Trust in its capacity as Corporate Trustee of the University Hospitals Dorset NHS Foundation Trust Charity. The Board of Directors of the Trust acts as the Board of Trustees for the Charity. The Committee provides assurance to the Trust Board that the Charity is administered and managed in accordance with applicable charity legislation, regulatory requirements and recognised standards of good governance, ensuring that charitable funds are applied appropriately and in support of the Trust's charitable objectives.
Finance and Performance Committee	• The Finance and Performance Committee meets monthly, and not fewer than ten times in each financial year. The Committee provides assurance to the Board and makes recommendations in relation to the development, delivery and monitoring of the Trust's Annual Operating Plan, Productivity and Efficiency Plan, Estates Strategy and Sustainability Strategy, ensuring alignment with the Trust's strategic objectives and system priorities. • The Committee is responsible for the scrutiny of the Trust's financial performance, including detailed review of monthly and year-to-date revenue and capital positions, material variances, and the effectiveness of mitigating actions. The Committee also oversees and monitors performance against key national and regulatory standards relevant to an acute provider, including elective, emergency and cancer access standards, to provide assurance on the Trust's financial balance, operational performance and long-term sustainability.
People & Culture Committee	• The People & Culture Committee meets a minimum of five times per financial year. The Committee provides assurance to the Board of Directors and makes recommendations in relation to the development, implementation, and ongoing monitoring of the Trust's People & Culture Strategy. Its responsibilities include reviewing progress against strategic objectives, evaluating the effectiveness of workforce initiatives, and ensuring that the Trust's people policies and practices promote a positive organisational culture, workforce engagement, and alignment with regulatory and statutory obligations
Quality Committee	• The Quality Committee meets monthly, and not fewer than ten times in each financial year. The Committee provides assurance to the Board of Directors that robust systems, processes, and governance arrangements are in place to support high standards of care across the Trust. • The Committee's responsibilities include: o Overseeing the effectiveness of the Trust's quality and safety framework, ensuring continuous improvement in patient care, clinical outcomes, and the overall patient experience. o Providing assurance that the Trust has appropriate mechanisms to monitor, evaluate, and improve the quality and safety of services across all areas of operation. o Acting as an internal assurance forum to support compliance with regulatory requirements, including the Care Quality Commission (CQC) standards, inspection frameworks, and related statutory obligations.

Transforming Care Together Group	• The Transforming Care Together Group is a time-limited advisory group established to provide strategic input and make recommendations to the Board of Directors and/or relevant Board Committees. The Group supports the delivery of the Trust's Service Ready, Build Ready, and People Ready programmes, ensuring that these initiatives are effectively planned, coordinated, and aligned with the Trust's strategic objectives and operational priorities.
Risk Oversight Committee	• The Risk Oversight Committee meets monthly, and not fewer than ten times in each financial year. The Committee is an executive-led management committee accountable to the Board of Directors

10.1 **Trust Management Group**

The Trust Management Group (TMG) is the main executive leadership group of the Trust. It has 4 elements:

- TMG Strategy Deployment Review
- TMG Business (Performance)
- Risk Oversight
- Health and Safety Group

The TMG SDR and Business meeting cadence runs on the basis of one TMG Strategy Deployment Review meeting per month and one TMG Business meeting. Reporting into our TMG is a series of other groups which provide oversight and/or ensure delivery against specific priorities and objectives.

It is the main "engine room" of the organisation, making recommendations to the Board of Directors through the Chief Executive on matters relating to the strategy of the Trust and the management of its operational services. It ensures that the three Care Groups are fully involved in corporate decision-making, and that the voice of clinicians and professionals from across the organisation is fully considered.

Trust Management Group serves to ensure that there is an effective framework within which assurances can be given across all areas of clinical governance, including quality, safety, clinical safety and clinical effectiveness.

10.6 Terms of Reference and Membership are expected to be in place for all groups identified within our structure, which define their objectives and responsibilities.

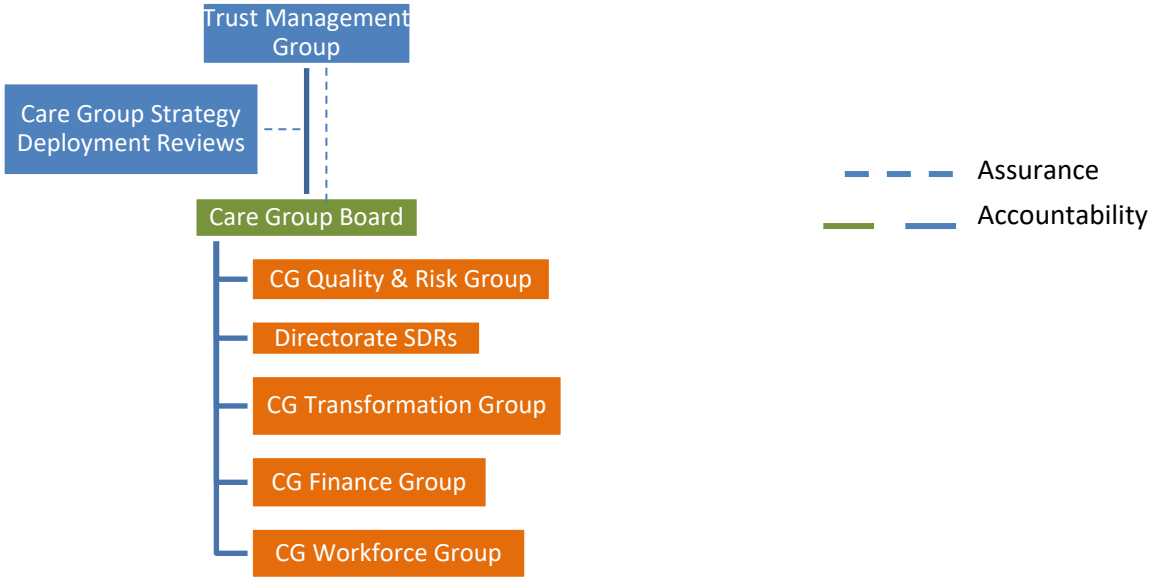
Part C: Care Group Governance

11 Care Group Governance Structure

11.1 Care Groups are expected to have a clear and cohesive structure in place which sets out the framework within which the performance of the Care Group is governed. Whilst it is recognised that Care Group structures need to be tailored to meet the governance needs of each Care Group, as a minimum they must have:

- A clear line of accountability into the Executive Directors through the Care Group Strategy Deployment Reviews (SDRs) (see section 14.3) and Executive Groups as appropriate. **This is part of our Patient First approach.**
- A fully constituted Care Group Board comprising the Directorate Management Team, with documented and approved Terms of Reference and Membership, with meetings being held monthly covering all aspects of Care Group strategy, performance, risk, patient safety, workforce, culture, and quality governance, aligned with our Strategic Priorities (an example template can be found at Appendix 3)
- The following forums held monthly or demonstration of the elements being covered within the governance structure:
    - Care Group Quality and Safety Group
    - Transformation Group
    - Finance Group
    - Workforce Group
- All Groups should have documented and agreed Terms of Reference and membership and are directly accountable to the Care Group Board.
- A forum within which Health & Safety matters are considered, with assurance being provided to the Trust Health and Safety Group. Health and safety may be included in the Care Group Quality and Safety Group, rather than a separate meeting.
- A documented and approved process for the management, escalation and oversight of risk, in accordance with the Risk Management Strategy.
- A regular (weekly) forum within which patient safety incidents are considered, investigated and reviewed in line with the Trust Patient Safety Incident Response Plan.
- Directorate Strategic Deployment Reviews, which align with the Performance Management Framework set out within this document.
- Arrangements to ensure consideration of reports from relevant Executive or Trust-wide Groups to ensure effective flows of information.

The minimum structure required is illustrated below. Where the Care Group is able to demonstrate that the elements below are covered but there is variation to this governance structure, this is permitted.



11.2 Care Group Board – Core Responsibilities

The Care Group Boards have delegated decision-making responsibility for defined areas, within the parameters of annual operating plans agreed by the Trust Management Group (and the Trust's Standing Financial Instructions). They provide assurance to Trust Management Group about progress and performance in defined areas and do the work-up on recommendations to TMG about policy, resource allocation and change plans.

To ensure consistency across the organisation, each Care Group Board has a core set of responsibilities which enable the effective oversight and scrutiny of its Care Group. These are outlined below and are covered within the example template Terms of Reference (Appendix 3).

Strategy

- Oversee development and implementation of strategy and operational plans at a Care Group level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available.
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Trust operational planning process and Patient First.
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Care Group level.
- Oversee the annual business planning process and advise the Board of Directors via Trust Management Group on the distribution of available resources.
- Review progress in delivering the Trust's transformation programme.
- Review and agree specific strategies prior to submission to TMG for approval. This may include the following:
    - The development of clinical services or the strategy on research and innovation.
    - Relationship management with external partners.

Performance

Monitoring of Care Group performance against the strategy is achieved through SDRs; cross-Care Group oversight of Directorate performance is delivered through Care Group Board.

- Oversee the delivery of the annual corporate objectives of the Trust, including the delivery of all financial, workforce, quality, access and other targets and standards.
- Receive assurance on the delivery of strategy and relevant key performance metrics, ensuring the appropriate allocation of resource via SDRs.
- Monitor the operational systems and processes which ensure competent management within the Care Group.
- Identify, delegate and review relevant actions to improve performance.
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Strategy Deployment Review (SDR) process.

Risk Management

- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy.

Patient Safety

- Monitor trends relating to LERNs and patient safety events, ensuring that lessons are learned, and appropriate action is taken. This may be delegated to the Care Group Rapid Review/PSIRF group although the care group board will retain responsibility for oversight.

Quality Governance

- Review clinical governance arrangements within the Care Group in order to be assured that directorates and specialties are holding regular Quality and Safety meetings in accordance with the Trust Quality Governance Toolkit.
- Review quality metrics, sharing good practice and recommend appropriate actions as required to improve performance.
- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate.
- Oversee / monitor implementation of Care Quality Commission actions plans arising from internal / external review, audit, assessment or accreditation.

Governance

- Review governance arrangements and performance, including meeting required clinical standards and recommend appropriate action.
- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate.
- Oversee/monitor implementation of actions plans arising from internal/external review, local and national clinical audits, internal and external assessment or accreditation.
- Approve business cases prior to their submission to the Finance and Planning Group and subsequently submission to the Trust Management Group, Finance and Performance Committee or Trust Board where necessary.
- Undertake an annual self-assessment of effectiveness to inform any changes to Terms of

Reference and Membership.

Part D: Accountability

12.1 Collective Responsibilities of the Board of Directors

The Board of Directors has ultimate collective responsibility for the governance, performance, and strategic direction of the Trust, including:

- Ensuring the delivery of safe, high-quality, and effective care for all patients and service users.
- Setting the strategic direction of the Trust and ensuring that the Executive team has the capacity, capability, and resources to monitor and manage both the quality of care and operational performance.
- Adding value to the success of the organisation and its system partners through effective leadership and decision-making.
- Exercising prudent and robust financial and operational controls to ensure the organisation is well-led, sustainable, and compliant with statutory obligations.
- Promoting and exemplifying the Trust's values and fostering a culture of integrity, inclusivity, and continuous improvement.
- Ensuring that all statutory, regulatory, and governance duties are fully met[7].

The Board of Directors is led by an independent Chair and comprises both Executive and Non-Executive Directors. As a unitary Board, it exercises collective responsibility and accountability, making decisions as a single entity and sharing responsibility and liability for all Board decisions and the overall performance of the Trust.

12.2 Decision-Making Considerations

In exercising its functions, the Board must consider the likely impact of its decisions on:

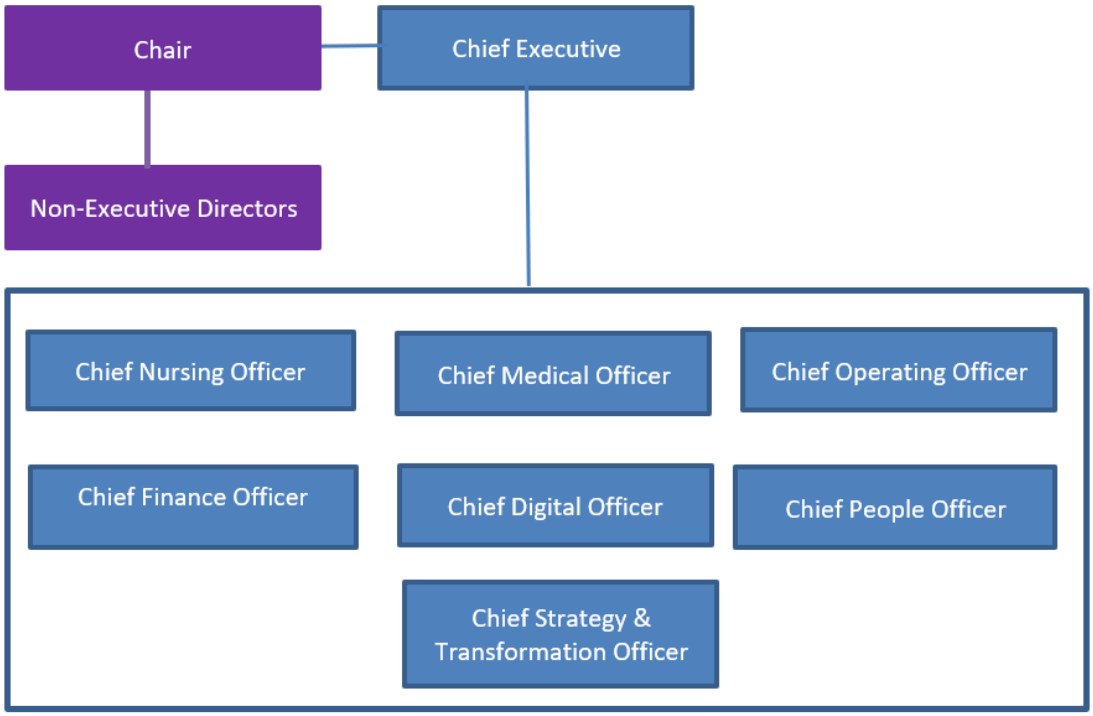
- The health and well-being of the population of England.
- The quality of services provided to individuals by, or under arrangements made by, relevant bodies for the prevention, diagnosis, or treatment of illness as part of the NHS.
- The efficiency, sustainability, and prudent use of resources by relevant bodies within the NHS in England.

12.3 Accountability to the Council of Governors

The Board of Directors is accountable to the Council of Governors. The Governors have a general duty to:

- Hold the Non-Executive Directors individually and collectively to account for the performance of the Board.

- Represent the interests of the Trust's members and the wider public, ensuring that the Trust operates in accordance with its Constitution, values, and statutory obligations.



The table below highlights the distinction between the roles of the Executive Directors and Non-Executive Directors.

	Chair	Chief executive	Non-Executive director	Executive director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose.	Leads strategy development process.	Brings independence, external skills and perspectives, and challenge to strategy development.	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CE to account for delivery of strategy Ensures board committees that support accountability are properly constituted.	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Act as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability.	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for that organisation and ensures that this is reflected and modelled in their own and in the Board's behaviour and decision making Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors.	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their behaviour Provides a safe point of access to the board for whistle-blowers	Actively supports and promotes culture for the organisation and reflects this in their own behaviour
Context	Ensures all board members are well briefed on external context.	Ensures all board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely & clear information to board/directors (and governors for FTs) are clear to executive.	Ensures requirements for accurate, timely & clear information to board/directors (and governors for FTs)	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinician and Staff • Key institutional stakeholders • Regulators	Plays key role as in effective communication and building strong partnerships with: • Patients and public • Members and governors (FT) • Clinician and Staff • Key institutional stakeholders • Regulators	Ensures board acts in best interests of the public Senior independent director is available to members and governors if they are unresolved concerns (FTs)	Leads on engagement with specific internal or external stakeholder groups

11.1 Trust Chair

The Trust Chair is responsible for leading the Board of Directors and for ensuring its overall effectiveness in setting the strategic direction, culture, and governance of the Trust. The Chair is accountable, through NHS England, to the Secretary of State for Health and Social Care for providing leadership to the Board and for ensuring that UHD NHS Foundation Trust delivers high-quality, safe, and sustainable services and achieves value for money within available NHS resources.

Leadership and Culture

The Chair provides visible, values-based leadership and is responsible for fostering a culture that promotes openness, transparency, compassion, and continuous improvement. This includes championing the Trust's values, leading by example, and ensuring that equality, diversity, and inclusion are embedded across the organisation for patients, staff, and stakeholders.

Governance and Decision-Making

The Chair promotes the highest standards of integrity, probity, and corporate governance throughout the Trust, with particular responsibility for the effective functioning of the Board of Directors. The Chair leads the Board in establishing clear, effective, and timely decision-making processes, ensuring constructive challenge, collective accountability, and acting as the guardian of due process.

Quality, Performance, and Sustainability

The Chair ensures that the Board maintains appropriate oversight of quality, safety, performance, and financial sustainability, providing assurance that robust systems of control and risk management are in place to support the delivery of high-quality care and value for money.

System Working and Partnerships

Working in close partnership with the Chief Executive, the Chair provides strong and cohesive leadership of the Trust within the wider health and care system. This includes representing UHD NHS Foundation Trust within the Dorset Integrated Care System and working collaboratively with system partners to support agreed system strategies and service transformation priorities.

11.2 Non-Executive Directors

Non-Executive Directors (NEDs) provide independent oversight and challenge to the Board of Directors, ensuring that robust governance arrangements are in place and that executive decisions are scrutinised effectively. While they are not involved in the day-to-day operational management of the Trust, NEDs play a critical role in supporting the Board to deliver strategic objectives, improve outcomes for patients and the public, and uphold the organisation's values and statutory obligations.

Key responsibilities include:

- Acting as guardians of corporate governance, ensuring that the Board operates with integrity, transparency, and accountability.

- Providing constructive challenge to the Executive Directors, holding them to account for the performance of the Trust, including quality, safety, operational delivery, and financial stewardship.

- Contributing expertise, experience, and independent judgement to the development and oversight of the Trust's strategy, ensuring alignment with system priorities and regulatory expectations.

- Supporting the Board in fostering a positive culture, promoting inclusivity, equality, and diversity, and ensuring that patient-centred care remains at the heart of decision-making.

- Serving as a bridge between the Board and the wider community, helping to ensure that the Trust remains responsive to the needs and expectations of patients, staff, and stakeholders.

- NEDs bring a breadth of knowledge and experience to the Board, enhancing its collective capacity to oversee the organisation effectively, ensure compliance with statutory and regulatory requirements, and drive continuous improvement in care quality and organisational performance.

In line with NHS England's guidance, "Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles", the Trust has appointed Non-Executive Director (NED) Champions to provide focused oversight, strategic insight, and expert input in key areas of organisational governance.

The purpose of the NED Champion roles is:

Area	Committee/Group	Role description
Security Management	Audit Committee People and Culture	Designated Non-Executive Directors provide independent oversight and strategic input on the Trust's approach to security management, which encompasses counter-fraud measures, prevention and management of violence and aggression, and the protection of the Trust's assets and estates. Strategic oversight of anti-crime activities is provided by the NHS Counter Fraud Authority, while oversight of violence and aggression prevention falls within the remit of NHS England. The designated Non-Executive Director Security Champion is responsible for promoting a comprehensive and proactive approach to security management across the Trust. This includes: • Ensuring that robust systems, policies, and processes are in place to protect patients, staff, assets, and information.

Area	Committee/Group	Role description
		• Providing independent scrutiny and challenge of security-related risk management and assurance arrangements. • Supporting relevant Board Committees in overseeing specific aspects of security, including anti-crime and violence and aggression prevention, to ensure compliance with statutory and regulatory requirements. • Promoting a culture of safety, awareness, and accountability in relation to security across the organisation. Through this role, the Security Champion strengthens the Board's oversight of organisational risks, contributing to the delivery of safe, secure, and well-managed services in line with national guidance and regulatory expectations.
Maternity Safety	Quality Committee	In response to the findings of the Morecambe Bay Investigation (2015), the role of a Board-level Maternity Champion was established through Safer Maternity Care (2016), which recommended that "Senior trust managers will want to ensure unfettered communication from 'floor to board' by appointing a board-level maternity champion." The role aligns with subsequent recommendations from the Ockenden Review (2020) and national maternity safety guidance. The Non-Executive Director (NED) Maternity Champion acts as a conduit between staff, frontline safety champions (obstetric, midwifery, and neonatal), service users, Local Maternity System (LMS) leads, the regional Chief Midwife, the lead obstetrician, and the Trust Board. The Champion ensures effective communication, promotes learning, and highlights both challenges and successes in maternity services. Key Responsibilities of the NED Maternity Champion The NED supports the Board Perinatal Safety Champion by: • Providing independent, constructive oversight and challenge to the quality and safety of maternity services. • Ensuring that the Board-level Safety Champion is appropriately resourced to carry out their responsibilities. • Challenging the Board to reflect on and respond to the quality and safety of maternity services. • Ensuring that the views and experiences of patients, families, and staff are actively heard and considered in decision-making. The Board-level Safety Champion:

Area	Committee/Group	Role description
		• Maintains a curious, questioning approach to understanding the quality and safety of maternity services. • Collaborates with frontline safety champions to draw on multiple sources of intelligence, including patient and staff feedback, audit outcomes, and incident reports, to develop a comprehensive view of service performance. • Provides regular updates to the Trust Board on matters requiring Board-level oversight or action. Assurance and Oversight • The NED Maternity Champion utilises approaches such as appreciative inquiry and the Maternity Self-Assessment Tool to provide assurance that the Trust delivers safe, high-quality maternity care. This role supports compliance with the National Staff and Patient Safety Initiatives, including the NSR Maternity Incentive Scheme Safety Action 9, which references the Board-level Safety Champion function. • Through this role, the NED strengthens Board oversight, promotes a culture of continuous learning, and ensures that the Trust's maternity services consistently meet national safety and quality standards.
Wellbeing guardian	People and Culture Committee	This role was established in response to the overarching recommendation from Health Education England's 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission, 2019) and subsequently embedded in policy through 'We Are The NHS: People Plan 2020/21 – Action for Us All'. The NED Staff Wellbeing Champion is responsible for promoting and challenging the Trust to adopt a compassionate and inclusive approach that prioritises the health, wellbeing, and psychological safety of all staff. The role supports the Board in embedding a preventative, proactive approach to staff wellbeing that addresses inequalities and ensures that workforce health is considered in all decisions. Key responsibilities include: • Providing independent oversight and challenge to ensure the Trust actively promotes staff health, wellbeing, and engagement across all levels. • Supporting the Board in embedding wellbeing as a core part of organisational culture, strategy, and operational planning. • Encouraging preventative measures and initiatives

Area	Committee/Group	Role description
		that reduce workplace stress, tackle inequalities, and promote resilience. • Acting as a visible advocate for staff, ensuring their experiences, concerns, and feedback are understood and addressed by the Board. • Supporting the development of sustainable wellbeing practices, with the expectation that, as wellbeing becomes embedded into routine Board decision-making, the requirement for specific oversight from the Wellbeing Guardian will reduce over time. The Guardian community website and associated resources provide guidance, tools, and best-practice examples to support the NED in fulfilling this role effectively.
Freedom to Speak Up NED Champion	People and Culture Committee	The Robert Francis Freedom to Speak Up Report (2015) highlighted the need to create a supportive, open, and transparent culture in which staff feel empowered to raise concerns about patient care, safety, and organisational practice. In line with these recommendations, all NHS trusts are expected to appoint a Freedom to Speak Up (FTSU) Guardian to provide staff with an independent, impartial, and clearly defined route for raising concerns. The Non-Executive Director (NED) FTSU Champion role is distinct from that of the Guardian but provides critical board-level support and oversight. The NED Champion: • Acts as an independent voice and advocate for staff raising concerns, promoting a culture in which openness, transparency, and psychological safety are embedded across the organisation. • Works closely with the FTSU Guardian to ensure that issues raised are communicated effectively to the Board of Directors, enabling informed oversight and timely action. • Provides constructive challenge to the Executive team on matters related to raising concerns, the Trust's response, and the overall culture of openness and accountability. • Raises questions and seeks assurance when concerns are not being addressed, ensuring that systemic issues are identified and resolved. • Supports the Board in monitoring trends, outcomes, and lessons learned from concerns, contributing to continuous improvement in patient safety, staff engagement, and organisational governance. The FTSU NED Champion, together with the Guardian, strengthens the Board's assurance that the Trust maintains a safe and transparent environment for speaking up and ensures compliance with national standards for staff

Area	Committee/Group	Role description
		empowerment and patient safety. A full description of NED responsibilities can be found in the FTSU supplementary guidance.

The Trust has appointed a Non-Executive Director (NED) Engagement Champion to provide independent oversight, support, and constructive challenge regarding the Trust's approach to stakeholder and public engagement. The Engagement Champion ensures that the development, implementation, and delivery of the Trust's engagement strategy are effective, transparent, and aligned with the organisation's strategic objectives.

The role of the Engagement Champion includes:

- Providing assurance to the Board that stakeholder and public engagement is meaningful, inclusive, and supports continuous improvement in service design and delivery.
- Offering independent challenge and guidance on the effectiveness of engagement activities and their impact on decision-making.
- Supporting the Trust's Equality, Diversity, and Inclusion (EDI) agenda, including oversight of strategy, implementation, and progress against planned improvements.
- Acting as a conduit between the Board, staff, patients, and the wider community to ensure that stakeholder perspectives are heard, considered, and incorporated into planning and service delivery.
- Promoting a culture of inclusivity, transparency, and accountability in the Trust's engagement and EDI activities.

Through this role, the Engagement Champion strengthens Board assurance, supports effective governance, and helps ensure that the Trust delivers services that are responsive, equitable, and reflective of the needs and views of patients, staff, and the public.

11.3 Chief Executive Officer

The Chief Executive Officer (CEO) holds overall executive responsibility for the leadership, management, and performance of the Trust. The CEO is accountable to the Board of Directors for the delivery of strategic objectives and operational performance, and, as Accountable Officer, to NHS England for the Trust's stewardship of public funds, compliance with statutory requirements, and overall organisational performance.

Key Responsibilities

The CEO is responsible for:

- Corporate Governance and Internal Control: Maintaining a sound system of internal control that supports the achievement of the Trust's objectives, ensures effective management of risks, safeguards public funds, and protects departmental assets.

- Financial Stewardship: Ensuring that the Trust is administered prudently and economically, with resources applied efficiently and effectively, and that robust arrangements are in place for the discharge of statutory functions.

- Risk Management: Ensuring that comprehensive risk management frameworks are in place across all organisational, clinical, and financial activities, including the identification, assessment, and mitigation of key risks.

- Strategy and Delivery: Supporting the Board in the development of the Trust's strategic vision and organisational objectives, modernising and improving services, and ensuring that plans and objectives are implemented effectively.

- Performance Oversight: Monitoring progress towards strategic and operational objectives, ensuring timely, accurate, and meaningful reporting to the Board using reliable data and management systems.

- Executive Leadership: Agreeing objectives for the senior executive team, reviewing their performance, and ensuring that leadership capacity and capability are aligned with the organisation's priorities.

Through this role, the CEO provides strategic direction, operational oversight, and executive leadership to ensure that the Trust delivers high-quality, safe, and sustainable services in line with national standards, regulatory requirements, and local system priorities.

11.4 Executive Director Level Leadership and Oversight

The Chief Executive leads a team of Executive Directors who (i) provide professional advice and support (ii) take functional responsibilities that have been delegated to them. An Executive Directors' meeting – including the Medical Director for Integrated Care (who also attends meetings of the Board) occurs weekly and its purpose is to ensure all executives are up to date on issues that affect the Trust internally and externally and to ensure there is robust strategic development and operational plans in place to facilitate the achievement of the Trust's objectives and Board of Directors' decisions. The role of Executive Directors is not to take decisions that should properly go to the Board Committees.

The table below outlines the key areas of accountability and responsibility for the Trust's Executives.

	Chief Executive Officer	Chief Finance Officer	Chief Medical Officer	Chief Nursing Officer	Chief Operating Officer	Chief People Officer	Chief Strategy & Transformation Officer	GP Exec lead	Chief Digital Officer
Executive Team Portfolio's - Trustwide Responsibility	NHS FT Accounting Officer	Strategic and Operational finance	Professional leadership of medical staff	Professional leadership of nurses, AHPs, and wider healthcare professionals	Operational management	HR management	Corporate strategy and strategic planning	Primary care risk and complaints	Digital including digital strategy and business
	Freedom to Speak up	Financial strategy, planning and modelling	Outcomes and clinical effectiveness / GIRFT	Integrated governance	Performance delivery	Recruitment, retention and reward	Estates & Capital Development	Primary care communications	Information Governance/ Data protection
		Capital planning and prioritisation	Patient consent	Policy management	Performance reporting and management	Bank and agency	Annual planning	Integrated clinical pathways inc Advice & Guidance and referral pathways	Freedom Of Information
		Financial reporting and external audit	Clinical networks	Risk management	Business change / service improvement	Employee relations	Annual Report	Primary Care IT	CISO Chief Information Security Officer (Cyber security)
		Cash and treasury management	Innovation, research and development	Infection prevention and control (DIPC)	Productivity improvement	Organisational development	Clinical Services strategy	Engagement GP Alliance, PCN and LMC	EHR (with CMO/CNO)
		Commissioning and contracting	Responsible officer for appraisal and revalidation	Patient safety, experience and engagement	Business continuity and emergency planning (EPPR)	Staff engagement	Partnerships (Bournemouth University, Networks)		Senior Information Risk Owner (SIRO)
		Procurement	Medical education	Safeguarding, children, adults at risk, Prevent (SAMA, LADO)	Complex Discharge Team	Education, training and, development	Health inequalities		
		Commercial Development	Medical workforce planning	Voluntary services	Site management and security	People strategy	Build Ready		
		Payroll	Medical workforce compliance	PALS and complaints	Facilities (Catering, portering, housekeeping)	Workforce planning	Transforming Care Together Programme		
		Counter fraud	Patient First (Continuous improvement)	Litigation, claims and insurance	Transforming Care Together Service Ready	Leadership development	Sustainability (Green UHD)		
		Internal audit	Guadian of Safe working	Maternity Safety Champion	Strategic and annual demand and capacity planning	Staff health and wellbeing (inc Occupational Health)			
		CIP management and delivery	Caldicott Guardian	PSIRF, Mortality		Communications & Public engagement			
		National and local financial insight and intelligence	Human Tissue Authority licence lead	CQC registration		Equality, Diversity and Inclusion			
		Business cases	Medicines Management	Nursing and AHP professional compliance (NMC, HCPC)		Health and Safety inc Violence and Aggression			
		Business Intelligence	Radiation protection (IRMER)	Workforce planning Nursing, Healthcare science and AHP					
		UHD Charity	Integrated Neighbourhood teams	End of Life lead					
		Clinical Coding	Mortality	Mental health					

*Red denotes statutory responsibility.

12 Care Group Accountability

It is intended that the main axis of accountability for line management, service and budgetary performance will be vertically through the Care Groups and directorates, with the horizontal responsibilities of all Care Groups being for standard setting, quality assurance and ensuring consistency of service across the organisation.

13.1 Care Group Leadership (Tri/Quadrumvirate)

(Care Group Director of Operations, Care Group Medical Director, Care Group Director of Nursing/Maternity)

Within each Care Group, a leadership triumvirate has been established, with the exception of the Women's, Children, Cancer and Support Services Care Group, where the role of the Director of Maternity is an integral part of a quadrumvirate at Care Group Level and the

individual holding this role is also an attendee of the Trust Quality Committee.

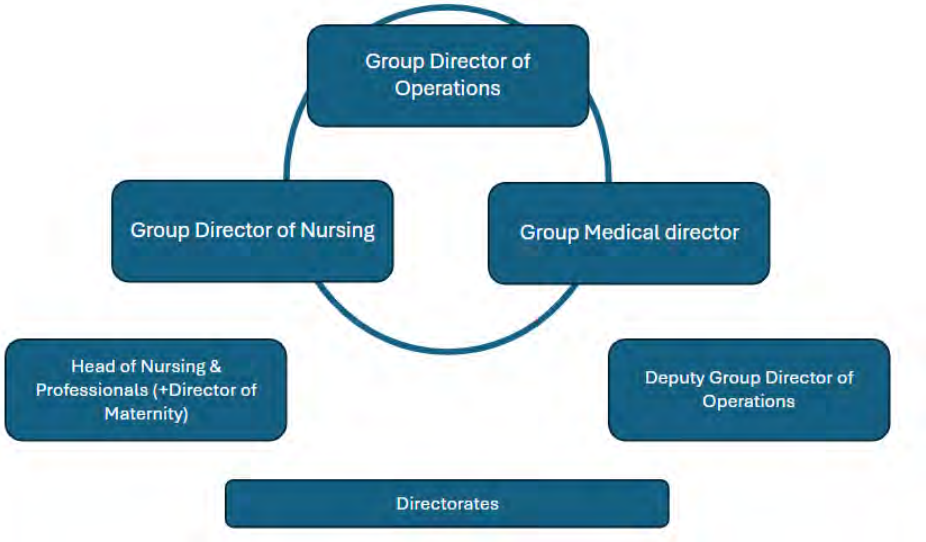
Our Care Group tri/quadrumvirates comprise of a Care Group Director of Operations (GDO), Care Group Medical Director (GMD), and Care Group Director of Nursing (GDoN) as well as leads from Human Resources, Finance, Operations, Information, Transformation and Informatics. The GMD and GDoN will be managerially accountable to the GDO. The structure has been designed to support the delivery of the vision and strategic themes, goals and breakthrough objectives for the Trust, through devolving leadership and accountability to a local level, at the same time as ensuring that there is a mechanism for driving standardisation across hospital sites and that there is appropriate Trust level oversight. Clinical services delivered through the Care Groups are viewed as *one service in multiple sites* with a single leadership team. The tri/quadrumvirate team's role is to ensure the delivery of services and performance across all sites within the Trust and includes services provided across Dorset.

All tri/quadrumvirate individuals have responsibility and accountability for all aspects of their Care Group performance (quality and safety, finance, workforce, transformation and operational performance). Each of the Care Groups is accountable under 'collective managerial and professional leadership' to the Chief Operating Officer, Chief Nursing Officer and Chief Medical Officer who hold the tri/quadrumvirate leaders in each Care Group to account for the delivery of Care Group specific key performance indicators. Although the professional lines of accountability as follows, also exist:

- Care Group Medical Directors are professionally accountable to the Chief Medical Officer,
    - Appraisal and objective meetings will be jointly carried out by the Chief Medical Officer and the Group Director of Operations

- Care Group Directors of Nursing are professionally accountable to the Chief Nursing Officer.
    - Appraisal and objective meetings will be jointly carried out by the Chief Nursing Officer and the Group Director of Operations

Group Structure



The mechanism through which Care Groups are held accountable for delivery is through

Strategy Deployment Reviews (SDRs), which are led by the Executive Team. The tri/quadrumvirate have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight and co-ordination of performance within and across all Directorates. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Executive Team key areas of risk that may affect delivery of organisational objectives and strategy. They are also responsible for reporting on areas of improvement and worthy of celebration.

13.2 Care Group Leadership

(Deputy CG (Care Group) Director of Operations, Heads of Nursing & Professions, Clinical Directors)

Supporting our Care Group tri/quadrumvirate and overseeing our Directorate Teams is our Care Group Leadership comprising Heads of Nursing and Professions, Clinical Directors and Deputy Directors of Operations. These individuals have responsibility and accountability for specific aspects / services within the Care Group portfolio (as well as deputising for Care Group Leadership). They are directly accountable to the Care Group Tri/quadrumvirate.

13.3 Directorate Leadership

(Clinical Directors, Senior Matrons, Directorate Managers)

Each of our Directorates is led by a Clinical Director, Senior Matron and General Manager. The General Manager has overall accountability for the Directorate. The Directorate Triumvirate has responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics, and the governance, oversight and co-ordination of performance within and across their Directorate. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Care Group Leadership Team key areas of risk that may affect delivery of organisational objectives and strategy. They are also responsible for reporting on areas of improvement and worthy of celebration.

Clinical Directors and Senior Matrons have designated leadership roles in relation to health and care professionals at a specialty level. They have key responsibilities and accountability for ensuring effective clinical and quality governance and that the values and professional standards are instilled within their workforce. They ensure that their teams are aware of and contribute to the organisation wide ambitions and promote essential standards to be delivered. Directorates are held accountable through Directorate Strategy Deployment Reviews (SDRs). The Directorate Leadership Team is accountable for supporting managers / leaders within individual wards and departments, who manage and lead our frontline staff on a day-to-day basis.

- Directorate Clinical Directors are professionally accountable to the Care Group Medical Director and managerially accountable to the General Manager.
    - Appraisal and objective meetings will be jointly carried out by the Care Group Medical Director and the Group Director of Operations

- Directorate senior matrons are professionally accountable to the Head of Nursing & Professions.
    - Appraisal and objective meetings will be jointly carried out by the Head of Nursing and Group Director of Nursing

13.4 All Staff

All staff have a responsibility for performance management and improvement, relevant to their role and are supported to identify improvement opportunities and to act as required, which is being enabled through the Patient First Programme. Specific and generic roles and responsibilities are outlined within all job descriptions.

Part E: Performance Management Framework

13 Performance Management

Performance management is integral to our Corporate and Care Group Governance Structure. We have agreed a broad range of metrics which form the basis of our performance management framework. Our metrics are based on our strategic priorities and consider all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching vision, enabling strategies and to address key areas of risk.

As part of the evolving Patient First Improvement Programme within the Trust these metrics are prioritised accordingly, and divided into three types:

- Driver metrics
- Watch metrics
- Discretionary Watch metrics

Type of metric	What is the purpose?	What happens to them?
DRIVER METRICS	Something we are trying to directly drive change on through our improvement effort	These are on the scorecard, and business rules are applied
WATCH METRICS	Something we are watching for any changes (+ or -) as a result of our improvement effort	These are on the scorecard, and business rules are applied
"OTHER" DISCRETIONARY WATCH METRICS	Something we are watching as required for: • operational BAU oversight and/or; • to provide context to another metric (watch or driver) and/or; • as a mandated or regulatory requirement.	These are on the scorecard, and business rules are applied, but they do not go to SDR meetings unless there is thought to be an issue and either a Care Group or Exec wants to raise it for consideration

A clear and agreed set of business rules are applied to the metrics consistently, to ensure that countermeasures are taken against performance deterioration as necessary, and that the proper scrutiny is applied. These business rules are attached as Appendix 4, and are broadly determined by the combination of:

1. The level of variation and any statistically significant special causes as identified through Statistical Process Control (SPC) charts, which:

a. Alert us to a situation that may be deteriorating.
b. Show if a situation is improving.
c. Demonstrate how capable a system is of delivering a standard or target.
d. Show if a process that we depend upon is reliable and in control.

2. Assurance against the target

14.1 Patient First Scorecard

A Patient First SDR scorecard is the main depository for data against the key driver, watch and discretionary watch metrics and is used to provide assurance on the strategy deployment at Trust, Care Group and Directorate/service level. This allows the Trust to identify both:

- Areas of performance to be actively worked on to improve, achieve and sustain an identified target, and
- Areas of performance which still require monitoring and reporting and will continue to be addressed through 'Business as Usual (BAU)' but not actively 'problem solved' as a team unless the business rules dictate a change.

The principle of having focus on specific metrics is a recognition of the limits to our resource and therefore this ensures that by identifying a smaller number of priorities we can ensure sufficient focus on addressing root causes and implementation of sustainable solutions, services doing well and those requiring further improvement and escalation to the Care Group Board or Executive Team.

Separate reporting mechanisms may exist for any mandated or statutory reporting requirements or where they form part of a wider Dorset system, Regional or National report.

14.2 Board/Committee/Executive Performance Oversight, Scrutiny and Accountability

Effective scrutiny relies on the provision of clear summary information through a range of documents. At Board/Committee/Executive level these include:

- An Integrated Performance Report (IPR)
- Strategy Deployment Review scorecard
- Corporate and Care Group Project Highlight reports
- A3 problem solving and Countermeasures Summary reports
- Speciality and ward level finance, quality and workforce reports.
- Board assurance framework and risk management (risk register) reports
- External reviews and inspection reports and associated action plans

The graphic below illustrates, at a high-level, the 'Ward to Board' reporting structures which reflect the clinical services of the Trust and the performance reporting arrangements that support the scrutiny of performance within each tier of the organisation.

The **Board's** responsibility for the performance of the organisation is enacted through scrutiny and monitoring of performance documented within the **Integrated Performance Report (IPR)**. The **Integrated Performance Report** is owned by the Executive Directors and is presented to the Trust Board each month. This, along with a selection of other assurance reports agreed by the Board as part of their annual Business Cycle, form the basis upon which Executive Directors are held to account.

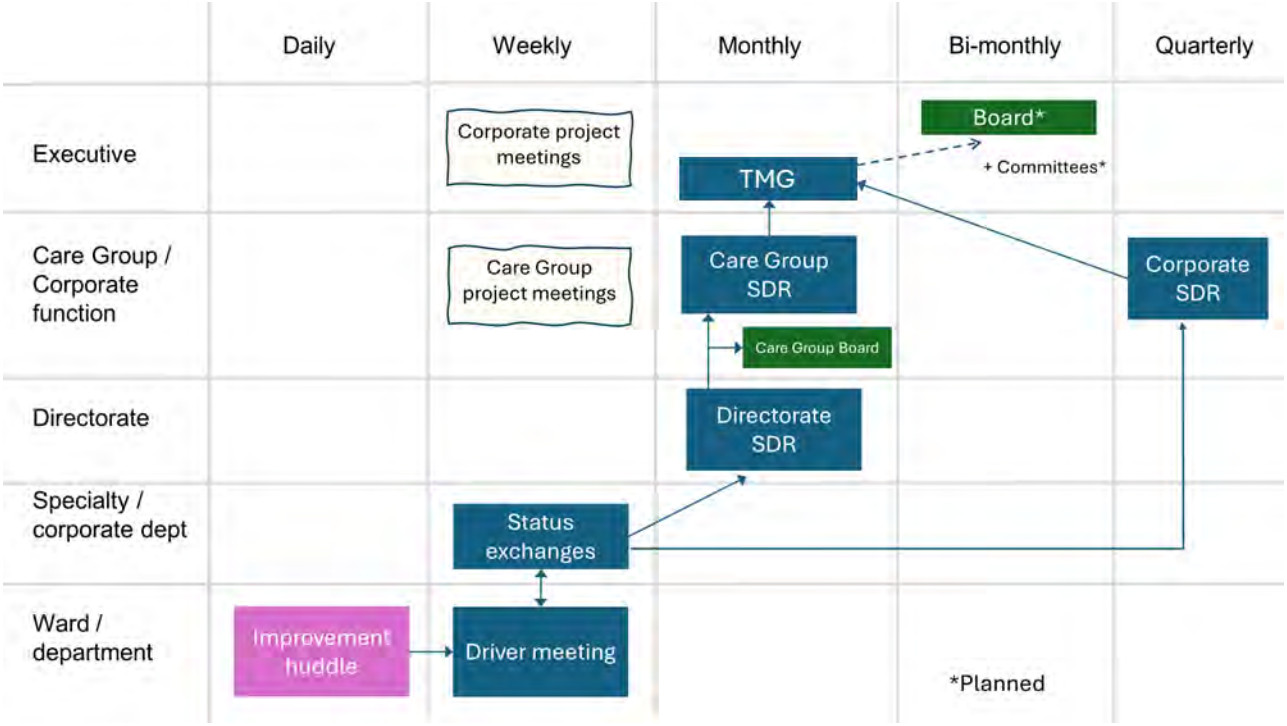
For **Committees** reporting to the Board the lead Executive Director presents reports for oversight and scrutiny. These reports (or the information within them) are generally scrutinised in the first instance through our Groups, according to their Terms of Reference.

There are also "Gemba[2]" opportunities for non-executive directors and executive directors to demonstrate coaching, support and accountability at all levels.

14.3 Strategy Deployment Reviews (SDR) – TMG, Care Group, Directorates and Specialties

The cadence of this 'Ward to Board' structure is summarised in this section.

[2] Gemba is an approach taken within Patient First action of going to see the actual process, understand the work, ask questions, and learn.



TMG Strategy Deployment Review (SDR) meetings (part of TMG arrangements) are held monthly and attended by Trust Executives, Corporate Directors and Care Group Triumvirates. Their purpose is to review progress:

- on corporate projects; and
- in creating enabling strategies, and deployment thereof.

Care Group Strategy Deployment Review meetings are held between the Care Group Leadership Team and the Executive Directors. The purpose of these meetings is to review the deployment of the agreed strategy for the organisation. These are the formal checkpoint at which Care Groups are held to account for delivery of the Breakthrough Objectives and agreed care group projects. The reviews seek to ensure that each Care Group is balancing patient safety, quality and staff wellbeing with financial and operational delivery and the overall sustained transformation and improvement of the Care Group.

Care Group Strategy Deployment Review meetings are held monthly, chaired by an Executive Director, and involve all Executive Directors and other nominated attendees. They use the Patient First scorecard and the business rules to ensure they are focused and effective.

Critical issues from Care Group SDRs will be escalated to TMG or other relevant forum, as required.

There is an annual “catchball” process run between Executive Directors and Care Groups prior to the start of each financial year. The purpose of this is to negotiate on the basis of the Trust’s operational plan and strategic objectives, the:

- metrics which the organisation or Care Group identify or are required to measure, and the targets thereof related to each of the strategic themes: Population and System; Our People; Patient Experience; Quality Outcomes and Safety; and Sustainable

Services

- improvement projects that the Care Group wants to achieve.

The catchball process also brings awareness of the corporate projects and the Care Group contribution to these, and any necessary transformation work. These areas are the focus of SDR meetings throughout the year.

Directorate Strategy Deployment Review meetings

These meetings are held between the Care Group Leadership Team and Directorate leadership. They hold Directorates to account for delivery of their share of the Care Group's performance using the Patient First scorecard. They review the maturity of the Patient First Improvement System within their Directorate, and use a coaching approach to problem-solving

Critical issues from Directorate SDRs will be escalated to the Care Group SDRs or other relevant forum, as required.

Specialty level Strategy Deployment Review is undertaken by the Directorate leadership through a series of weekly "Status Exchanges" which are short, focused meetings to enable two-way flow of information, with a standardised agenda. This process is supported by Specialty scorecards, which will be hosted in a central repository and maintained by the Specialties.

Overview of Performance Management Framework

Performance management forum	Accountability	Frequency	Performance information
Trust Board	Non-Executive Directors hold Executive Directors to account	Monthly	Integrated Performance Report (IPR)
Trust Board Committees	Non-Executive Directors hold Executive Directors to account supported by subject matter leads	Monthly/Bi-Monthly/Quarterly	Quality, Patient Safety, Risk, People and Culture, Finance and operational performance reports – as appropriate to the remit of the Committee
Trust Management Group	Executive Directors monitor the performance of the Trust holding members to account.	Twice Monthly	Integrated Performance Report (IPR) with standing items on operational performance, finance, workforce, quality & safety.
Care Group SDR	Executive Directors hold Care Group Boards to account.	Monthly	SDR scorecard driver and watch metrics
Care Group Boards	Care Group Boards scrutinise the holistic delivery of care within their Care Group, using appropriate information and agree actions as required	Monthly	SDR scorecard driver and watch metric and other relevant reports including Quality, workforce, transformation and finance reports as appropriate
Directorate SDR	Care Group Boards hold directorate/ speciality teams to account.	Monthly	SDR scorecard driver and watch metric and other relevant reports as appropriate
Specialty Status Exchange	Directorates hold Specialties to account	Weekly	Specialty scorecard used on a weekly basis to underpin focused conversations or “Status Exchanges” between the leaders

14.4 Quality and Safety

The Trust has an established governance structure which is outlined in the Trust Risk Management Strategy and Quality Governance Toolkit. Quality reporting through these structures supports review, analysis and delivery of key metrics related to patient safety, patient outcomes and patient experience. Quality and safety reporting is structured around the CQC domains of Safe, Caring, Responsive, Effective and Well Led. Board and Board sub-

Committee reporting supports and integrates with wider quality assurance processes such as peer review, annual self-assessment and internal and external audit.

Similar to the Board and Quality Committee reports, Care Group and Directorate Quality and Safety reporting will routinely include:

- Risk issues, mitigations and action plans.
- Patient and staff safety reports, LERN and Patient safety incident response plan (PSIRP) trends, actions and earning.
- Patient experience reports including patient feedback, patient engagement and patient surveys
- Patient outcome reports including compliance with national guidance (e.g. NICE), national and local clinical audits.
- Internal Quality assurance reports and ward accreditation progress reports for wards and clinical areas in the Care Group
- External Quality assurance reports (and associated action plans) including accreditation and peer review reports from professional and regulatory bodies including the Care Quality Commission
- Mortality data review
- Internal comparisons and external benchmarks where available.
- Directorate, specialty, ward level safety and quality data where appropriate.

14.5 Finance

Each year the Trust is required to operate within a set of financial parameters agreed within the Dorset Integrated Care System and with its regulator, NHS England. Achievement of this agreed financial plan is a crucial annual objective for the Trust.

Devolving financial decisions to those individuals and teams best placed to make them is a key part of the Trusts financial management process and supports strong and appropriate financial governance. This is supported by appropriate training and guidance for budget holders, including, but not limited to, the Trusts Standing Orders, Scheme of Delegation and Standing Financial Instructions.

Each year the Trust will undertake a comprehensive operational planning process. Care Groups and Corporate Directorates will be required to fully support and engage with this process and sign off their resulting annual budget. This ensures that the overall resources available to the Trust are appropriately prioritised and delegated prior to the start of the financial year. It also allows financial risks and opportunities to be identified and managed.

This budget sign-off process will require physical signatures as follows:

Care Groups	Corporate Directorates
Chief Finance Officer Chief Operating Officer Group Director of Operations	Chief Finance Officer *(Chief Executive for Finance, Commercial and Business Intelligence Directorate)* Corporate Chief Officer

Each month, the Trust is required to submit detailed financial returns to NHS England and report its financial performance through the Finance and Performance Committee to the Board. This reporting includes detailed analysis of the in-month and year-to-date position,

together with the forecast for the remainder of the financial year.

Oversight of financial issues and metrics forms an important part of the Trust's performance management and accountability arrangements. Accordingly, a suite of driver and watch metrics forms part of the SDR scorecard for each Care Group and scrutiny is led by the Chief Finance Officer.

It should be noted that any material failure to deliver on the part of one Care Group or Corporate Directorate may require other areas of the organisation to take additional action, to support the collective achievement of the overall Trust financial plan.

14.6 Workforce

Oversight of the key people and culture issues and metrics forms an important part of the Trust's performance management and accountability arrangements. Accordingly, a suite of key performance indicators forms part of the SDR scorecard for each Care Group and scrutiny is led by the Chief People Officer.

14.7 Transformation and Improvement

The progress of the Transforming Care Together programme is governed by the Reconfiguration Ready Group (RRG), Build Ready Group (BRG), People Ready Group (PRG) and Move Ready Group (MRG), each of which report into Trust Management Group. Assurance is provided by the Transforming Care Together Group. Build, Reconfiguration, People and Move, Ready groups all have an associated plan with an identified critical path and progress against objectives and critical path actions (CPS's) are monitored though the groups above. Critical path actions are also monitored via Care Group SDR reviews.

Each group has a clear escalation process into TMG. The Reconfiguration Ready Group is supported by the Planned Care Hospital Group and the Emergency Care Hospital Group which undergo regular 'Advise, Alert, Assure' reviews to ensure risks and issues are appropriately escalated if needs be. Delivery of Transforming Care Together forms part of the UHD 'Sustainable Services' Patient First strategy.

Underpinning transformation delivery is a Service and Gateway review process with a risk-based approach to gateways, whereby high-risk services or those 'red' rated against KLOE's (i.e. those requiring more intervention) require more frequent review than those rated 'Green' or 'Amber'. All services are required to undertake a Gateway 3 ('Go/No-Go') review before moving into a new location, with higher risk services requiring Gateway 1 and/or Gateway 2.

Delivery of clinical benefits of the transformation programmes (Merger, STP wave 1 and NHP schemes) will be monitored by 6 monthly audits against benefits that are outlined in the business cases and the results reported to Care Groups and Transforming Care Together Group. Financial benefits of the same programmes will be monitored by the Finance and Performance Group. All benefits form part of Care Group and Specialty transformation plans, with financial benefits included in Care Group finance plans. At specialty level when all services have been reconfigured a lessons learnt report will be completed and will cover off the assessment against the benefits.

14.8 Operational Performance

Achievement of the mandated national NHS performance targets is a key priority for the

Trust and includes the following groups of standards:

- Cancer Performance Standards
- Emergency/Urgent care Standards
- Diagnostics (DM01)
- Referral to Treatment (RTT)
- Organisational flow
- Activity

These have been incorporated into the SDR scorecard.

14.9 Corporate functions performance management

Corporate functions have Strategy Deployment Review meetings similar to Care Groups. Corporate functions' performance is measured through existing performance reporting at a corporate level e.g. financial and workforce information. The Corporate Directors are held to account by other Corporate functions as part of the whole Trust response to key indicators such as budget monitoring, vacancy control and absence management information. On request, Corporate Directorates may be required to present their performance and achievements directly to any of the Trust's relevant Committees.

15 Escalation, Oversight, Intervention and Support

15.1 The table below sets out the framework that we are working towards to ensure a consistent approach to escalation, oversight, intervention and support. This requires corporate teams to ensure the timeliness and accuracy of information to support Care Group Strategy Deployment Reviews. This is aligned to our model of SPC and should be replicated at a Care Group level, by Care Group Boards.

15.2 An assessment against the escalation framework is conducted by Executives and Care Groups as part of the preparation work for Care Group SDRs and shared within the SDR to reach agreement. (Appendix 5) Where performance is within the identified thresholds, management of any adverse performance remains within the remit of the Care Group Tri/quadrumvirate supported by the Care Group Board. Where performance is adverse, escalation, which may include additional oversight, intervention or support should be enacted.

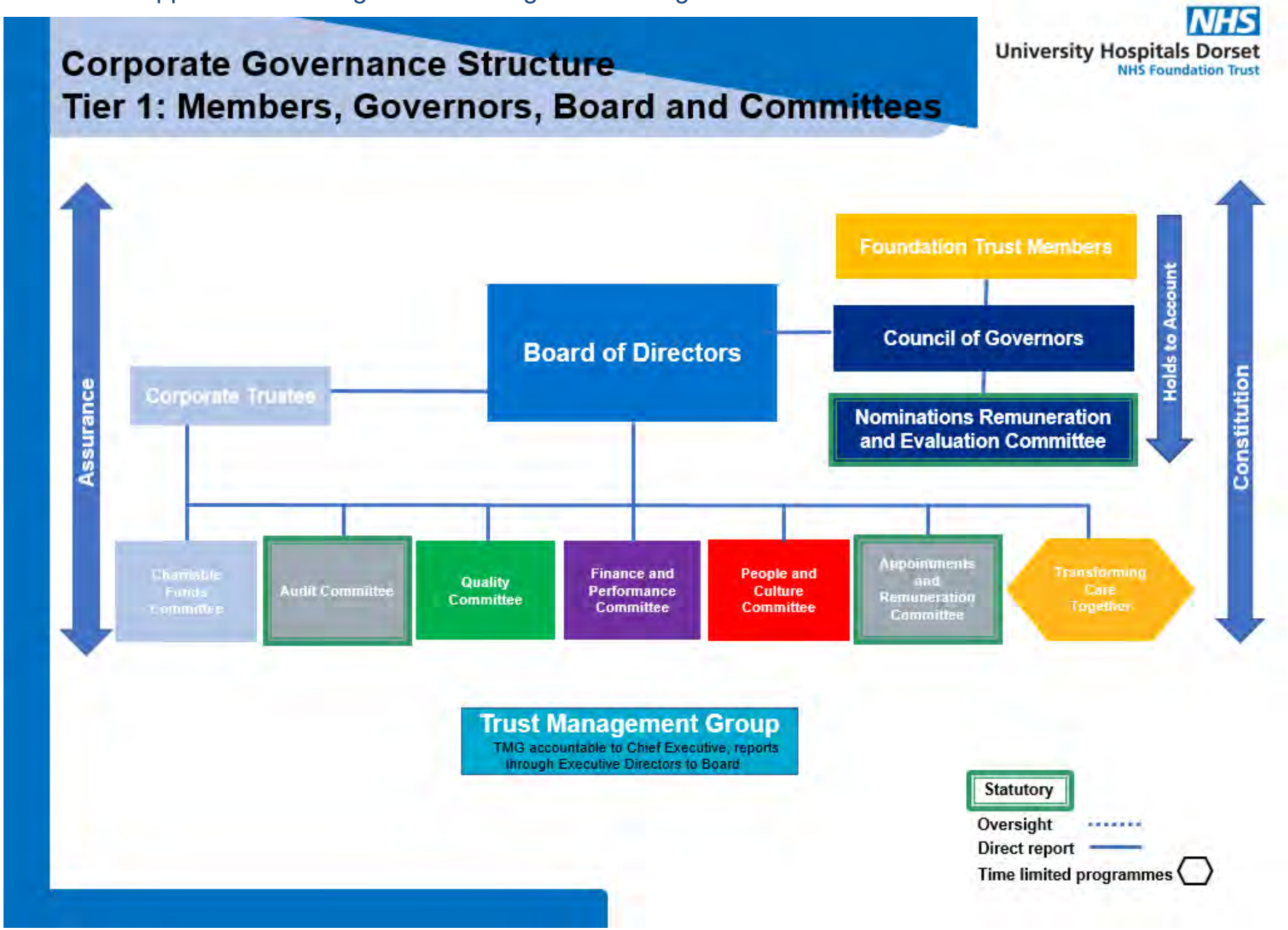
Escalation Level	Characteristics of a Care Group/ Directorate at this level	Oversight	Escalation actions	Additional Support options
Care Group/	Consistent delivery or improvement against strategic objectives across all 5 domains at Care Group/Corporate Directorate level: Population & Systems, Our People, Patient Experience, Quality Outcomes & Safety and Sustainable Services. Sub-Care Group metrics indicating continued under performance such that it is impacting overall Care Group or Trust operational performance, or raises finance, quality, or safety concerns. Enhanced support may be triggered also by significant one-month deterioration depending on the performance metric.	Escalation of issue via **Care Group/Corporate Directorate Governance** structures and area asked to provide assurance of plan in place to recover/ improve performance. Operational Delivery Group or other relevant group (finance, quality, workforce, or safety) may provide enhanced oversight of specific performance area including assurance of plan in place to address underperformance and identification of support needs.	**No Executive enhanced interventions at this level**, beyond which is considered business as usual. **Targeted interventions by Care Group triumvirate/Corporate Directorate lead** should include: • enhanced frequency or escalation of oversight • additional management/ clinical support • consideration of additional individual performance support	Local senior support and Continuous Improvement expertise as required. Executive support, if required, is focused on **development opportunities.** Additional support from outside of the Care Group/Corporate Directorate (if required), including external Trust expertise to assess recovery/action plans.
Low intensity Executive enhanced support	Enhanced support triggered by early warning signs of deteriorating performance (<2months) and/or a significant one-month deterioration at Care Group level depending on the performance metric.	Enhanced oversight at Care Group SDR of area of underperformance including assurance of plan in place to address underperformance and identification of support needs. Decision on escalation actions determined or ratified at Care Group/Corporate Directorate SDR.	In addition to the above: **Improvement plan,** trajectory/target and timescales required to be in place. **Executive and/or external enhanced interventions** agreed, if required, and/or enhanced in-month oversight and reporting group/ arrangements agreed.	Executive support if required, is focused on **improvement opportunities.** Local senior support and Continuous Improvement expertise, as required. Additional support from outside of the Care Group/Corporate Directorate (if required), including external Trust expertise to assess recovery/action plans.
Medium intensity Executive enhanced support	Delivery issues identified against one or more strategic objectives where Full Countermeasures Summary is not demonstrating improvement or evidencing further deterioration >2 consecutive months and/or there are significant performance concerns. Performance metrics indicating continued under performance (for more than 2 months) such that it is impacting overall Trust operational performance, or raises finance, quality, or safety concerns. OR Variation indicates inconsistent delivery of improvement.	Step 1: Improvement plan/ trajectory to be reviewed by relevant Executive Lead and/or external advisor outside of SDR. Step 2: Alert to relevant Board Committee for information and assurance on action plan and recovery trajectory. Step 3: Consider if improvement plan/ trajectory should be shared with relevant System Delivery Group for information.	Actions to be agreed focused on **supporting improvement and Executive oversight** to be maintained in-month. Improvement trajectory/target and timescales agreed. **Broader intervention** may be deployed as deemed appropriate by the Executive Director in agreement with the Care Group/Corporate Directorate. **Potential service / capability review or diagnostic** (internal or external).	Support focused on **specific improvement** issues. **Enhanced support from corporate functions**, i.e. Transformation, Performance, Quality Teams where appropriate Partnering with another high performer
High intensity Executive enhanced support	Delivery issues identified against one or more strategic objectives where Full Countermeasures Summary is not demonstrating improvement for >3 consecutive months. Performance metrics indicating continued under performance (for more than 3 months) such that it is impacting overall Trust operational performance, or raises finance, quality, or safety concerns. Consistent indications of 'special causes of concerning nature' or 'consistent falling short of targets/objectives' within SDR scorecard. Issue identified which requires significant support to achieve recovery. Executive team have limited confidence in the capacity/ability to deliver improvement without additional support and challenge.	Step 1: Improvement plan/ trajectory to be reviewed by relevant Executive Lead and/or external advisor outside of SDR and scrutinised by Board Subcommittee. Step 2: Improvement plan/trajectory shared with System Recovery Group/relevant system delivery group for information and/or assessment. Step 3: Consider escalation to Provider Collaborative Board to discuss/ identify further actions to be taken across provider organisations	Agreement on **additional improvement actions** between Executive Lead and Care Group and plan tabled for approval of Executive Team **Intensive oversight arrangements** (as deemed appropriate / proportionate) Restriction on Care Group autonomy/decision capabilities in areas to be agreed. Mandated service / capability review or diagnostic (internal or external)	Support focused on **rapid quality or safety, financial or operational improvement**. **Lead Executive Director** working with the team directly on delivery of improvement actions. Divisional triumvirate coached by Executive counterpart. **Enhanced support from corporate functions**, i.e. Transformation, Performance, Quality Teams where appropriate Partnering with another high performer or provision of external support / coaching where appropriate

15.3 Any Care Group asked to produce a counter measure support/recovery plan may also be requested to attend the Trust's Finance and Performance Committee, People & Culture Committee or Quality Committee, where a review of the plan will be undertaken. If any group or body is tasked with addressing adverse performance, a summary update on progress will be expected.

15.4 The principles within this document are equally applicable to the system of performance management undertaken by Care Groups when reviewing the performance of their portfolio of clinical services. In this respect the Care Group is acting under its span of control. The system of performance management at this level includes routines and reports including, but not limited to:

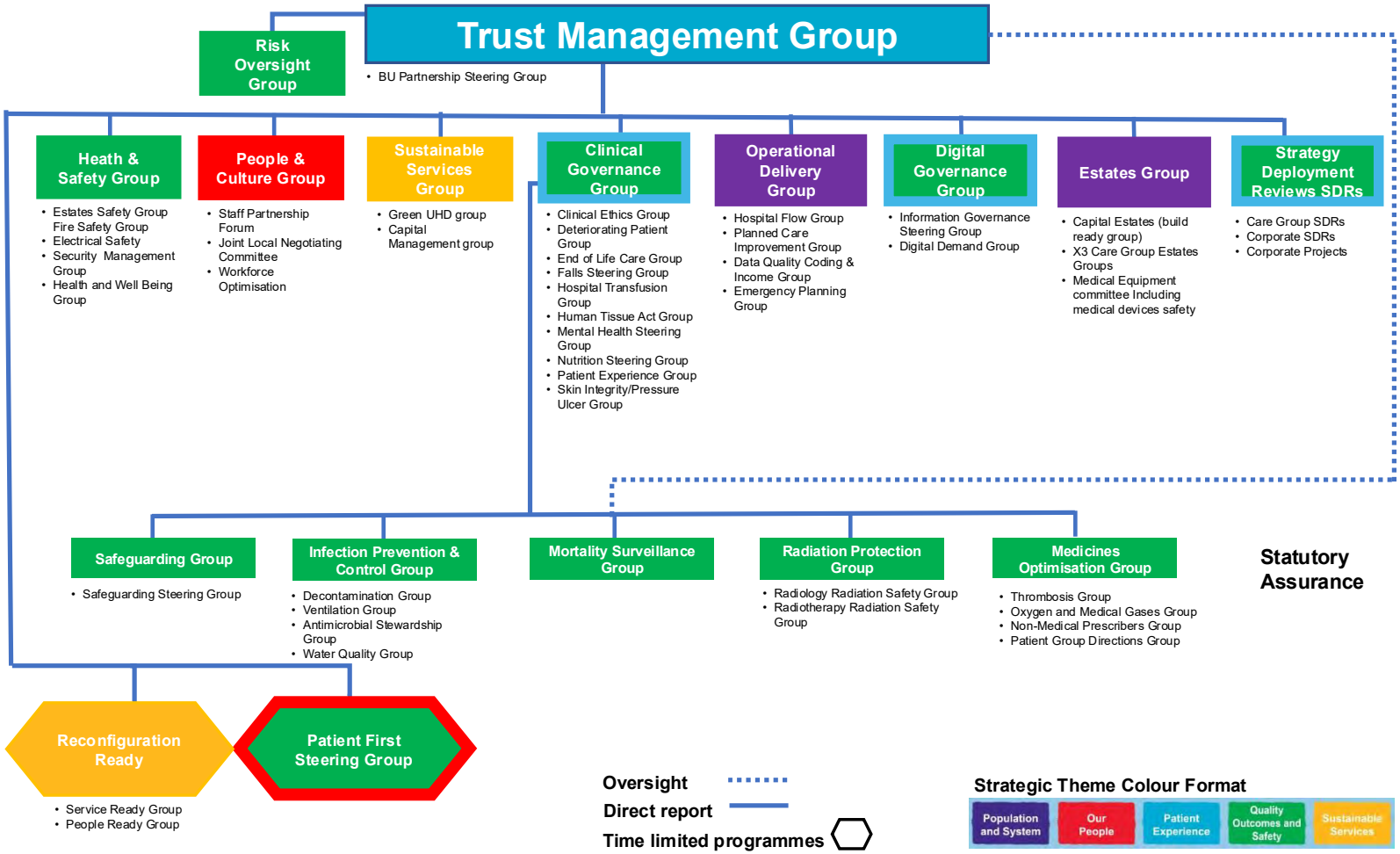
- Care Group to meet at least monthly with a standard agenda, minutes and action tracking where required.
- the agenda will include a minimum range of review areas such as quality, workforce, activity and performance, finance, and risk; and
- escalation triggers are expected to be as robustly applied as those applicable to Care Group

Appendix 1 - A diagram illustrating the Trust's governance structure

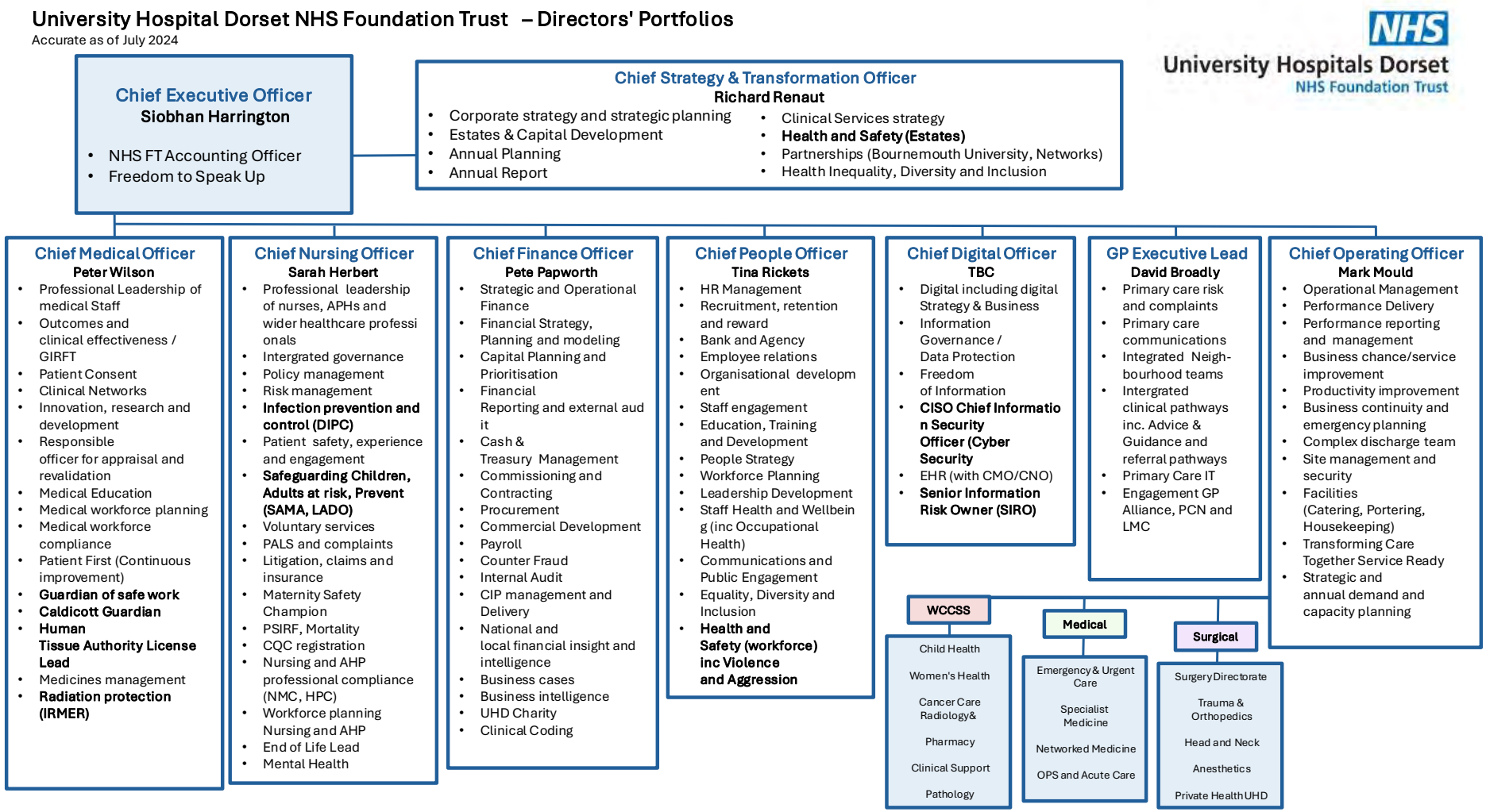


Corporate Governance Structure
Tier 2 and 3: Executive Led Groups

University Hospitals Dorset NHS Foundation Trust



Appendix 2 - A diagram illustrating the Directors' Portfolios



Appendix 3 – Template Care Group Board Terms of Reference and Membership and Agenda

Template

[…] Care Group Board

Terms of Reference and Membership

Date

1. PURPOSE

The Care Group Board is the main senior leadership group of the Care Group, with delegated decision-making responsibility for defined areas, within the parameters of annual operating plans agreed by the Trust's Board of Directors and/or Trust Management Group (TMG) (and the Trust's Standing Financial Instructions).

The Care Group Board functions to support oversight, scrutiny and assurance at a Care Group level in accordance with the Trust's Accountability Framework. It is required to provide assurance to TMG about progress and performance in defined areas and do the work-up on recommendations to TMG about policy, resource allocation and change plans.

The Trust Management Group will receive the minutes of Care Group Board meetings and an Alert, Advise and Assure report.

2. RESPONSIBILITIES

The primary aim of the Care Group Board is to ensure scrutiny, assurance and delivery of all objectives / targets, to monitor, control and escalate risks as appropriate and develop and oversee implementation of strategies and plans for all services within the Care Group.

The Care Group Board shall provide advice to the Chief Executive and Chief Officers on the development of the Trust strategy, quality improvement strategy, development of services and any proposed capital investments. It will also monitor the performance of the Care Group, advising and agreeing any mitigating or corrective action as appropriate. This will include the following:

Strategy

- Oversee development and implementation of strategy and operational plans at a Care Group level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available.
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Trust operational planning process and Patient First.
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Care Group level.
- Oversee the annual business planning process and advise the Board of Directors via the TMG on the distribution of available resources.
- Review progress in delivering the Trust's transformation programme.
- Review and agree specific strategies prior to submission to TMG for approval. This may include the following:
    - The development of clinical services;
    - Trust's strategy on research and innovation;
    - Relationship management with external partners.

Performance

- Oversee the delivery of the annual corporate objectives of the Trust, including the delivery of all financial, workforce, quality, access and other targets and standards.
- Receive assurance on the delivery of strategy and relevant key performance metrics, ensuring the appropriate allocation of resource via SDRs.
- Monitor the operational systems and processes which ensure competent management within the Care Group.
- Identify, delegate and review relevant actions to improve performance.
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Strategy Deployment Review (SDR) process.

Risk Management

- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy.

Patient Safety

- Monitor trends relating to LERNs and patient safety events, ensuring that lessons are learned, and appropriate action is taken. This may be delegated to the Care Group Rapid Review/PSIRF group although the care group board will retain responsibility for oversight

Quality Governance

- Review clinical governance arrangements within the Care Group in order to be assured that Directorates and Specialties are holding regular Quality and Safety meetings in accordance with the Trust Quality Governance Toolkit.
- Review quality metrics, sharing good practice and recommend appropriate actions as required to improve performance.
- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate.
- Oversee / monitor implementation of Care Quality Commission actions plans arising from internal / external review, audit, assessment or accreditation.

Governance

- Review governance arrangements and performance, including meeting required clinical standards and recommend appropriate action.
- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate.
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment or accreditation.
- Approve business cases, prior to their submission to, and approval by, the Trust Management Group, Finance and Performance Committee or Board of Directors where appropriate.

- Undertake an annual self-assessment of effectiveness to inform any changes to Terms of Reference and Membership

3. MEMBERSHIP AND ATTENDANCE

3.1 Membership of the Care Group Board comprises:

- The Group Director of Operations (Chair)
- The Group Medical Director
- The Group Director of Nursing
- Directorate Managers and General Managers
- Directorate Clinical Governance Leads
- Directorate Clinical Directors
- Directorate Matrons
- Directorate Heads of Profession

3.2 In addition, it is expected that the following individuals will routinely attend the meetings:

- Finance business partner
- HR business partner
- Business intelligence representative
- Quality and Safety team representation
- Transformation & improvement leads for the Care Group
- Communications representative

3.3 The Care Group Board will be chaired by the Group Director of Operations. In his/her absence, an individual nominated by the Group Director of Operations will take the chair.

3.1 Subject to paragraph 3.2 above, only members of the Care Group Board have the right to attend its meetings. If one of the individuals referred to in paragraph 3.1 or 3.2 above is unable to attend, he/she may exceptionally nominate a suitable deputy empowered to act in his/her place.

3.2 Members should aim to attend all scheduled meetings but are expected to attend a minimum of two thirds of meetings on an annual basis. The secretariat for the Care Group Board will maintain a register of members' attendance.

3.6 Other individuals may be invited to attend for all or part of any meeting, as invited by the Chair. The Chief Medical Officer, Chief Nursing Officer and/or Chief Operating Officer may attend meetings of the Care Group Board by prior notice to the Chair.

4. CONDUCT OF BUSINESS

4.1 The Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Care Group Board and any of its meetings.

4.2 The Care Group Board will normally meet monthly and at such other times as the Chair shall require. Executive Directors (or some of them) will attend meetings of the Care Group Board on a quarterly basis.

4.3 Meetings of the Care Group Board shall be quorate if there are at least eight members present with representation required from all Directorates and the Care Group senior management tri/quadrumvirate.

4.4 Meetings of the Care Group Board shall be called by [ ] at the request of the Group Director of Operations.

4.5 [ ] is responsible for preparing the agenda for agreement by the Chair. [ ] shall collate and circulate papers to Care Group Board members. Unless otherwise agreed by the Chair, the agenda and papers should be circulated not less than five working days before the meeting.

4.6 Business of the Care Group Board 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.

4.7 Proceedings and decisions made will be formally recorded by [ ] in the form of minutes, which shall be submitted to the next meeting of the Care Group Board for approval.

5. RELATIONSHIPS & REPORTING

5.1 The Care Group Board is accountable to the Chief Executive for the operational management of the Trust to meet the Trust's corporate objectives and the implementation of its strategy and policies.

5.2 Care Group Board members will be responsible for ensuring that staff within their areas of responsibility, are kept appropriately informed about Care Group and Trust issues.

6. MONITORING

7.1 Attendance will be monitored at each meeting of the Care Group Board. A matrix (see example in the Appendix to these Terms of Reference) of membership attendees will be used for monitoring purposes.

7. REVIEW

7.1 These Terms of Reference will be reviewed annual or sooner if appropriate.

Example Template

[….] Care Group Board

Agenda

Meeting held on xx20xx at xx [time]

Venue, site or via Microsoft Teams

Time	No.	Agenda Item	Purpose	Lead	Format
		PROCEDURAL ITEMS			
	1.	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	2.	Declarations of Interest	Assurance		Verbal
	3.	Minutes of the Meeting held xx 2022	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	5.	Feedback from TMG	Information		Verbal
		RISK MANAGEMENT			
	6.	Risk Register – including risks scoring 8 and above, risk register performance reports			
		HIGH QUALITY			
	x.	Care Group Quality and Safety Group Report (date)	Assurance		
	x.	CQC Action plan update	Information		
	x.	Patient Safety Performance Report			
		PEOPLE			
	x.	Care Group Workforce and Culture Group Highlight Report (date)	Assurance		
	x.	Executive People and Culture committee report	Information		
	x.				
		RESOURCES			
	x.	Care Group Finance Report	Assurance		
	x.	Business Cases (ad hoc)	Approval		
	x.				
		RESPONSIVE			
	x.	Directorate SDR escalations	Assurance		
	x.	Executive Finance and Performance Committee report	Information		
	x.				
		IMPROVING AND INNOVATING			
	x.	Care Group Transformation Steering Group highlight report	Assurance		
	x.				
		SYSTEMS AND PARTNERS			
	x.				
	x.				
		CLOSING MATTERS			
	x.	Review of meeting effectiveness			Verbal
	x.	Items for celebration			Verbal
	x.	Agreement of Items for Escalation to Executive Groups			Verbal
		Any other business			Verbal
		DATE AND TIME OF NEXT MEETING			

[...] CARE GROUP BOARD - MEETING ATTENDANCE RECORD

NAME OF CARE GROUP BOARD:												
REPORT TO :												
Membership (as per Terms of Reference). Please give names and/or full job title below:												
	January											
Was the meeting held in quorum? (Please refer to Terms of Reference) Y / N												

Notes
1. Please include names and titles of any staff deputising at individual meetings, and indicate who they are deputising for

Appendix 4 – Strategy Deployment Review Business Rules

Variation	Assurance	What does this mean?	Business rules for DRIVER	Business rules for WATCH
		Special cause of a concerning nature due to Higher (H) or Lower (L) values. Metric is consistently Passing (P) the target	**Verbal Countermeasures Summary** to support continued delivery of the target	**Note performance**, but do not consider escalating to a Driver metric presently
		Common cause variation – no statistically significant change. Metric is consistently Passing (P) the target	**Note performance**, consider revising the target or downgrading to a Watch metric	**Note performance**
		Special cause of an improving nature due to Higher (H) or Lower (L) values. Metric is consistently Passing (P) the target	**Note performance**, consider revising the target or downgrading to a Watch metric	**Note performance**
		Special cause of a *concerning* nature due to Higher (H) or Lower (L) values. Metric is inconsistently hitting or missing the target	**Verbal Countermeasures Summary** to support consistent delivery of the target	**Note performance**, but do not c onsider escalating to a Driver metric presently
		Common cause variation – no statistically significant change. Metric is inconsistently hitting or missing the target	**Verbal Countermeasures Summary** to support consistent delivery of the target	**Note performance**, but do not consider escalating to a Driver metric presently
		Special cause of an improving nature due to Higher (H) or Lower (L) values. Metric is inconsistently hitting or missing the target	**Note performance**	**Note performance**
		Special cause of a *concerning* nature due to Higher (H) or Lower (L) values. Metric is consistently Failing (F) the target	**Full Countermeasures Summary** to support actions and delivery of improved performance	**Full Countermeasures Summary** to support actions and delivery of improved performance. Consider escalating to a Driver metric
		Common cause variation – no statistically significant change. Metric is consistently Failing (F) the target	**Full Countermeasures Summary** to support actions and delivery of improved performance	**Verbal Countermeasures Summary**, but do not consider escalating to a Driver metric presently
		Special cause of an improving nature due to Higher (H) or Lower (L) values. Metric is consistently Failing (F) the target	**Full Countermeasures Summary** to support actions and delivery of improved performance	**Note performance**, but do not consider escalating to a Driver metric presently
		No variation data available. Metric is Passing (P) the target	**Note performance**	**Note performance**
		No variation data available. Metric is Failing (F) the target	**Full Countermeasures Summary** to support actions and delivery of improved performance	**Verbal Countermeasures Summary**
		Special cause of a *concerning* nature due to Higher (H) or Lower (L) values. No target available	**Full Countermeasures Summary** to support actions and delivery of improved performance	**Verbal Countermeasures Summary**. Consider escalating to a Driver metric
		Common cause variation – no statistically significant change. No target available	**Verbal Countermeasures Summary** to support continued delivery of performance	**Note performance**
		Special cause of an improving nature due to Higher (H) or Lower (L) values. No target available	**Note performance**	**Note performance**
		No target available. No variation data available.	**Note performance**	**Note performance**

Appendix 5 – Assessment Template against the escalation framework

		Care Group Assessment		Executive Team	
STRATEGIC THEME	BREACKTHROUGH OBJECTIVES	LEVEL OF ESCALATION (None/Low/ Medium/High)	RATIONNALE (Key triggers for escalation)	Agree with Care Group Assessment? (Yes/No)	RATIONNALE (Key triggers for escalation)
POPULATION AND SYSTEM					
OUR PEOPLE					
PATIENT EXPERIENCE					
QUALITY OUTCOMES AND SAFETY					
SUSTAINABLE SERVICES					

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: 7.1

Subject:	Risk Management Strategy Update
Prepared by:	Jo Sims, Associate Director Quality Governance and Risk
Presented by:	Sarah Herbert, CNO

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☐ ☐ ☐ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	All	
Purpose of paper:	Decision/Approval	
Executive Summary:	The revised UHD Risk Management Strategy includes the following changes: • Amended risk categories and types • Update risk appetite and risk tolerance descriptions • Risk Oversight Committee details • Revised risk escalation process (TMG replaced by Risk Oversight Committee)	
Background:	The UHD Risk Management Strategy has been updated to reflect Board Development discussion on the 1/10/25 and subsequent recommendations from a GGI review and report. The updated Risk Management Strategy was agreed at the Risk Oversight Committee on the 22/12/25 and has been submitted to the Quality Committee meeting on the 6/1/26 and the Audit Committee on 15/1/26.	
Key Recommendations:	To approve the revised Risk Management Strategy	
Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation Quality	☐ ☐ ☐ ☐ ☒ ☐ ☐ ☒

	Regulatory Strategy/Transformation System	☒ ☐ ☐
CQC Reference:	Safe Effective Caring Responsive Well-Led Use of Resources	☒ ☒ ☐ ☐ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Risk Oversight Committee	22/12/25	Changes discussed and agreed
Quality Committee	6/1/26	Paper for AC submitted before QC meeting held
Audit Committee	15/1/26	Audit Committee recommend for approval at 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

Risk Management Strategy

When using this document please ensure that the version you are using is the most up to date either by checking on the Trust intranet or if the review date has passed, please contact the author.

'Out of date policy documents must not be relied upon'.

Approval Committee	Version	Issue Date	Review Date	Document Author
Shadow Interim Board	1	1 Oct 2020	1 Oct 2021	Head of Governance & Risk
Board of Director's	2	July 2021	July 2022	Head of Governance & Risk
Board of Director's	3	July 2022	July 2023	Head of Risk Management
Board of Directors	4	June 2023	July 2024	Associate Director Quality Governance and Risk, Head of Risk Management
Board of Directors	5	September 2024	September 2025	Associate Director Quality Governance and Risk, Head of Patient Safety and Risk
Board of Directors	6	Jan 26	Jan 27	Associate Director Quality Governance and Risk,

Version Control

Version	Date	Author	Section	Principal Amendment Changes
2	16/07/2021	JH	2	Refreshed and in line with 21/22 Trust objectives. Risk escalation thresholds articulated
			5	Amendment to the definitions of roles
			6.1	Amendment to the responsibilities within the Trust's Governance Structure
			6.11	• Review of the BAF six monthly (Q2 and Q4) • New risks are presented to the committee by an in-depth report by the executive sponsor or relevant Care Group Director (or designated deputy).
			6.10-20	Addition - Sustainability Committee
			6.21-22	Addition - Transformation Committee
			6.23 onward	'Quality Governance Group 'Title amended and report requirements in line with Risk Appetite statement
			7	Responsibilities and Scheme of Delegation for Risk Management Titles amended Role of Risk Manager added
			8.16	Reference to and link to the Risk Register Toolkit
			8.17-24	• Further clarity re: escalation, agreement and sign off prior to notification to Trust Board • Onward management and update of 12+ risk
			Appendix B	Update to the BAF report template
			Appendix C	• Added cover sheet template • Update to Risk Report template • Remove Risk matrix from subsequent appendix as repeated
			Appendix F	• Content table and link to Risk Register Toolkit
3	06/07/2022	JH		• Refresh risk appetite in line with 2022/23 board objectives • Add (4.0) specific risk management objectives for 2022/23 in line with national and local priorities

				• Appendix A updated governance chart • Appendix E refresh to provide additional information on risk matrix definitions • Section (5.0) additional guidance on risk controls • Section (7.7) additional clarity on the role of the Executive sponsor of a risk rated 12-25 • Section 8.23 additional clarity on risk escalation to Care Group Board and Quality Committee.
4	June 2023	JS/TS		• Refresh risk appetite in line with 2023/24 board objectives • Update organisational chart and committee structures • Amend risk reporting requirements to align with UHD Accountability Framework (approved May 23)
5	Sept 2024	JS/TS		• Refresh risk appetite in line with 2024/25 Board objectives • Amend risk management escalation definitions and reporting structures • Amend risk reporting requirements to align with revised UHD Accountability framework (Sept 24) • Align reporting and risk escalation processes to Patient First objectives and Strategic Deployment review processes
6	Jan 26	JS		• Refresh risk categories and types • Update risk appetite and risk tolerance • Include new Risk Oversight Committee details • Remove TMG in risk escalation process (replaced by Risk Oversite Committee)

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Executive Summary

University Hospitals Dorset Hospitals NHS Foundation Trust aims to provide excellent person-centred emergency and planned care to the people we serve. The Board recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify and contextualise risk, ensuring that the Trust understands the risks it is prepared to accept in pursuing the Trust's aims and objectives. This strategy sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds, and states how the delivery of the Trust's Risk Management Strategy will be achieved.

The Trust has key aims that the risk management strategy supports in the delivery of;

- Devolved decision making and accountability for the management of risk throughout the organisation; from the point of delivery to the Board.
- Promoting a culture of assurance, monitoring, and improvement, ensuring risks to the delivery of Trust strategic objectives are well understood.
- Supporting patients, carers, and other stakeholders through the management of risks to patient safety, patient experience, and service delivery.
- Refining processes and systems to ensure engagement in risk management is efficient and effective, enabling good decision making through robust reporting to relevant decision-making groups and scrutiny groups.
- Supporting the Trust Board, commissioners, and other key stakeholders in receiving and providing assurance that the Trust understands its risk profile and is working to mitigate key risks in appropriate and timely ways.

The overall aim of the Trust is to achieve a culture where risk management and safety is everyone's business, that there is open and honest recording of risks and a culture that encourages organisation wide learning and risks are continuously identified, assessed and minimised. A culture of ownership and responsibility for risk management is fostered and supported throughout the organisation.

The Trust Board of directors recognise that Risk Management is an integral part of the Trust's quality, governance, and performance management processes. The Board, with support from its committees will ensure a robust system of risk management is effectively maintained, and champion a culture whereby risk management is embedded across the Trust through policy, strategy, and plans (business planning, policy documentation, strategies, etc. should all explicitly reference risks they are seeking to manage)

Effective Risk Management is the responsibility of every member of staff, either permanent, temporary or to those contracted working within, or for, the Trust. Further, we require that organisations with whom we contract services to provide risk, assurance, and performance information.

The strategy covers all aspects of risk including clinical risk, staff related risk, environmental risk, corporate risk and financial risk. The principles and procedures described within this document and the Trust Risk Assessment and Risk Register Guidance are applicable for all types of risk.

This Risk Management Strategy is underpinned by policy and toolkits guiding staff on the day to day delivery of effective risk management processes. Policy guidance is provided as part of this combined Risk Management Strategy & Policy document.

The Strategy refers to two key processes for managing risk at a strategic level these are:

- The Board Assurance Framework (BAF) – The BAF is a key mechanism to reinforce the strategic focus of the board and better manage risk. It is used to help the organisation capture, report and monitor key risks to the strategic objectives, implement corrective action and report to Board on progress. It is designed to provide assurance that the organisation is delivering on its objectives and draw attention to areas of concern.

- The Risk Register – The Trust uses a risk register to record, prioritise and monitor risks across the organisation.

The difference between the risk register and BAF is described below:

Board Assurance Framework (BAF)	**Risk Register**
Comprises strategic risks aligned to the organisation's strategic objectives – the risks which prevent the Trust from achieving the strategy.	Typically comprises of operational risks arising from the Trust' day to day activities.
Risk descriptions are Trust-wide in their scope and impact	Some risks are Trust-wide in nature, others are specific to particular services or departments but have been escalated to the corporate risk registers because of the high level of risk or because action is required by executives, or colleagues from other services, to mitigate the risk.
Usually contains no more than ten risks	The number of risks vary between organisations but can be over 50 in some Trusts.
For each risk, both controls and assurances (evidence that shows whether the controls are working) need to be identified.	Usually, only controls and gaps in controls are identified.
Risks are identified, defined and assessed by the executive team or Board (top down).	Risks are usually identified by services or departments themselves and escalated accordingly.
Reported to the Board in full and discussed usually quarterly or bi-monthly.	Not always reported to the board or reported in summary form only.
Board assurance committees review risks relating to their remit in detail.	Board committees may receive an extract of risks relevant to their remit and discuss risks by exception, e.g. new risks or those for which there is a lack of progress with action plans.

Ref: Differences between the Board Assurance Framework (BAF) and the Corporate Risk Register
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1.0 Risk Management Framework

1.1 Outline

The business of healthcare is, by its very nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing University Hospitals Dorset NHS Foundation Trust's Board of Directors with assurance on the framework for clinical quality and corporate governance.

The Trust has identified standard processes and procedures for the identification, assessment and appropriate management of risks at all levels of the organisation.

The Risk Management Framework explains how a variety of processes fit together to create a consistent and effective way of managing risk across the Trust. The key elements of risk management encompass the activities relating to the risk identification, assessment, control, monitoring and reporting of risk. These have been set out in the following sections of this document.

- **Risk Management (Purpose and Strategy)** – How we articulate the Trust's risk management priorities and how it is aligned to the Trust's strategy.
- **Risk Appetite** – How much risk we can take in order to deliver the Trust's strategy while ensuring we provide safe and effective patient outcomes.
- **Governance** – How we organise ourselves, make decisions and take approved risks.
- **Risk assessment and control** – How we understand our risks and limit undesirable outcomes from occurring.
- **Implementation, Monitoring and assurance** – How we ensure effective implementation and how we check that controls are working and highlight when risks require attention.

2.0 RISK MANAGEMENT PURPOSE AND STRUCTURE

2.1 Aim

The Trust's Board aims to take all reasonable steps in the management of risks to ensure that the organisation's vision, values and strategic objectives are achieved.

The Trust manages risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving those objectives (Board Assurance Framework risks)
- Regular monitoring of the effectiveness of the Board Assurance Framework by the Trust's Board, Board sub-committees and the Audit Committee
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified and the controls in place to mitigate them e.g. internal and external audit, commissioned independent reviews, Care Quality Commission (CQC) reports and other external/peer review inspections
- Regular monitoring and review of the risk register and risk appetite ensuring the risks are managed effectively and at the appropriate level within the organisation and escalated where appropriate
- Integrating risk management into board development, business planning, quality improvement and cost improvement planning processes, ensuring that objectives that are set across the organisation with plans to manage risk in accordance with quality impact assessment and risk assessment procedures.

2.2 Definitions of Risk

Risk can be defined as the combination of the probability of an event and its consequences.

The following risk definition is used by the Trust:

"The chance of something happening that will have an adverse effect on an objective."

Risk can relate to:

- **A threat** – an event or circumstance which could cause harm or loss or affect the ability of the organisation to achieve its objectives.
- **An opportunity** – the organisation must take some risks in order to obtain a benefit; to innovate, grow and improve.

Based on this definition, consistent statement of risks can be framed as an 'if … 'then' statement, for example: ***If*** *we continue to or fail to do something* ***then*** *the result will be…..*

Likelihood & Impact reflect the probability of a risk occurring, and potential impact (also referred to as consequence or severity) caused to if the risk were to occur. Both likelihood and consequence are scored between 1 and 5 and are discussed in detail in the Risk Matrices provided within section 5.2
Risk Score: risks are scored against impact and likelihood. This provides a risk a score of between 1 and 25 that reflects the prioritisation that the risk should receive. Risks are scored in three stages:

- **Initial Risk Score:** this score reflects the impact (also referred to as consequence or severity) and likelihood of the risk, once, and at the point of assessment and articulation of the risk reflecting the prior management/actions that have been undertaken and the reflecting the identified gaps in controls at that time.

- **Current Score:** this score reflects the current state of the risk, bearing in mind the controls in place to mitigate against both impact and likelihood. This score will reflect the progress to delivery of controls and the gaps that may increase or decrease during the life of a risk. This assessment and potential to re-grade will be considered and amended as appropriate at each risk review.
  Note: at the point of submission to the risk register initial and current risk score will be the same

- **Target Score:** this risk score reflects the future state of the risk, when gaps in controls have been addressed and any outstanding actions completed.

Risk controls: the identified actions processes or methods by which a risk is neutralised, reduced, mitigated or eradicated. Through reviewing whether the controls are adequate, any gaps in controls will be identified. Risk evaluation needs to consider whether current controls are reducing risk or harm to its lowest level and moving the risk towards its target risk rating. To improve the effectiveness of controls, additional mitigating actions might need to be undertaken.

Actions (Mitigations): any identified gaps in controls should prompt an action to close the identified gap. Actions should be specific, nominate clear owners, and provide a date for completion e.g. to develop a policy or training programme.

Risk Assessor: The Risk Assessor is responsible for ensuring that the risk is assessed, and progress updates added to the risk record in line with the requirement for review and that any need to materially amend or upgrade the risk is escalated to the Risk Owner

Risk Owner: The Risk Owner takes oversight of the accuracy and timely review of the risk record. The Risk Owner is ultimately responsible for the risk, the control framework, and ongoing management and grading of the risk.

Risk Register: all identified risks are recorded on the Trust risk register. This is a dynamic and responsive collection of risks that the Trust faces across clinical and corporate areas. This is managed on the Datix system; access to which can be requested through the Patient Safety and Risk Team.

2.3 Risk Types

The Trust has defined five Risk Types. These are the principal risks which arise from the nature of the Trust's operating environment. They are also our Patient First strategic themes.

- Our People
- Population and System
- Quality (Outcome and Safety)
- Sustainable Services
- Patient Experience

Definitions for each of the five Risk Types are set out below:

- **Our People** - The risk of inadequate systems and processes associated with the Trust's workforce supply, skills, wellbeing, training and education, capacity, performance and retention and culture.

- **Population and System** - Risks resulting from inadequate or failed internal operational processes and systems and/or from external healthcare system process or events.

- **Quality (Outcome and Safety)** - The risk of poor patient outcomes and/or patient harm resulting from inadequate systems and processes associated with the management of 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.

- **Sustainable Services** - The risk of direct or indirect loss resulting from inadequate systems and processes relating to the Trust's management of its estate, equipment, physical and digital infrastructure, financial reporting, funding and cash management.

- **Patient Experience** – The risk of poor patient experiences resulting from inadequate systems and processes.

2.4 Risk Categories

The Trust has also defined Risk Categories, each aligned to one of the five Risk Types.

These were determined through aligning the specific risks contained within the Trust's risk register to a broader, industry-recognised Risk Category. Appendix A2 sets out the list of the agreed Risk Types and Risk Categories. Appendix A5 provides the definitions for each Risk Category.

Patient First Objective					
Risk Type	**Our People**	**Population and System**	**Quality (Outcome and Safety)**	**Sustainable Services**	**Patient experience**
Risk Categories	Staff Health, Safety and Wellbeing	Flow and Capacity	Infection Prevention and Control	Financial Management	Patient Experience
	Knowledge and Skills - Capability	Partnership Working	Patient Safety	Information Governance (including information Security)	
	Resourcing - Capacity		Medicines Management	Medical Equipment	
	Behaviours – Culture		Patient Outcome (Clinical Effectiveness)	Physical Assets	
				Information Technology	

2.5 Risk Category Executive Sponsor

As part of the work to define and agree a set of Risk Types and Risk Categories, we have also agreed the accountabilities for the management and oversight for these relevant risk categories. We have worked with the Executive Team to agree a set of broad, consistent accountabilities for each Risk Category.

Appendix A4 sets out under each relevant Executive Team member those risk categories for which they may be asked to be a risk sponsor for a risk rated 15-25.

2.6 Risk Categories and Board Committees

Risk categories have also been aligned to Board subcommittees as follows:

People and Culture Committee	Finance and Performance Committee	Quality Committee
Staff Health, Safety and Wellbeing Risk	Flow and Capacity Risk	Infection Prevention and Control Risk
Knowledge and Skills - Capability	Financial Management Risk	Patient Safety Risk
Resourcing - Capacity	Information Technology Risk	Patient Experience Risk
Behaviours – Culture	Information Governance (including information Security)	Medical Equipment Risk
	Partnership Working Risk	Patient Outcome (Clinical Effectiveness) Risk
	Physical Assets Risk	Medicines Management Risk

3.0 RISK APPETITE

3.1 Background

The Trust recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of the Trust's aims and objectives.

The Trust's Risk Appetite Statement makes clear the Board of Directors' expectations in relation to the category of risks they expect the Trust's management to identify and the level of such risk that is acceptable.

The statement is based on the premise that the lower the risk appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk.

The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls.

3.2 Why Risk Appetite is important

Risk Appetite provides a framework which enables the Trust to make informed planning and management decisions. By defining Risk Appetite, the Trust will be able to clearly set the optimal position in pursuit of its strategy and vision.

The benefits of adopting a Risk Appetite include:

- Supporting informed decision-making.
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision making
- Supporting performance improvement
- Focusing on priority areas within the Trust; and
- Informing spending review and resource prioritisation processes.

Since budgetary constraints may prevent achievement of Risk Appetite (at least in the short-term), the defining of a Risk Tolerance enables the Trust to clearly set an acceptable position in pursuit of its strategy and vision.

3.3 Definitions

The Trust has adapted definitions for Risk Appetite and Risk Tolerance from the 'Orange Book – Risk Appetite guidance notes', Government Finance Function (October 2020), which are stated below:

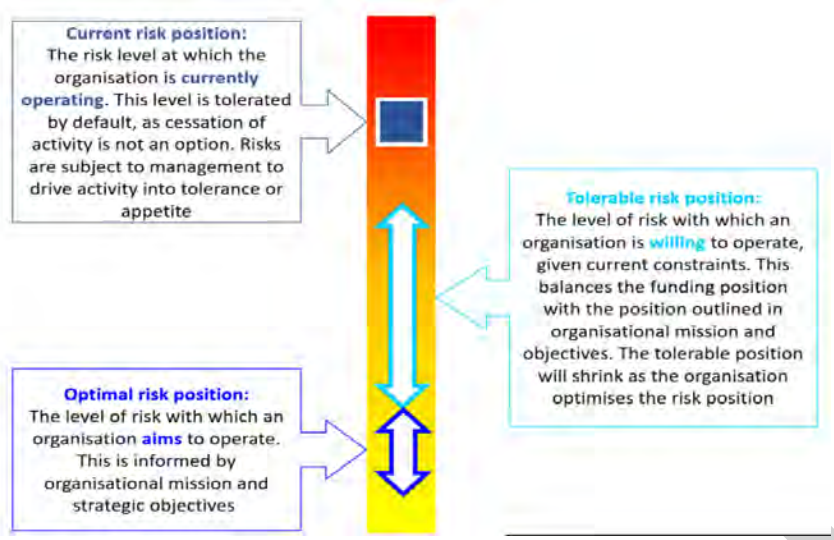
Risk Appetite: **the amount of risk that the Trust is prepared to accept, tolerate or be exposed to at any point in time in pursuit of its objectives**.

Risk appetite is a statement and describes the amount of risk an organisation needs to open itself up to in order to achieve a specific goal.

Risk Tolerance represents the application of risk appetite to specific objectives and refers to the "acceptable level of variation to achievement of a specific objective".

Risk tolerance is a score (using the standard 5 x 5 risk scoring matrix). It is a measure of managed risk. It describes the level of risk an organisation is prepared to hold, being the limit of where useful effort is to be deployed in reducing a level of current risk.

The terms should not be used interchangeably.



3.4 Risk Appetite Scales

Based upon Risk Appetite guidance provided within the 'Orange Book' and following consultation with the Executive Team, we have agreed to utilise the following Risk Appetite scales that broadly show the different appetites an organisation could have to meet its strategic objectives.

Eager	•Willing to be innovative and to choose options that suspend previous held assumptions and accept greater uncertainty.
Open	•Willing to consider all options and choose one that is most likely to result in successful delivery.
Cautious	•Preference for safe options that have a low degree of residual risk.
Minimal	•Preference for safe options that have a low degree of inherent risk.
Averse	•Avoidance of risk and uncertainty is key objective.

3.5 Risk Appetite Statements by Risk Category

The Trust has developed its Risk Appetite in an iterative manner between the Board, its Committees, Executive Team, specialist corporate governance and risk management advice internally and externally and, internal audit support. Involvement from these key stakeholders will make future iterations of the Trust Risk Appetite easier to embed across the organisation. It is intended that the approach will become more developed over time.

The Trust has set out the Risk Appetite level for each Risk Type and Risk Category. The matrix adopts a 5 point scale for all Risk Types, however the definition for what constitutes an "averse" Risk Appetite will differ across Risk Categories. Full details of the risk appetite scale for each risk category are available in summary below and in full detail in Appendix A6.

Our People

Our People Risk is 'the risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with the Trust's workforce supply, skills and capacity, performance and retention, within an appropriate culture'.

The Trust sees protecting our staff and their physical and mental wellbeing as key priority. Our staff are vital in keeping patients safe and delivering the organisation's aims.
We will not tolerate unprofessional conduct, bullying and harassment, or any activity that contradicts our values.

The Trust's appetite for our people risk is cautious. We will accept only limited risks if by taking them they could lead to improvements to patient care and outcomes within the Trust, but we will not accept such risks where this is not the case.

Our People	Statement	Risk Appetite Scale
Knowledge and Skills - Capability	We are willing to take some level of risk which may have implications for our workforce but could improve the skills and capabilities of our staff. We will ensure we have an empowered, well trained workforce that can deliver better outcomes and performance for our patients	Cautious
Resourcing - Capacity	We are prepared to take limited risk with regard to workforce capacity. When attempting to innovate we would seek to understand where similar actions have been successful before taking any decision. We will aim to deliver a healthy, right sized and sustainable workforce.	Cautious
Behaviours – Culture	We have little appetite for inappropriate behaviours. We will ensure that the culture of the organisation reflects our core values of caring, one team, listening to understand, open and honest and inclusive.	Minimal
Staff Health, Safety and Well being	We have little or no appetite for decisions that could have a negative impact on the health, safety and well-being of our staff We will protect the health and safety of our workforce by delivering	Minimal

	services in line with or in excess of minimum health & safety laws and guidelines	

Population and System

The risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external healthcare system process or events.

The Trust's appetite for operational and performance risk is cautious.

Population and System	Statement	Risk Appetite Scale
Flow and Capacity	Our preference is for risk avoidance, but we recognise it may be necessary to take decisions on operational performance where there is a degree of inherent risk and the possibility of improved outcomes with appropriate controls in place. We will aim to ensure that capacity is planned to meet the demand for elective and non-elective (acute) admissions to our hospitals, managing the risk to provide safe treatment and care to our patients.	Cautious
Partnership Working	We are prepared to accept the possibility of short term negative impact on partnership working with potential for longer term rewards. We will aim to maintain well established stakeholder partnerships which will mitigate the threats to the achievement of the organisations strategic goals.	Open

Quality (Outcome and Safety)

The risk of poor patient outcomes and/or patient harm resulting from inadequate systems and processes associated with the Trust's infection prevention & control, safeguarding, medicines management, patient safety, clinical effectiveness and research & development.

The Trust's appetite for clinical risk is averse. Delivery of high quality, safe, services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an ongoing commitment to being a learning organisation. The Trust

will not accept risks which compromise the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

We will pursue innovation where appropriate. We are willing (open) to take decisions where there may be inherent risks but the potential for significant longer term gains. We will deliver agreed minimum research and innovation priorities with health, social care, voluntary, education and private sectors

Quality (Outcome and Safety)	Statement	Risk Appetite Scale
Infection Prevention and Control	We have little appetite for decisions that may have an uncertain impact on ensuring high standards of infection prevention and control to reduce the transmission of infection in our hospitals	Averse
Patient Safety	We have little appetite for decisions that may have an uncertain impact on patient safety. We will provide high quality services to patients and manage risks that could limit the ability to achieve safe care for our patients and visitors.	Averse
Patient Outcome (Clinical Effectiveness)	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal
Medicines Management	We have no appetite for decisions that may have an uncertain impact on quality outcomes or may compromise compliance with statutory, regulatory or policy requirements. We will ensure medicines are prescribed, administered and stored in accordance with legal requirements and best practice.	Averse

We are averse to risks that might threaten compliance with frameworks provided by national bodies. We will operate the Trust in compliance with the Law and UK Corporate Governance Code, where applicable. We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.

Sustainable Services

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.

The Trust's appetite for financial risk is cautious. Our financial decisions are heavily scrutinised, with value for money and patient care and outcomes being a key factor in decision making. We will accept risks that may result in limited financial impacts or losses on the basis that there may be upside opportunities with the safe and effective delivery of patient care and outcomes, but we will not accept risks that may lead to material variances to forecast, reporting misstatements or unplanned overspend against our agreed revenue control target. We also adopt a zero-tolerance approach to fraud.

Sustainable Services Risk	Statement	Risk Appetite Scale
Financial Management	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern. We have no appetite for decisions or actions that may result in financial loss due to fraud We will deliver sound financial management and reporting for the Trust, aiming to at least break even, with no material variances to forecast.	Cautious
Information Governance (including information Security)	We will avoid any decisions that may result in heightened regulatory challenge in relation to data protection and information governance unless absolutely necessary. We will appropriately manage information management risk through the collection, transmission, storage, management and maintenance of information.	Minimal
Medical Equipment	We are prepared to accept the possibility of limited financial and operational risk in relation to management of our medical equipment.	Cautious

Physical Assets	We are prepared to accept the possibility of limited financial risk in relation to management of our Estates. We will aim to optimise patient and workforce experience through the effective management of our buildings and estates.	Cautious
Information Technology	We will pursue innovation where appropriate. We are willing to take decisions where there are inherent risks but the potential for significant longer term gains. We will aim to develop and maintain stable, secure and resilient services, operating to consistently high levels of performance.	Open

Patient Experience Risk

The Trust's appetite for patient experience risk is Minimal.

Patient Experience Risk	Statement	Risk Appetite Scale
Patient Experience	We will avoid decisions that may result in heightened public challenge and negatively impact on patient experience unless absolutely essential.	Minimal

3.6 Applying Risk Appetite

It is important for Risk Appetite considerations to be taken into account as part of:

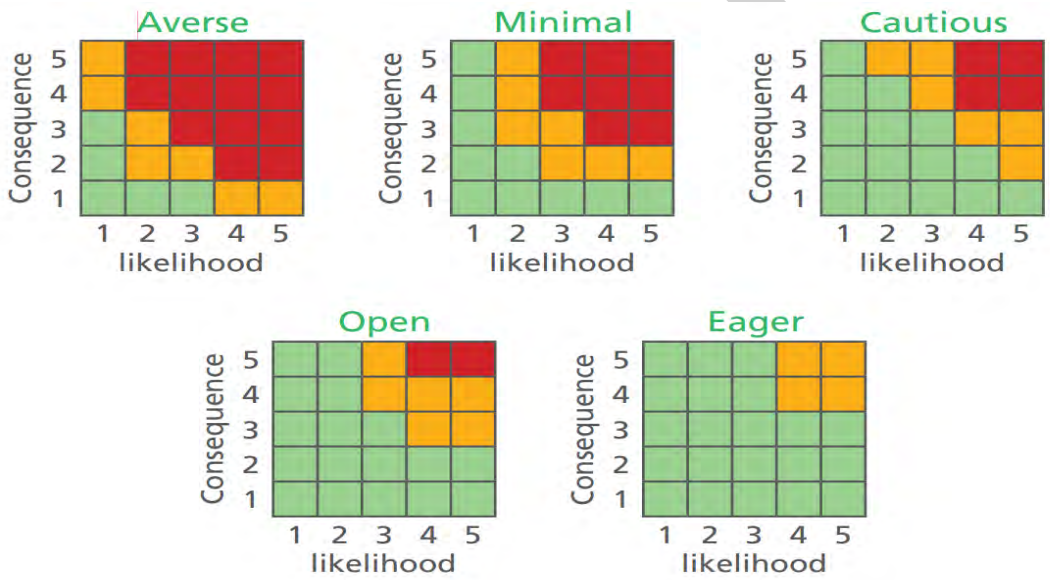
- Patient First – our risk decisions should be shaped by our Patient First vision and values
- Strategic Planning
- Business planning, Decision making and Quality Impact Assessments
- Risk escalation – where risks are identified that do not adhere to the Trust Risk Appetite these instances should be escalated.

3.7 Risk Appetite Breaches

What constitutes an 'averse' Risk Appetite will differ across Risk Types. To aid decision making, each appetite definition by Risk Category has been aligned to an applicable residual risk score range (using the ICB/UHD standard 5 x 5 risk scoring matrix)

Illustrative Risk Appetite matrices have been set out below to show residual risk scores for the Risk Appetite scale.

- Within Risk Appetite is shown as **GREEN**
- Within Risk Tolerance is shown as **AMBER**
- Outside Risk Appetite and Risk Tolerance is shown as **RED**



Risk Appetite Scale	Appetite (by Residual Risk Score)	Tolerance (By Residual Risk Score)
Averse	1-3	4-6
Minimal	1-5	6-10
Cautious	1-8	9-15
Open	1-10	12-20
Eager	1-15	16-25

The Risk Oversight Committee and Board Sub-Committees will review applicable risks, applicable to their function, where:

- The residual (current) risk is 15 or above (15-25)
- The residual (current) risk is not aligned to the applicable Risk Appetite Statement
- The residual (current) risk is not within Risk Tolerance

Committees will review the risk to validate that the risk has been assessed appropriately and if so, the risk owner (and Executive Director lead) will consider the adequacy and effectiveness of controls and other mitigation actions to reduce the risk rating with an aim for this to be at least within the Risk Tolerance, where this is possible.

4.0 GOVERNANCE

4.1 The Trust's Governance Structure is set out in the Trust Accountability Framework.

The following Committees and Groups hold explicit responsibility for the review, challenge, action, and escalation of risks as appropriate:

- The Trust Board
- Risk Oversight Committee
- Board Sub Committees
- Care Group Boards
- Directorate Governance

4.2 The Trust Board

The Trust Board of Directors set the strategic direction of the Trust which includes setting strategic objectives and ensuring that patient and staff safety is prioritised, and that effective and robust risk management systems are in place throughout the organisation.

The Board of Directors develop, monitor and manage the Board Assurance Framework which records the strategic risks to the Trust that may affect the achievement of the Trust's strategic objectives. The Board will review the full Board Assurance Framework every 6 months.

The Board will allocate time to 'horizon scan' risks in their Committee and Board meetings and also at their Board Development sessions.

Part 1 of the Board meets every other month. A Risk Register report on all current (approved) risks rated 15-25 will be presented to the Part 1 meeting each time.

4.3 Audit Committee

The Audit Committee is a committee of the Board of Directors, chaired by a non-executive director, which ensures effective evidence and assurance of internal control, including Risk Management, is in place throughout the Trust.

The Audit Committee reviews the full Board Assurance Framework quarterly and receives a report on all current risks rated 15-25 at each meeting.

The professional association for healthcare finance (HFMA) Audit Committee Handbook provides that: The Audit Committee may, as appropriate, request a deep dive into risks within the assurance framework. A deep dive may be undertaken for an area not overseen by another committee, or ones that have a particular relevance to the committee's responsibilities around good governance. A deep dive into an individual risk should focus on the evidence that supports management's assessment of residual risk and whether the remedial action plan to get to the target level is achievable and within a realistic timeframe.

4.4 Quality Committee

The Quality Committee is a committee of the board of directors and is chaired by a non-executive director. The committee receives detailed quality, safety and performance reports so that it can ensure that patient safety and quality of services meet registrations and compliance requirements.

The Committee receives a monthly heat map report on any current Quality (Safety and Outcome) and Patient Experience Risks rated 12-25. The heat map will be used to review current risks rated 12-25, potential emerging themes and consideration of risk aggregation.

The Committee receives a quarterly report on any current BAF risks linked to achieving the Quality (Safety and Outcome) and Patient Experience strategic objectives.

4.5 Finance and Performance Committee

The Finance and Performance Committee is a committee of the Trust Board and is chaired by a Non-Executive Director.

The Finance and Performance Committee provides the Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's finance and investments in the context of delivering the Trust's strategy, the underpinning financial plan and associated clinical activity data. The Committee has over-arching responsibility for financial risks, sustainability risks and operational performance risks on behalf of the Board.

The Committee receives a monthly heat map report for each meeting on any current Population and System Working risks and Sustainable Services risks rated 12-25. The heat map will be used to review current risks rated 12-25, potential emerging themes and consideration of risk aggregation.

The Committee receives a quarterly report on any current BAF risks linked to achieving the Sustainable Services and Population Health strategic objectives.

4.6 People and Culture Committee

The People and Culture Committee is a committee of the Trust Board and is chaired by a Non-Executive Director.

The Committee provides the Board with assurance concerning all aspects of strategic and operational workforce and organisational development relating to the provision of care and services. It also provides assurance to the Board that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of high quality, safe patient care.

The Committee receives a monthly heat map report for each meeting on any current Our People risks rated 12-25. The heat map will be used to review current risks rated 12-25, potential emerging themes and consideration of risk aggregation.

The Committee receives a quarterly report on any current BAF risks linked to achieving the Workforce strategic objectives.

4.7 Risk Oversight Committee

The Risk Oversight Committee is an executive-led management committee accountable to the Board.

The responsibilities of the committee are to:

- Receive and consider reports on risks following relevant investigations or failures in healthcare provision (within or external to the Trust) and to discuss and agree subsequent action required to keep the residual risk under prudent control.
- Systematically review, scrutinise and challenge risk profiles across all Care Groups and Corporate Directorates ensuring the correct strategy is adopted for managing each key risk, and verifying controls and action plans are in place and effective for those risks which remain intolerant.
- Monitor, evaluate and scrutinise all risks recorded on the risk register with a current risk rating of 15 or more, escalating to the Board those that pose a significant threat to the operations, safety, financial health or reputation of the Trust.
- Monitor, evaluate and scrutinise all risks recorded on the risk register with a current risk rating that breach risk appetite and/or risk tolerance escalating to the Board those that pose a significant threat to the operations, safety, financial health or reputation of the Trust.
- Oversee the population and management of the Board Assurance Framework, which is presented to the Board of Directors and Audit Committee at least twice a year.

- Review and approve the Trust's Risk Management Strategy and related policies and procedures.

- Work closely with the Board's Quality Committee, Finance and Performance Committee, Audit Committee and People and Culture Committees to understand the corporate risk profile and, where necessary, to clarify the arrangements for dealing with those risks between committees.

As part of Care Group and Corporate reporting, the Risk Oversight Committee will receive details on any proposed new risks rated 15-25 for approval. The Care Group report, and ROC presentation, will provide the following details of the new proposed risk:

- Risk title
- Risk description
- Risk Type and Risk Category
- Risk owner
- Executive sponsor (The Exec sponsor should be the Exec for the relevant Risk Category)
- Risk rating
- Controls
- Gaps in controls and assurances
- Action plan

4.8 Responsibilities and Scheme of Delegation for Risk Management

The Trust's risk management framework requires engagement from all staff throughout the Trust, including contractors and temporary staff. All are expected to participate in the risk management process. Individual staff and groups have specific responsibilities and accountability around risk management which are detailed below.

The **Chief Executive Officer** has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health and Social Care and Care Quality Commission in respect of governance. The Chief Executive chairs the Trust Risk Oversight Committee.

The **Chief Medical Officer** and **Chief Nursing Officer** have joint delegated responsibility for managing the strategic development and implementation of organisational risk management and clinical governance.

The Chief Nursing Officer has specific responsibility for acting as to the Board lead for monitoring compliance with the Care Quality Commission. The CNO also acts as the Director of Infection Prevention and Control and therefore has responsibility for advising the Board on all risk issues relating to the prevention, management and control of infection.

The Chief Medical Officer is the Trust Caldicott Guardian.

The **Chief Finance Officer** has delegated responsibility for ensuring that the Trust complies with NHS England and Monitor's requirements for financial risk management.

The **Chief People Officer** has delegated responsibility for all aspects of human resource risk management, Health and Safety and for the co-ordination and implementation of the Trust's strategy for occupational health services.

Executive Directors: Executive Directors agreeing (as part of formal escalation process) to act as Lead Executive for risks are responsible for monitoring compliance and supporting the management, progress and further escalation of risks on the Trust's risk register that are relevant to their delegated roles and responsibilities. Executive Director leads are responsible for ensuring that reported risks are updated in accordance with the Trust Risk Management strategy and risk appetite and for ensuring the adequacy of any agreed controls and action plan to mitigate or reduce identified risks. New risks rated 15-25 are presented to the Board of Directors by the executive sponsor.

Care Group Directors, Deputies and Heads of Nursing and Professions: have the following responsibilities in relation to risk management.

- Review with the Directorate Governance Group leads, Directorate Manager and Matrons the directorate risk register, integrated performance report, CQC action plan and other associate quality reports
- Provide a Care Group report to the Quality Committee and escalation of any areas of risk or concern. Provide a report on any mitigating actions, recommendations/ or learning points.
- Ensure quality patient safety, patient outcomes and patient experience is a standard agenda item at all directorate governance and risk meetings and is a core objective for all managers across the Care Group
- Ensure all escalated new risks are consistent with Trust approach to the articulation and assessment of risks and that they have a current action plan

Directorate Clinical Governance Clinical Lead

- Directorate leads are responsible for reporting any significant clinical governance or risk issues for CGG attention and for dissemination any important learning points from the directorate review of patient safety investigations, complaints, clinical audits, mortality reviews or external inspections/reports.
- Responsible for ensuring their directorate retains an effective directorate risk register.
- Ensure all pending or new risks are consistent with Trust approach to the articulation and assessment of risks and that they have a current action plan

Directorate Managers, Senior Matrons and Matrons responsibilities for risk management include:

- To ensure that the directorate has a robust structure for the management of quality, clinical governance and risk, and that this is communicated and applied across all areas of the directorate.

- Ensuring that, as appropriate, risks agreed at Directorate Governance (Directorate Quality and Safety Groups) are escalated for consideration, review and acceptance at Care Group Board.
- To ensure that lessons learned, and best practice are disseminated across the directorate and Trust
- To ensure that the Directorate Quality and Safety meetings are multidisciplinary and cover directorate wide activity and responsibilities. Ensuring that the risk register is reviewed at each meeting.

Managers / Heads of Department / Ward Leads are responsible the management of local risks. This is done by adhering to the following roles and responsibilities:

- Carrying out local risk assessments and escalating these at directorate level
- Ensuring all learning events are reported, recorded investigated and acted upon within their designated area(s) and scope of responsibility in accordance with Trust policy
- Disseminating information on the Trust's Risk Management Strategy (and associated policies and procedures) within their designated area(s) of responsibility, via local induction, appraisal and mandatory training
- Ensuring that all staff are made aware of the risks and associated risk control plans within their work environment and their individual responsibilities via the processes above.
- Ensuring that all staff have appropriate information, instruction and training to enable them to work safely. Those responsibilities extend to anyone affected by the Trust's operations including sub-contractors, members of the public, visitors etc.

Associate Director for Quality Governance and Risk is responsible for.

- Supporting the Chief Nursing Officer and Chief Medical Officer in the strategic leadership for quality governance and risk management for the Trust ensuring the Trust has a robust framework which meets the requirements of NHS Improvement, NHS England, the Care Quality Commission and the CCG to deliver year on year improvements in patient care.
- Overseeing the Trust Risk Management Strategy and risk register process.
- Working with the Chief Medical Officer and Chief Nursing Officer to ensure that quality and clinical governance systems and processes are integrated across the Trust and appropriately aligned with the Care Group/Directorates

Head of Patient Safety and Risk is responsible for.

- The development of strategic plans, policies, procedures and statement of purpose documents with regard to risk management.
- Development, support and oversight of the implementation of the risk functions and of the Risk Management Strategy
- Provision of training, information and support to clinical and corporate teams
- Ensuring relevant risks are reported to external agencies such as commissioners through appropriate oversight groups.

- Responsibility for ensuring systems and processes relating to clinical risk management are embedded throughout the Trust, including clinical incident reporting and investigations; ensuring lessons learnt from LERNS are shared throughout the governance structure; reviewing risk assessments to identify risks which are prevalent across the organisation.
- Ensuring the risk management system and associated processes are maintained and updated in line with Organisational requirements and the Trust Risk Appetite.
- Provide, through oversight, a 'check and challenge' process for risks on the register with the risk owners through a systematic and documented process.

Staff, every member of staff (including contractors and agency staff) must be aware of the Trust Risk Management Strategy & Policy and their individual responsibilities with regards to maintaining safety. All staff have a responsibility for risk management and a commitment to identifying and minimising risks. In particular, key responsibilities are to:

- Escalate perceived risks to team leaders and line managers,
- Understand and support the controls in place in work areas to mitigate risks,
- Report Learning Events (including incident, concerns, near misses)
- Act safely in accordance with training, policy guidance, and good practice,
- Comply with Trust policies, procedures and guidelines in place to protect the health, safety and welfare of anyone affected by the Trust activities
- Neither intentionally nor recklessly interfere with or misuse any work equipment provided for the protection of safety and health
- Be aware of emergency procedures (e.g. resuscitation, evacuation, fire and major incident procedures) relevant to their roles and work area(s)
- Attend mandatory training and any other risk management training deemed necessary for their role and/or area of work
- Comply with professional guidelines (as applicable to their role and profession) and acting in accordance with such guidelines and codes of practice

5.0 RISK ASSESSMENT

5.1 Risk Identification;

Risks will be identified in many ways and prompted by both internal and external events. The Trust aims to be proactive in its identification of risk The Trust has a range of risk assessment tools to identify risk and potential risks associated with its activities. Examples include risk assessments (clinical and non-clinical), audit (clinical and non-clinical), impact assessments, CQC inspections and monitoring visits, complaints and concerns, LERNs and LERN Reviews, etc.

Risks should be titled with a brief summary of the risk and can be framed as an '*if … 'then'* statement, for example: If we continue to or fail to do something then the result will be. The description of the risk should be succinct and summarises the causes of the risk, and the consequences/outcome if the risk were to occur. Providing this context will help to align controls and actions to specific causes and consequences.

Consider the risk against the key strategic objectives. Is there impact on the Trust workforce (Our People), Finance (Sustainable Services), Quality (Outcome and Safety), Patient Experience or Reputation and Innovation (Population Health & System).

5.2 Risk Assessment

The Trust uses a standardised approach to risk assessment that ensures consistency across the organisation. Risks are assessed based on the impact that the risk might have if it were to occur, and the likelihood of the risk occurring. The impact can be based on a variety of factors including; financial implications, the number of service users affected and the severity of harm, or the impact on staff morale and wellbeing.

The Trust uses a standard 5x5 risk scoring matrix for assessing the impact and likelihood of the risk. The matrix has been adopted as part of a pan-Dorset Risk Management framework.

	Likelihood Score				
	1	2	3	4	5
Impact Score	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Figure 2. 5 X 5 risk scoring matrix.

Risk rating 1-4 Very low
4-6 Low
8-12 Moderate
15-25 High

Risk scores are not intended to be precise mathematical measures of risk but are a useful tool to help in the prioritisation of control measures for the treatment of risk. The scoring system allows the levels of risk to be easily identified and therefore prioritised.

Controls to manage the risk should be described to provide detail on the management systems and processes the Trust have in place to manage its risks. Examples include policy guidance, staff training, appropriate skill mixes and staff numbers.

Actions should be recorded to provide detail on further work planned to mitigate the risk. These should align to gaps in controls or controls that are understood to be ineffective. Actions should be specific, measurable, achievable, relevant, and time specific.

An element of the risk assessment process is to agree the course of action. Courses of action can be summarised as either to:

- Treat – identify new actions that will, once completed, become controls and further mitigate the risk.

- Tolerate – agree that the control framework in place is appropriate and reflective of the seriousness of the risk, and that no further action is necessary.

- Transfer – move the risk away from the organisation through, for example, outsourcing activity.

- Terminate – agree that the risk cannot be practically mitigated further, is in excess of risk appetite, and therefore to consider terminating the activity that produces the risk.

5.3 Risk Register System (Datix)

Risks are recorded onto the Risk Register (Datix). The register is a management tool that enables the organisation to be aware of its risk profile. The register is a dynamic living document which is populated through the organisations risk assessment and evaluation processes. This enables risks to be quantified and ranked and shared at the appropriate levels.

5.4 Care Group Risk escalation

New Risks rated 1- 8 must be reviewed and approved at the relevant Directorate Quality and Safety Group meeting

New Risks rated 9-12 must be reviewed at the relevant Directorate Quality and Safety Group and then escalated for approved at the relevant Care Group Board

New Risks rated 15-25 must be reviewed at the relevant Directorate Quality and Safety Group and Care Group Board and then escalated for approved at the Risk Oversight Committee. There must be evidence of escalation of appropriate risks to Care Group Board (9-12 rated risks) and Risk Oversight Committee (15-25 risks) for approval.

Risk Score	Level of Approval	Exec Lead	Risk Owner	Risk Assessor
V.Low 1-3	Directorate Governance	Not required	Clinical or Operational Departmental Lead	Ward/Departmental /Specialty Lead
Low 4-6	Directorate Governance	Not required	Clinical or Operational Departmental Lead	Ward/Departmental /Specialty Lead
Moderate 9-12	Care Group Board	Not required	Care Group Director	Directorate General Manager/ Senior Matron/ Governance Lead

Risk Score	Level of Approval	Exec Lead	Risk Owner	Risk Assessor
High 15-25	Risk Oversight Committee	All risks 15+ risks	Care Group Director	Care Group Director/ Operational/ Governance Lead. Or Subject Matter Lead Or Trust Operational Lead

As part of escalation to Risk Oversight Committee, new potential 15+ rated risks must be discussed with the relevant Executive Director lead. The Executive Director lead will be the Exec linked to the Risk Type and Risk Category for the proposed new risk (see Appendix A4 for guidance). Confirmation of Executive Director sponsorship should be sought prior to the risk being presented to Risk Oversight Committee for approval. This will ensure that the risk narrative and controls identified are agreed and that any action plan can be supported by the Care Group and by an Executive Lead.

5.5 Corporate Groups – Risk Escalation Process

It is recognised that corporate groups do not have Care Group Quality and Safety Board meetings.Risk escalation processes are therefore as follows:

Risk Score	Level of Approval	Exec Lead	Risk Owner	Risk Assessor
V.Low 1-3	Directorate Meeting	Not required	Team Lead	Team Lead
Low 4-6	Directorate Meeting	Not required	Team Lead	Team Lead
Moderate 9-12	Directorate Meeting	Executive Director or deputy (Advise only)	Executive Director or deputy	Senior Manager
High 15-25	Directorate Meeting and then escalation to Risk Oversight Committee	Assign for all 15+ risks	Executive Director	Senior Manager

5.6 Risk Review Process

Regular review of the risk register at all levels should include:

- A review of scores, controls, and action plans for risks recorded on the risk register.
- A challenge of the risks recorded as an accurate reflection of the area's risk profile.
- Agreement of escalation of risks in excess of the Trust's risk appetite.
- A review of mitigated risks with completed action plans, with a view to closing these risks.

Directorate and Care Group Leads are responsible for keeping their risk register up to date and ensuring risks are reviewed in the following timescales:-

Current Risk score	Frequency of review (minimum)	Threshold for compliance reporting
12 and above	Once a month	35 days
8-11	Every 2 months	70 days
4-7	Every 3 months	105 days
1-3	Every 6 months	200 days

5.6 Risk Register Hygiene Rules

Risk register 'hygiene' will be maintained by ensuring that:

- all risks graded as Very Low and Low that have met their target risk grading are closed,
- all risks currently graded as Moderate that have met their target risk grading are reviewed at Care Group Boards for consideration of closure as a tolerated risk,
- risks graded as Very Low and Low that have not been reviewed for a year are closed unless statutory reason for extended planned review date
- risks designated 'in holding' status are reviewed and become accepted onto the risk register within 60 days or are considered for rejection or closure.

5.7 Horizon Risks

It is recognised that the identification of risks in the NHS is an evolving process and that risks may arise as a result of:

- Transformation
- New legislation or national guidance

- New system level pathways, processes, contractual arrangements or funding agreements
- Advances in technology
- Workforce changes (nationally and locally)
- Economic and Political influences

The risk register represents current risks; however the Board, Board Sub-committees and Care Groups Boards should consider any potential future risks that may require early discussion.

6.0 IMPLEMENTATION, MONITORING AND ASSURANCE

6.1 Training

The Trust Board recognises that training is central to the successful implementation of this strategy and to staff understanding their roles and responsibilities for risk management across the organisation.

Risk management training not mandatory for all staff. Those in leadership or management positions and those with explicit responsibility for risk management should receive risk management training. This training is provided by the Patient Safety and Risk Team. Full details are available on the Trust intranet.

It is expected that all staff will familiarise themselves with this Strategy & policy document and be able to identify, communicate, and escalate risks in their areas.

6.2 Monitoring

Criteria	Method of Monitoring	When	Method of following up non compliance	Follow up of action plan by	Criteria
The Risk Strategy has a process for Board or high-level committee to review the organisation wide risk register	Annual review by Internal Audit of risk Management functions and Assurance Framework	Annually	Results of Audits reviewed and shared with Risk Oversight Committee (ROC)	Internal Audit	Internal Audit Report –Audit Committee

The Risk Strategy has a process for management of risk locally, which reflects the Trust risk management strategy	Directorate Internal Audit Reports (rotational) Looking at whether risk management processes function appropriately at local level.	Annually	Results of audit reviewed and shared with ROC and Audit Committee chairs, action plans to address non-compliance requested	Internal Audit	Internal Audit Report –Audit Committee
	Review of results of Annual Governance Audit tool, identifying whether staff are made aware of processes for risk management.	Annually	Results reviewed by Health and Safety Group and action plans re non-compliance requested	Health and Safety Group	Annual review of results and action plans by Health and Safety Group

7.0 APPROVAL, IMPLEMENTATION AND REVIEW

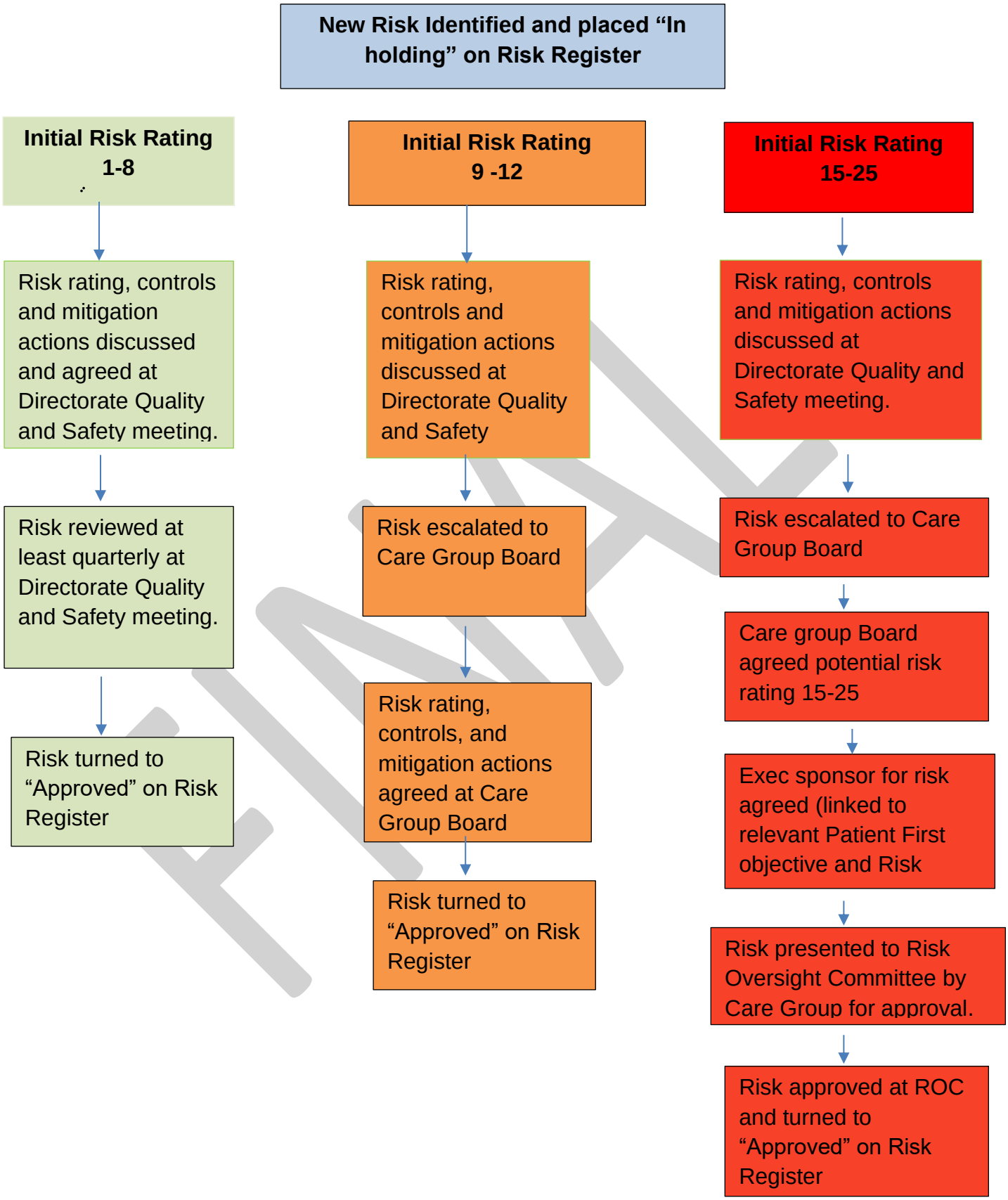
Once approved, the strategy will be placed on the Trust intranet.

The Board is responsible for reviewing the strategy annually and updating it as necessary.

8.0 REFERENCES

- Risk Register Toolkit
- Risk matrix
- Risk Grading descriptors

Appendix A 1
Risk Management Cycle



Appendix A 2

Risk Types and Risk Categories

Patient First Objective					
Risk Type	**Our People**	**Population and System Working**	**Quality (Outcome and Safety)**	**Sustainable Services**	**Patient experience**
Risk Categories	Staff Health, Safety and Wellbeing	Flow and Capacity	Infection Prevention and Control	Financial Management	Patient Experience
	Knowledge and Skills - Capability	Partnership Working	Patient Safety	Information Governance (including information Security)	
	Resourcing - Capacity		Medicines Management	Medical Equipment	
	Behaviours – Culture		Patient Outcome (Clinical Effectiveness)	Physical Assets	
				Information Technology	

Appendix A 3

Risk Categories aligned to Board Committees

People and Culture Committee	Finance and Performance Committee	Quality Committee
Staff health, Safety and Wellbeing Risk	Flow and Capacity Risk	Infection Prevention and Control Risk
Knowledge and Skills – Capability Risk	Financial Management Risk	Patient Safety Risk
Resourcing - Capacity Risk	Partnership Working Risk	Patient Experience Risk
Behaviours - Culture Risk	Information Governance (including information Security)	Medical Equipment Risk
	Information Technology Risk	Patient Outcome (Clinical Effectiveness) Risk
	Physical Assets Risk	Medicines Management Risk

Appendix A 4

Risk Categories - Executive Sponsors 15+ Risks

Chief People Officer	**Chief Operating Officer**	**Chief Finance Officer**	**Chief Nursing Officer**	**Chief Medical Officer**
Staff Health, Safety and Wellbeing	Flow and Capacity	Financial Management	Infection Prevention and Control	Patient Outcome (Clinical Effectiveness)
Knowledge and Skills - Capability			Patient Safety Risk	Medicines Management
Resourcing - Capacity			Patient Experience Risk	
Behaviours – Culture				
	Chief Informatics Officer			**Chief Strategy and Transformation Officer**
	Information Governance (including information Security)			Partnership Working
	Information Technology Risk			Physical Assets
				Medical Equipment

Appendix A 5 - Risk Category Definitions

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 - Capability Risk	To ensure that the Trust has processes to ensure staff develop the knowledge and skills requried to support the needs of our patients and the organisation.
Resourcing - Capacity Risk	To ensure that the Trust maintains a sustainable workforce capacity to meet the needs of our patients
Behaviours – Culture Risk	To ensure that there are people processes and systems in place to support and organisational cuture that embodies the Trust values
Population and System Working Risk	The risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external healthcare system process or events.
Flow and Capacity Risk	To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to meet constitutional standards.
Partnership Working Risk	To ensure the Trust has effective partnership working arrangements in place, working in conjunction with health, social care, voluntary and private sectors.
Quality (Outcome and Safety) Risk	The risk of poor patient outcomes and/or patient harm resulting from inadequate systems and processes associated with the Trust's infection prevention & control, safeguarding, medicines management, patient safety, clinical effectiveness and research & development. The risks of harm to staff as a result of inadequate safe systems of work and compliance with legal requirements for health and safety at work.
Infection Prevention and Control Risk	To ensure the Trust has effective processes in place for the management of infection prevention and control to reduce the transmission of infection in hospital and maintain patient safety
Patient Safety Risk	To ensure the Trust has effective systems and processes in place for high standards of patient safety
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 A 6 - Risk Appetite and Risk Tolerance by Risk Type and Risk Category

Risk Type	Risk Category	Risk appetite scale	Risk appetite score	Risk tolerance	UHD subcommittee
Our People risk	Staff Health, Safety and Wellbeing	Minimal	1-5	6-10	People and Culture
	Knowledge and Skills – Capability	Cautious	1-8	9-15	People and Culture
	Resourcing - Capacity	Cautious	1-8	9-15	People and Culture
	Behaviours - Culture	Minimal	1-5	6-10	People and Culture
Populations and System Working Risk	Flow and Capacity	Cautious	1-8	9-15	Finance and Performance
	Partnership Working	Open	1-10	12-20	Finance and Performance
Quality (Outcome and Safety) Risk	Infection Prevention and Control	Averse	1-3	4-6	Quality Committee
	Patient Safety	Averse	1-3	4-6	Quality Committee
	Patient Outcomes (Clinical Effectiveness)	Minimal	1-5	6-10	Quality Committee
	Medicines Management	Averse	1-3	4-6	Quality Committee
Sustainable services Risk	Financial Management	Cautious	1-8	9-15	Finance and Performance
	Information Governance including information security)	Minimal	1-5	6-10	Finance and Performance
	Medical Equipment	Cautious	1-8	9-15	Finance and Performance & Quality Committee

Risk Type	Risk Category	Risk appetite scale	Risk appetite score	Risk tolerance	UHD subcommittee
	Physical Assets	Cautious	1-8	9-15	Finance and Performance
	Information Technology	Open	1-10	12-20	Finance and Performance
Patient Experience Risk	Patient Experience	Minimal	1-5	6-10	Quality Committee

Appendix C: Quality and Risk Group Meeting Toolkits – content and link

https://intranet.uhd.nhs.uk/index.php/quality-risk/quality-governance/toolkits

- Terms of Reference template and meeting documentation templates for the following groups:
- Care Group Quality and Risk Group
- Directorate Quality and Risk Group
- Specialty Quality and Risk Group
- Ward/Department Quality and Risk Group

Appendix D: Risk Register Toolkit - content and link

https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

- Role of the Risk Register
- Acceptance onto the 'Live' Risk Register
- Risk Submission
- Risk escalation
- Reviewing a risk
- Risk Closure
- Running reports
- Appendix A: Flow chart: Escalation and agreement of risks rated 12 and above.
- Appendix B: Grading the Risk and Risk Matrix / Descriptors

EQUALITY IMPACT ASSESSMENT (EIA) SCREENING FORM

1. Title of document/service for assessment	Risk Management Strategy
2. Date of assessment	01/9/2024
3. Date for review	Sept 2025
4. Directorate/Service	Patient Safety and Risk
5. Approval Committee	Trust Board

	Yes/No	**Rationale**
6. Does the document/service affect one group less or more favourably than another on the basis of:		
• Race	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Gender (including transgender)	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Religion or belief	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Sexual orientation, to include heterosexual, lesbian, gay and bisexual people	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Age	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Disability – learning disabilities, physical disabilities, sensory impairment and mental health issues	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Marriage and Civil Partnership	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Pregnancy and Maternity	No	Policy applies to all staff groups and adverse incidents are treated uniformly
7. Does this document affect an individual's human rights?	No	Policy applies to all staff groups and adverse incidents are treated uniformly
8. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	No	Policy applies to all staff groups and adverse incidents are treated uniformly

9. If the answers to any of the above questions is 'yes' then:	**Tick**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid		
Adjust the policy to remove disadvantage identified or better promote equality		
If neither of the above possible, submit to Diversity Committee for review.		

10. Screener(s)

Print name……J Sims ……

11. Date Policy approved by Committee	Sept 2024

12. Upon completion of the screening and approval by Committee, this document should be uploaded to Papertrail.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: **9.1**

COVER SHEET – ALERT, ADVISE, ASSURE	
TITLE:	Risk Register Report – risks rated 15 and above
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)	All
Purpose of paper:	Information
Executive summary:	There are 213 approved risks on the UHD risk register as at the 26/2/26.
ALERT:	There are 16 risks rated 15-25. Full details provided in the report.
ADVISE:	N/A
ASSURE:	N/A
Celebrating Outstanding:	N/A
RECOMMENDATION:	To review risks rated 15-25
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Assessment Framework:	Safe ☐

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Risk Oversight Committee	23/02/2026	Risk discussion held

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

University Hospitals Dorset
NHS Foundation Trust

Risk Register Report

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

For the period to 26/02/2026

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 213 approved risks on UHDs Risk register, of which 16 are rated as 15 and above.

Rating movement key

- **Stayed the same**
- **Increased**
- **Decreased**
- **New**

Action status key

Overdue	Due in month	Not due

Risk Type - Population & System **Risk Category - Capacity Planning**	**Appetite = Cautious** **Tolerance = 9-15**
Risk ID	1460
Risk Title	Inability to meet UEC 4-hour safety standard leading to an adverse impact on patient safety and quality
Date risk raised on the risk register	05/02/2021
Date risk approved as 15+ risk	22/02/2021
Risk Rating	16 
Risk Description	There is a potential risk of harm and impact on quality of care to patients waiting in excess of 4 hours in ED and being cared for in an inappropriate setting.
Executive sponsor	Chief Operating Officer
Controls in place	Compliance with National 4 hr performance Standard • Performance review against metrics • Daily breach analysis • Efficient patient pathways and streaming process to SDEC's and UTC • Link to Risk 1426(Ambulance Queues) • Link to Risk 1387 and 1131 (Beds and Flow) • Patient assessment form (SHINE) • ED Trigger tool/ Delayed Care pathway

Risk Register Report

<table>
<tr><td></td><td>

TAD Process evoked
Compliance with Trust and ED Escalation plans/SOPs
Avoidable lost time and patient delay
ED Primacy
IPS optimisation
All elements of initial assessment: TTT, TT first clinician and TT decision are all within 3 hrs of arrival
Diagnostic delays standards (blood tests/x-ray and CT)
‘Surge Management’ criteria and plan
External transfers procedures compliant with patient category
Implementation of 4- and 12-hour escalation process and UHD ambulance divert policy.
4-hour performance metrics linked to ED escalation
Escalation email/text process along with ED shift report template improvement

</td></tr>
<tr><td>Gaps in controls</td><td>Gaps in assurance for sustainable delivery of 4-hour standard

SDEC pathways not in place 12 hours a day 7 days a week across all services.
Revised Escalation processes (ED and wider organisation) not yet embedded.
Gaps in recruitment remain a key challenge.
Capacity across the organisation to respond to the issues and take necessary action.
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.

</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>System Exec meeting to review pressures, agree action and implementation plans</td><td>Closed</td></tr>
<tr><td>Revise and implement ED Action Plan (attached)</td><td>Closed</td></tr>
<tr><td>Improving Hospital Flow Programme report and actions</td><td>Closed</td></tr>
<tr><td>ED 4 Hour Safety Standard Implementation Plan</td><td>Closed</td></tr>
<tr><td>4-hour standard 60 day plan</td><td>31/08/2023</td></tr>
</table>
</td></tr>
<tr><td>Tolerance breach?</td><td>Yes</td></tr>
<tr><td>Target Risk Rating</td><td>6</td></tr>
<tr><td>Progress update</td><td>Discussed at Risk Oversight committee, moved back to Capacity risk category but linked to Quality Monitoring Committee for reporting purposes to the Quality Committee.</td></tr>
</table>

Risk Register Report

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

Action plan(s)

Action	Due date
Monitor TATs	Closed
Report for Finance committee	Closed
Trust to support demand management initiative	Closed
Trust to review MDT requirement to reduce commitment from pathology and radiology	Closed
Department to implement digital pathology	30/03/2026
Department to implement AI	30/03/2026
Department to implement order comms	30/03/2026
Adress demand and capacity staffing issues in Cellular Pathology	30/03/2026
Funding Stream	30/03/2026
Trust to initiate cultural review with a view to optimising productivity in consultant body	31/03/2026
Department to accelerate BMS cut up training programmes	30/04/2026
Implementation of Automation project to modernise and streamline up to 40% of the work flow	03/06/2026

Risk Register Report

	Report delays in recruitment	30/06/2026
	Department to accelerate BMS reporting training programmes	30/07/2026
Tolerance breach?	Yes	
Target Risk Rating	4	
Progress update	• Digital Project: 2 substantive pathologists still outstanding, seeking medical Director support. NHSE target met. Outlier escalated to Medical Director awaiting feedback. Automation Project: PO with suppliers pre-enabling work on-going Staffing resources: majority of staff responded to survey for extended working pattern. HR informed of potential staff consultation.	

Risk Register Report

Risk Type - Population & System Risk Category - Capacity Planning	Appetite = Cautious Tolerance = 9-15
Risk ID	1665
Risk Title	School age Neurodevelopmental service
Date risk raised on the risk register	03/09/2021
Date risk approved as 15+ risk	15/08/2023
Risk Rating	15 ⟷
Risk Description	The school age neuro-developmental service does not have enough capacity to meet demand for children aged 5-16 yr olds who are: - medicated and monitored to manage neurodevelopment issues - referred to the school age Neurodevelopmental service for advice, guidance and treatment. There remains an untriaged cohort of referrals (approx. 7 months behind) and this may hold unknown risk.
Executive sponsor	Chief Operating Officer
Controls in place	• 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)	

Risk Register Report

	Action	Due date
	Dedicated admin support for referral screening process	Closed
	Reduce backlog of un-triaged referrals	Closed
	Listening events & senior leadership visibility	Closed
	Recruitment of nurse specialist to support workforce	Closed
	Supporting SENCo's with regards to referrals	Closed
	Medical recruitment	Closed
	Process mapping exercise	Closed
	To monitor the CDC School age service transformation plan	Closed
	Engagement with ICB All Age Autism Pathway review	Closed
	Medical / AHP recruitment	Closed
	Review delay in uploading referrals to eCamis	Closed
	Medical / AHP recruitment	Closed
	Engagement with ICB All Age Autism Pathway review	30/06/2026
	Monitor backlogs of referrals	30/06/2026
Tolerance breach?	No	
Target risk rating	3	
Progress update	Risk remains. Updates regarding recruitment, external capacity potentially coming online in Mar/Apr 26 which will support more long waits being seen but waiting list continues to grow and there remains a significant backlog in untriaged referrals.	

Risk Type - Population & System **Risk Category - Capacity Planning**	**Appetite = Cautious** **Tolerance = 9-15**
Risk ID	2070
Risk Title	Using multiple UHD Theatres for surgery which currently do not have UPS or IPS
Date risk raised on the risk register	15/05/2024
Date risk approved as 15+ risk	18/09/2024
Risk Rating	15 ⟷
Risk Description	Currently multiple theatres across UHD do not have UPS back up and would solely rely on a diesel generator in the event of power failure. If an internal power fault occurred most theatres would lose power from their wall sockets which could result in loss of vital medical equipment such as electro surgical and various laparoscopic/robotic, such delays and loss of equipment could lead to significant harm or death to patient/s
Executive sponsor	Chief Strategy and Transformation Officer
Controls in place	• **Poole** • Barn and Level 1 theatres have UPS back up - any patients needing to continue surgery will be transferred to these areas

Risk Register Report

	safely
	• Move to open surgery if loss of stack/robotic systems
	• Patients are to be made safe, woken and taken to recovery area
	• Anaesthetic machines, theatre lights have approx 30 mins back up
	• No surgery will continue unless life or limb in Level 1 or Barn theatres
	• **RBH**
	  • Move to open surgery if loss of stack/robotic systems
	  • Patients are to be made safe, woken and taken to recovery area
	  • Anaesthetic machines, theatre lights have approx 30 mins back up
	  • No Surgery will continue unless life or limb

Gaps in controls	• Multiple UHD Theatres do not have UPS or localised UPS - various medical equipment would depower in a power failure if the generator was not to kick in and function, such equipment is deemed as life preserving such as electrosurgical to maintain haemostats. All equipment used for keyhole/robotic surgery would lose power under these circumstances which would require the surgeon to immediately convert to open surgery which if occurring during a perioperative bleed.
Action plan(s)	**Action** / **Due date** UHD Theatres Team to investigate if a local UPS solution is available and then put it in place – Closed The Surgical Care Group to escalate the risk to the Trust Board and Clinical Governance Group – Closed The UHD theatre team to liaise with the estates and clinical engineering teams to put in place a permanent UPS solution (battery supplies to be installed in the theatres). – Closed Plan of rollout of user training – 27/02/2026
Tolerance breach?	No
Target risk rating	4
Progress update	Theatre matron discussed portable UPS units and training with clinical engineering lead - clin engineering lead scoping training need and how to deliver to ensure safe roll out of units.

Risk type - Quality (Outcome and Safety) **Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10**	
Risk ID	1855
Risk Title	Lack of Breast Radiologists
Date risk raised on the risk register	23/02/2023
Date risk approved as 15+ risk	21/11/2024
Risk Rating	20 ⟷
Risk Description	If we do not increase the number of breast radiologists, we will be unable to sustain the demands of the service.

Risk Register Report

Executive sponsor	Chief Medical Officer
Controls in place	• Review of Incidents and complaints reported • Weekly planning meeting to discuss previous week and week going forward • Meticulous rota planning • Robust and ongoing Recruitment/retention processes • Creation of new post to support consultant radiographers and promote succession planning • Review of pressures in both clinic pathways to ensure priorities are addressed • Weekend working and extra clinic in RBH • Waiting list to record backlog • Staff in post spreadsheet to document staff in post. • Staff supporting HSU training in own time to maximise future opportunities for joint working and new staff joining the service • Staff working as single practitioner in clinics where two are required
Gaps in controls	• Lack of radiology capacity to sustain service. • Lack of suitable applicant for both substantive and locum positions - 2 WTE breast radiologists for which service is funded have not been filled, nor has the WTE consultant radiographer post. • Reliance on staff who are already working extra shifts • Radiologist on call rota and time off in lieu reduces available staff for sessions • Inability to provide legislative axilla scanning of Melanoma patients
Action plan(s)	**Action** / **Due date** Increase Radiology capacity DBSU — Closed Reduce Symptomatic Patient Backlog (Jigsaw/LBU) — Closed Review of radiology on call rota — Closed Update Risk weekly with numbers of cancelled clinics/slots/uncovered — Closed Completion of monthly data summary report — 30/04/2026
Tolerance breach?	Yes
Target risk rating	2
Progress update	Discussed at Care Group Board. Risk to remain same currently

Risk Register Report

Risk Type - Quality (Outcome and Safety) **Risk Category - Patient Safety and Outcome Risk Appetite = Minimal Tolerance = 6-10**	
Risk ID	1970
Risk Title	Lack of sufficient provision of glaucoma service
Date risk raised on the risk register	22/09/2023
Date risk approved as 15+ risk	02/05/2024
Risk Rating	16 
Risk Description	If we do not address the workforce gaps for the provision of the glaucoma service and the outstanding review backlog then there is a risk that patients won't be seen in a timely basis leading to preventable and/or irreversible sight loss. There is also a risk to the Trust of litigation.
Executive sponsor	Chief Medical Officer
Controls in place	• Dept SOP- If a patient's eye pressure is found to be high (more than 30mmHg) then they are prioritised for a review. If the Technicians have any concerns, then they will flag the patient using a separate email account. This is then prioritised. • Patient information - The patient is advised to present to Eye Emergency if the Technicians are really concerned and identify that the patient needs to be reviewed on the same day their pressures have been taken. • SOP - Technicians ask a series of questions which will inform them whether to flag the patient as a concern. • Timetable review for Glaucoma Nurse Specialists to enable them to support with virtual reviews. • Monitoring the number of overdue patients • Additional clinics run every weekend (8 additional clinics each weekend) - insourcing team are supporting this process • CD's PA time - supporting the review process and clinical outcomes • Risk rating is assigned to all patients being reviewed – a system helps to manage these appointments • LERNS and complaints monitoring • Admission clerk is prioritising glaucoma operations over cataract • Setting up POD clinics - all patients have the consultant review completed - clinics run once per week - to be increased to 2/3 clinics when senior clinicians present • Plan to visit the Exeter clinics to review their process • CD stepped down from CD role to have more pt contact
Gaps in controls	• When a patient's pressure is high, but less than 30mmHg, or they have progressive field loss, as the patient is often not aware of the field loss, they can have permanent sight loss. • No nurse specialist in post to help to manage the reviews • No additional substantive/locum glaucoma consultant in post - there should be 2 additional consultants supporting the service • GIRFT recommendation re LCAD (latest clinically acceptable date) - if the pt is delayed it needs to be reported • Lack of capacity to grade all patients • Backlog of emails/admin work due to the lack of PA support - admin freeze in UHD
Action plan(s)	**Action** / **Due date** To present the plan to set up additional clinics to the directorate / Closed

Risk Register Report

	Visit to Exeter	Closed
	Monitor number of patients waiting to be reviewed/followed up	02/03/2026
	Virtual Glaucoma Review Clinics to be supported by a Glaucoma Consultant in the same location as the reviewing clinicians and nurses	11/03/2026
	Succession plan for Glaucoma Nurse Specialist	11/03/2026
	To map the progress of the actions against waiting times metrics	01/04/2026
	Ophthalmology Nurse Specialist to commence (glaucoma module) training course.	15/04/2026
	Recruit locum Glaucoma Consultant	30/06/2026
	Glaucoma POD Virtual Review Clinic Model to be Implemented	30/06/2026
	Ophthalmology Nurse Specialist to support with Glaucoma Virtual Reviews	30/06/2026
	Recruit substantive Glaucoma consultants x2	01/07/2026
Tolerance breach?	Yes	
Target Risk Rating	6	
Progress update	Risk discussed at Risk Oversight Committee on 23.02.2026 - confirmed there is currently work on the job plans to identify capacity to start POD clinics in March 2026. The team asked to explore opportunity to recruit to a substantive post rather than locum (consultant post), this will be taken forward. Head and Neck team raised there is an issue re consultant slots this will be discussed. Decision made that the risk should stay at the level of 16 until mitigations are put in place - POD clinics, permanent post option explored etc. Re level of harm - the team raised this is difficult to quantify the level of harm for now - proactive risk management to avoid patient harm. Action to map the progress of the actions against the 22 week waiting times.	

Risk type - Quality (Outcome and Safety) **Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10**	
Risk ID	1214
Risk Title	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices
Date risk raised on the risk register	10/11/2017
Date risk approved as 15+ risk	17/02/2023
Risk Rating	16 ⬌
Risk Description	There is a high risk that mismanaged point of care devices will result in incorrect results, misinforming diagnosis and treatment and leading to patient harm.
Executive sponsor	Chief Strategy and Transformation Officer
Controls in place	• MHRA standards • Compliance with national standards • Service contracts

Risk Register Report

	• Point of Care co-ordinator • Contingency policy for majority tests by sending sample to the laboratory • Incidents • MDI procedures • Medical devices policy • Corporate project in place to support the improvements across POCT
Gaps in controls	• Ungoverned POCT devices non-compliant with MHRA standards • Unidentified POCT devices in the Trust • Non-compliance with national standards • Point of Care testing team under resourced creating a single point of failure as insufficient staffing and succession planning not in place. • POC policy and standards need improving
Action plan(s)	

Action	Due date
Quarterly EQA testing of glucose and ketone meters by Pathology	Closed
Audit of all Abbott blood sugar glucose and ketone equipment within service contact	Closed
Review training for glucose and ketone meters provided within contract	Closed
Support for ketone monitors training/assurance by Diabetes CNS as time allows	Closed
Meeting between pathology diabetes CNS to review issues	Closed
Ward management of quality for blood gas analysers	31/12/2025
Provide updated Medical Devices POCT Action log on a regular basis	31/05/2026

Tolerance breach?	Yes
Target risk rating	6
Progress update	The audit of devices has been expanded, and data collection continues. Additional resource has been added to the project in January. Governance is being reviewed and a business case will be developed to request the necessary support for the ongoing management and compliance of these devices. A draft policy has been produced for the acquisition, verification and management of devices, this will need to be refined. Risk content reviewed, rating remains the same at present and will be reviewed at the next POC working group in February. Updated project documentation attached to risk.

Risk type - Quality (Outcome and Safety) **Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10**	
Risk ID	1974
Risk Title	Significant time delays for macular injection treatment
Date risk raised on the risk register	05/10/2023
Date risk approved as 15+ risk	01/07/2024
Risk Rating	16 ⬌

Risk Register Report

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

Risk Register Report

	Action	Due date
	Recruitment of consultant	Closed
	Identify space for macular service	Closed
	Recruit additional Health Care Support Workers	Closed
	Daily review of the waiting lists for macular appointments, undertaken by the Macular coordinators	Closed
	Weekly Macular Time Table Meeting	Closed
	Digital improvements in macular	Closed
	Submit A3 for Macular Workforce	Closed
	Weekend Nurse Injection Clinics to run if required	Closed
	Standardisation of macular clinics	Closed
	Monitor number of patients waiting for appointment	11/03/2026
	POD virtual review clinic model	11/03/2026
	support recruitment and retention	10/03/2026
	Increase number of patients in macular One Stop clinics	11/03/2026
	Identify additional space to provide macular assessments and treatments	11/03/2026
	Absence Management	11/03/2026
	Ophthalmology Practitioner Training (OPT) - macular module, for all Macular Nurse Specialists	01/05/2026
Tolerance breach?	Yes	
Target risk rating	9	
Progress update	Action progress discussed at Risk Oversight Committee on 23.02.2026 - noted that it will take some time to mitigate/downgrade the risk. The team asked to check if any improvement can be made until September 2026 - suggestion to review outsourcing options? Re: harm reviews - list provided - Quality team to advise regarding harm review process for patients. For now, the patients on the list are clinically reviewed by the consultants.	

Risk type - Quality (Outcome and Safety) **Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10**	
Risk ID	1378
Risk Title	Lack of Electronic results acknowledgement system
Date risk raised on the risk register	01/02/2021
Date risk approved as 15+ risk	29/11/2022
Risk Rating	15 
Risk Description	A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment.

Risk Register Report

Executive sponsor	Chief Digital Officer - Beverley Bryant
Controls in place	Compliance standards • Compliance with GMC guidance re: the responsible clinician • Royal College standard regarding referrers responsibilities • Task & Finish Group to support the move of requesting and reporting to paperless across the Trust to further support the results sign off.
Gaps in controls	• The functionality in [redacted] is not a single user interface for clinicians to manage their results sign off • No effective single user interface for clinicians to manage their core care processes.
Action plan(s)	**Action** / **Due date** Referrer awareness — Closed App — Closed
Tolerance breach?	Yes
Target risk rating	4
Progress update	First batch of Pilot areas are now paperless requesting for all Radiology and Pathology (excluding Blood transfusion and histopathology) with continued engagement and feedback to the project. Paperless reporting for Pathology and Radiology Trust wide other than Blood transfusion and histopathology. IT equipment to support Trust roll out of [redacted] requesting is ordered and awaiting delivery.

Risk type - Quality (Outcome and Safety) **Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10**	
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

Risk Register Report

Gaps in controls	• Staffing is reliant on bank and agency and therefore levels not always met. • Additionally, where the corridor is under the care of other agencies, there is the risk of a lack of clinical oversight from UHD.
Action plan(s)	**Action** / **Due date** Decompress the Emergency Department to prevent crowding – Closed Improve the facilities for patient privacy and dignity in Bournemouth corridor – 31/12/2025
Tolerance breach?	Yes
Target risk rating	3
Progress update	Gap analysis against HSSIB recommendations is being completed. THP SOP breached. Data to be reviewed in relation to care in non-clinical areas. Increase in use. Phase 3 option under review. Risk 1429 to be amalgamated into this risk reflecting that there is potential for harm when patients are cared for in non-clinical areas as a result of the need for timely handover of ambulances. Risk 1429 to close.

Risk type - Quality (Outcome and Safety) **Risk Category - Infection Prevention and Control Appetite = Minimal Tolerance = 6-10**	
Risk ID	2246
Risk Title	Inability to access a second obstetric theatre
Date risk raised on the risk register	14/09/2025
Date risk approved as 15+ risk	24/11/2025
Risk Rating	15 ⬌
Risk Description	Emergency obstetric patients needing to access a operating theatre in a timely fashion for Category 1 and 2 deliveries where there is concern regarding maternal or fetal wellbeing, manual removal of placenta, perineal repair, post partum haemorrhage. If we do not provide this service there will be risk to maternal and fetal life.
Executive sponsor	Chief Medical Officer
Controls in place	• Triaging potential emergency cases • Ongoing monitoring of patient whilst awaiting theatre • Alerting elective surgical teams to consider where lists can be paused during core working hours • Flow chart from Protocol to risk assess and summon a second emergency obstetric team to theatres is in place and agreed by maternity, obstetrics, theatres and anaesthetics (displayed in Labour ward/ maternity theatres/fishbowl) • An additional emergency team to be compiled from CEPOD and existing obstetric theatre team where available • Staff training, skills and drills • Consider moving patient to main theatre if both maternity theatres are occupied • Escalation to Clinical Site Team
Gaps in controls	• Unpredictability of obstetric emergencies. Obstetric emergencies can arise quickly and may escalate quickly from Cat 2 to Cat 1 making triaging very dynamic

Risk Register Report

	• Numbers of appropriate staff/skill mix might not be available to compile a second emergency team • Awareness for CEPOD team of the urgency/ priority of the obstetric cases • There are only 2 obstetric theatres. If there is an elective patient using one theatre and one patient using the 2nd theatre in an emergency, there is no other theatre for a 2nd emergency case • Obstetric teams do not have oversight of elective lists in main theatres • Physical and clinical risks for moving a patient • Accuracy of the data. Driver metrics. Data source
Action plan(s)	

Action	Due date
Protocol to risk assess and summon a second emergency theatre team for obstetrics	Closed
Improve Obstetric staff education and awareness regarding the above protocol	Closed
Ongoing collection of data through LERN submission	Closed
Theatre capacity	28/11/2025
Improve anaesthetic staff education and awareness regarding the above protocol	30/11/2025
Review communication tools for contacting CEPOD team	24/12/2025
Improve theatre staff education and awareness regarding the above protocol	30/01/2026
Improve theatre staffing to facilitate formation of a second emergency obstetric team	27/02/2026

Tolerance breach?	Yes
Target risk rating	5
Progress update	Monthly meeting being held between obstetric lead consultant and senior theatre matron. Theatre directorate plan to employ theatre staff on bank to increase emergency theatre team numbers and allow a third emergency theatre within UHD to be opened with more reliability. This will start from February. Communication methods between obstetric theatres and CEPOD theatres has improved. Risk to remain at 15 until increased staffing for the emergency teams has been seen.

Risk type - Quality (Outcome and Safety) **Risk Category - Infection Prevention and Control Appetite = Minimal Tolerance = 6-10**	
Risk ID	2229
Risk Title	Obstetric Ultrasound Scanning Service
Date risk raised on the risk register	03/07/2025
Date risk approved as 15+ risk	29/09/2025

Risk Register Report

<table>
<tr><td>Risk Rating</td><td>15  </td></tr>
<tr><td>Risk Description</td><td>If we do not improve our numbers of staff competent in delivering obstetric ultrasound imaging, we risk missing essential screening windows for our obstetric patients, delaying foetal diagnosis and treatment, impacting trust funding from MIS (maternity incentive scheme), as well as increasing rates of repetitive strain injury (RSI) in our staff.</td></tr>
<tr><td>Executive sponsor</td><td>Chief Medical Officer</td></tr>
<tr><td>Controls in place</td><td>• 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</td></tr>
<tr><td>Gaps in controls</td><td>• 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</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>Insourcing support for obstetrics</td><td>Closed</td></tr>
<tr><td>Align Preceptorship SOP</td><td>Closed</td></tr>
<tr><td>Upskilling of substantive staff</td><td>01/09/2026</td></tr>
<tr><td>Sonographer enhanced practice.</td><td>01/09/2026</td></tr>
</table>
</td></tr>
<tr><td>Tolerance breach?</td><td>Yes</td></tr>
<tr><td>Target risk rating</td><td>6</td></tr>
<tr><td>Progress update</td><td>Risk remains the same in terms of Student sonographers. Another Student has not been able to commence programme due to off sick with Repetitive Strain Injury (RSI). 1.0 Whole Time Equivalent (WTE) leaving 27/2/26. Interviews appointed 1.5 WTE neither have started. 1.0 awaiting second MNS before can commence (due end of Feb.) and 0.5 still going through employment checks and will need to work notice period after this . Work ongoing with HR to support . Currently 8WTE vacancies.</td></tr>
</table>

Risk Register Report

Risk type - Quality (Outcome and Safety) **Risk Category - Infection Prevention and Control Appetite = Minimal Tolerance = 6-10**	
Risk ID	1397
Risk Title	Provision of 24/7 Haematology/ Transfusion Laboratory Service
Date risk raised on the risk register	13/11/2020
Date risk approved as 15+ risk	23/07/2025
Risk Rating	15 ⇔
Risk Description	Lack of experienced Biomedical scientists to provide robust out of hours on call service for haematology and transfusion. If this continues, this could lead to inability to provide emergency blood within safe timeframe for patients with major haemorrhage
Executive sponsor	Chief Medical Officer
Controls in place	• Additional staff being cross-site trained to give a more resilient service and providing options should one site have gaps in the roster that can't be filled. • Onboarding 2 x locums for Poole • Planning to redistribute the staffing evenly across the rotas, now that the cross-site consultation is completed • Proactive ongoing recruitment to maximise opportunities • Additional mitigation is for Band 7's to backfill shifts but this impacts on supervision, training & quality activity • Ongoing staff support to optimise retention • Sickness and absence procedures • JACIE, MHRA and UKAS accreditation standards. • laboratory closure OOH procedures • SOP in place at both sites for service delivery • SOP and Flow chart for obtaining flying squad blood
Gaps in controls	• Lack of establishment to support robust and sustainable model to ensure patient safety
Action plan(s)	

Action	Due date
Review residual risk	Closed
Recruitment and retention of staff	Closed
Completion of OOH action tracker Oct 22	Closed
Table top exercise testing Blood Transfusion Contingency Plan	Closed
Establishment of Robust Out of Hours Service	30/03/2026

Tolerance breach?	Yes
Target risk rating	1

Risk Register Report

Progress update	2nd locum which had issues onboarding has been replaced and is on a 2 week trial. The other locum is supporting the Poole Out of Hours (OOH) rota by doing 2 nights per week. Additional substantive member of staff has started working some OOH shifts at RBH. Still working towards the end of July to be able to close Poole OOH post phase 3 move, the Equality Impact Assessment (EQIA) has been accepted in principle and will have final signoff at the next EQIA oversight panel.

Risk Type - Sustainable Services Risk **Risk Category - Financial Management Risk Appetite = Cautious Tolerance = 9-15**	
Risk ID	1595
Risk Title	Medium Term Financial Sustainability
Date risk raised on the risk register	27/05/2021
Date risk approved as 15+ risk	28/06/2021
Risk Rating	16 ⇔
Risk Description	There is a risk that the Trust cannot achieve its strategic priority to return to a financial surplus by 2026/27. Failing to deliver a financial break-even position would result in regulatory intervention, an unplanned reduction in cash and the inability to afford the medium term capital programme.
Executive sponsor	Chief Finance Officer
Controls in place	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, and other finance policies and procedures in place. • Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions. • Patient First 'driver' and 'watch' metrics agreed and monitored monthly. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery. • Financial planning with system partners • Efficiency Improvement Programme in place with oversight by Finance and Performance Committee. • QIA policy and process in place. • Regular contract performance meetings with commissioners. • Weekly MTP meetings. • Regular System triple lock meetings. The trust is not authorised to approve new investments above £25k, subject to triple lock process. • Detection control NHSE regulatory assessment (Risk Of Non Delivery Assessment (RONDA)) • Weekly escalation of the efficiency position to the executive team. Exec lead EIP meetings with each care group to challenge the recurrent and non recurrent nature of schemes.

Risk Register Report

Gaps in controls	• • Weaknesses in temporary staffing controls and roster management. Mitigation: Temporary staffing controls and roster management mitigation: External review of TSO, re-establishment of e-roster steering board, new e-form in development for approval of nursing/ HCA agency (Lead = CPO). • Weaknesses in the alignment of medical job plans, medical staff rotas and financial budgets. Mitigation: Alignment of medical job plans, medical staff rotas and financial budgets Mitigation: Medical staffing Patient First corporate project (Lead = CMO). • Weakness in high cost drugs spend controls by holding these in a non-directorate cost centre. Mitigation: High cost drugs spend controls mitigation: Harmonise legacy reporting processes to single data source, reporting spend at Care Group level improving accountability (Lead = CFO) • At present the trust has not identified sufficient savings / opportunities to deliver the full year efficiency improvement programme and financial outturn requirements.
Action plan(s)	**Action** / **Due date** Medium Term Financial Sustainability / 31/03/2026
Tolerance breach?	Yes
Target Risk Rating	8
Progress update	The Risk was reviewed by FPC as part the financial report, no changes to the risk grading were noted.

Risk type - Sustainable Services **Risk Category - Information Technology Appetite = Cautious Tolerance = 9-15**	
Risk ID	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

Risk Register Report

	• 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
Present Audit results to Mortality Group	Closed
Palliative care coding standard operating procedure	Closed
External Audit of Clinical Coding	27/02/2026
Competency framework for coders	31/03/2026
Palliative Care Coding SOP	31/03/2026
Clinical Coding Consultation - Service Transformation	01/06/2026
Implementation of new Clinical Validation Plan	01/06/2026

Tolerance breach?	Yes
Target risk rating	4
Progress update	Agreed at Risk Oversight Committee 26/01/2026. Coding consultation formally launched February 2026.

Risk type - Sustainable Services **Risk Category - Information Technology Appetite = Cautious Tolerance = 9-15**	
Risk ID	1950
Risk Title	The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose
Date risk raised on the risk register	01/08/2023
Date risk approved as 15+ risk	04/10/2023
Risk Rating	15 ⇔

Risk Register Report

<table>
<tr><td>Risk Description</td><td>There is a risk that the Trust EPR is going to be unsupported with no planned replacement and the current solution is not fit for purpose for UHD and the wider Dorset System. There is a risk that this impacts on patient flow (1872), patient safety and results acknowledgement (1378), clinical engagement and staff morale.</td></tr>
<tr><td>Executive sponsor</td><td>Chief Digital Officer</td></tr>
<tr><td>Controls in place</td><td>• The Electronic Health Record Programme (EHR) is moving forward where UHD will partner with Somerset and Dorset to procure a new system that will replace all the current key IT systems.

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</td></tr>
<tr><td>Gaps in controls</td><td>• Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals).
• No effective single user interface for clinicians to manage their core care processes.
• Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by March 2024.</td></tr>
<tr><td>Action plan(s)</td><td><table><tr><th>Action</th><th>Due date</th></tr><tr><td>Option appraisal</td><td>Closed</td></tr><tr><td>Business continuity Plan</td><td>Closed</td></tr><tr><td>EPR internal mitigation</td><td>Closed</td></tr></table></td></tr>
<tr><td>Tolerance breach?</td><td></td></tr>
<tr><td>Target risk rating</td><td>6</td></tr>
<tr><td>Progress update</td><td>Finalising the developments of the EPR system so that the commercial extension can be completed.
Business continuity within the scope of [redacted] and the current systems continues to be looked at.</td></tr>
</table>

Risk Register Report

Risk Heat Map- UHD

UHD						
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	22	24	7	1
	Possible (3)	3	26	43	14	4
	Unlikely (2)	0	8	28	11	2
	Rare (1)	0	0	3	2	0

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

Current Risk Score– UHD total	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Very Low (1-3)	4	6	6	5	6	5	5	5	5	4	6	6
Low (4-6)	74	71	72	72	75	71	79	79	75	70	64	67
Moderate (8-10)	99	96	94	93	92	92	93	95	96	87	86	86
Moderate (12)	41	40	45	46	44	44	43	36	32	31	34	38
High (15 -25)	21	19	19	19	19	14	14	15	14	15	16	16
Total number of risks under review	239	232	236	235	236	226	234	230	222	207	206	213

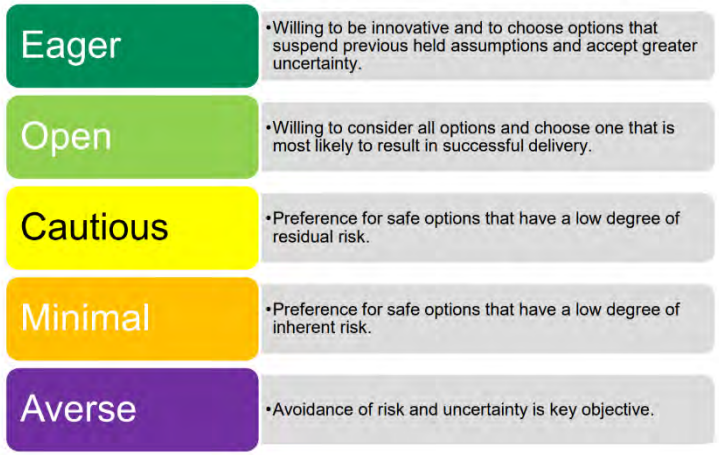
Risk Register Report

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

Risk Type	Risk Category	Risk Appetite Scale	Risk Appetite score	Risk tolerance	Executive sponsor 15 + risks
Workforce Risk	Staff Experience Risk	Cautious	1-8	9-15	Chief People Officer
Workforce Risk	Leadership and Talent Management Risk	Cautious	1-8	9-15	Chief People Officer
Workforce Risk	Recruitment and Retention (Staff Offer) Risk	Cautious	1-8	9-15	Chief People Officer
Workforce Risk	Workforce Risk	Cautious	1-8	9-15	Chief People Officer
Workforce Risk	People Function Risk	Cautious	1-8	9-15	Chief People Officer
Population and System Risk	Capacity Planning Risk	Cautious	1-8	9-15	Chief Operating Officer
Population and System Risk	Partnership Working Risk	Open	1-10	12-20	Chief Strategy and Transformation Officer
Quality (Outcome and Safety) Risk	Infection Prevention and Control Risk	Minimal	1-5	6-10	Chief Nursing Officer
Quality (Outcome and Safety) Risk	Patient Safety and Outcome Risk	Minimal	1-5	6-10	Chief Nursing Officer AND Chief Medical Officer
Quality (Outcome and Safety) Risk	Research Innovation and Development Risk	Open	1-10	12-20	Chief Medical Officer
Quality (Outcome and Safety) Risk	Health and Safety Risk	Averse	1-3	4-6	Chief People Officer
Quality (Outcome and Safety) Risk	Legal and Governance Risk	Averse	1-3	4-6	Chief Executive
Quality (Outcome and Safety) Risk	Regulatory Risk	Averse	1-3	4-6	Chief Nursing Officer
Sustainable Services Risk	Financial Management Risk	Cautious	1-8	9-15	Chief Finance Officer
Sustainable Services Risk	Counter Fraud Risk	Averse	1-3	4-6	Chief Finance Officer
Sustainable Services Risk	Financial Reporting Risk	Minimal	1-5	6-10	Chief Finance Officer
Sustainable Services Risk	Revenue Funding and Cash Management Risk	Cautious	1-8	9-15	Chief Finance Officer
Sustainable Services Risk	Information Governance and Security Risk	Cautious	1-8	9-15	Chief Informatics Officer
Sustainable Services Risk	Supply Chain Risk	Cautious	1-8	9-15	Chief Finance Officer
Sustainable Services Risk	Physical Assets Risk	Cautious	1-8	9-15	Chief Strategy and Transformation Officer
Sustainable Services Risk	Business Continuity Risk	Cautious	1-8	9-15	Chief Operating Officer
Sustainable Services Risk	Information Technology Risk	Cautious	1-8	9-15	Chief Informatics Officer
Patient Experience Risk	Patient Experience Risk	Minimal	1-5	6-10	Chief Nursing Officer

Risk Appetite Scales

Risk Register Report



Risk type and category definitions

Workforce Risk	The risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with the Trust's workforce supply, skills & capacity, performance and retention, within an appropriate culture.
Staff Experience Risk	To ensure the Trust provides a safe environment for staff where all feel respected, valued and included at work
Leadership and Talent Management Risk	To ensure that the Trust has processes to support a well led workforce
Recruitment and Retention (Staff Offer) Risk	To ensure that the Trust recruits and retains the best people
Workforce Risk	To ensure that the Trust maintains a sustainable workforce that is adaptable and organised to meet the needs of our patients
People Function Risk	To ensure that there are people processes and systems in place to support care groups and corporate directorates to deliver their priorities

Population and System Working Risk	The risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external healthcare system process or events.
Capacity Planning Risk	To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to maintain patient safety and meet constitutional standards.
Partnership Working Risk	To ensure the Trust has effective partnership working arrangements in place, working in conjunction with health, social care, voluntary and private sectors.

Risk Register Report

Quality (Outcome and Safety) Risk	The risk of poor patient outcomes and/or patient harm resulting from inadequate systems and processes associated with the Trust's infection prevention & control, safeguarding, medicines management, patient safety, clinical effectiveness and research & development. The risks of harm to staff as a result of inadequate safe systems of work and compliance with legal requirements for health and safety at work.
Infection Prevention and Control Risk	To ensure the Trust has effective processes in place for the management of infection prevention and control to reduce the transmission of infection in hospital and maintain patient safety
Patient Safety and Outcome Risk	To ensure the Trust has effective processes in place for monitoring patient safety and outcomes, including learning from patient safety incidents and audit findings
Research Innovation and Development Risk	To ensure the Trust has an effective research and innovation strategy and a robust structure in place for research governance
Health and Safety Risk	To ensure that the management of Health and Safety and is designed to prevent harm to patients, staff, visitors, and volunteers.
Legal and Governance Risk	To ensure that the Trust controls and manages legal risk in accordance with Risk Appetite and operates an effective Corporate Governance Framework
Regulatory Risk	To ensure the Trust has effective processes in place for monitoring performance and progress against regulatory quality standards.

Sustainable Services Risk	The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its estate, infrastructure, finances, financial reporting, funding, and cash management.
Financial Management Risk	To ensure that financial information reported internally is accurate and complete, including waste reduction programme, and enables the Trust to manage its financial position appropriately, on an ongoing basis
Counter Fraud Risk	To ensure that the Trust's Systems and Controls are designed to detect, prevent, and deter organisations and individuals (internal and external) from committing acts of fraud against the Trust and its patients.
Financial Reporting Risk	To ensure that financial information reported externally is correct, true, and fair and does not contain material misstatement. Also, to ensure that the tax position of the Trust is understood, appropriately managed, and reported correctly
Revenue Funding and Cash Management Risk	To ensure that the Trust's funding sources are adequately managed, held in the required state and available as the business requires
Information Governance and Security Risk	To ensure that the Trust has the right processes and systems for collecting, storing, managing, and maintaining information (includes archiving and deletion) in all its forms in order to support business needs and comply with regulations. To ensure that the management of information security is designed to protect confidential, private and sensitive information or data from unauthorised access, use, misuse, disclosure, destruction, modification, or disruption.
Supply Chain Risk	To ensure that the selection, ongoing management, and termination of third-party suppliers are managed appropriately to protect the Trust's patients, assets, operations and finances.

Risk Register Report

Physical Assets Risk	To ensure that the management of the Trust's physical assets related to buildings and infrastructure is designed to prevent harm to patients, staff, visitors, volunteers, and property.
Business Continuity Risk	To ensure the Trust is able to maintain key patient services during, as well as after, significant failures of systems, cyber-attacks or security breaches, failure of critical and important third-party suppliers or an environmental disaster, such as a fire or flood, impacts to workforce supply
Information Technology Risk	To ensure the Trust has appropriate processes in place to manage the use, ownership, operation, involvement, development, and adoption of IT to prevent unplanned business disruption

Patient experience Risk	The risk of poor patient experience resulting from inadequate systems and processes associated with the fundamentals of care.
Patient Experience Risk	To ensure the Trust has effective processes in place to monitor feedback from patients and use this to improve services and patient experience.

Appendix B: Matrix and descriptors for Risk Register Assessment

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

Risk Register Report

	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.	• Overall treatment or service suboptimal	• Treatment or service has significantly reduced effectiveness	• Major injury leading to long-term incapacity/disability	• An issue which impacts on a large number of patients,

• Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• 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	• 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	• 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	increased probability of death of irreversible health effects • Gross failure to meet national standards • Multiple breeches in statutory or regulatory duty • Prosecution • National media coverage with >3 days service well below reasonable public expectation. • Incident leading >25 per cent over project budget • Non-delivery of key objective/ Loss of >1 per cent of budget • Loss of contract / payment by results • Claim(s) >£1 million • Permanent loss of service or facility • Catastrophic impact on environment

Table 2 Likelihood score (L)

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

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

Agenda items discussed:	At its meeting held on **3 February 2026**, the Committee received the following:
	• Update on ED care in non-clinical areas
	• Risk Register: risks rated 12 – 25 (Quality & Safety)
	• Integrated Performance Report
	• Medical Device Replacement Programme
	• Maternity and Neonatal:
	  o Quality and Safety Report
	  o Safety Champions Report
	• Clinical Audit & Effectiveness Report, including Get It Right First Time (GIRFT) report
	• Report from the Clinical Governance Group

ALERT	The Committee wishes to alert members of the Board that: • An ongoing issue relating to neonatal ventilators (newly purchased though now judged not to be suitable) will hopefully be resolved following an upcoming meeting with the company. • The GIRFT team will be visiting Urgent and Emergency Care shortly.
ASSURE	The Committee wishes to assure members of the Board that: • The clinical leadership for the Emergency Department presented how they oversee care of patients in non-clinical areas to ensure a strong focus on quality and mitigate threats to care. It was evident that along with the executive quality of care for patients remains a priority. • In the integrated performance report, it was noted that overall Infection Prevention Control was better than the previous year, however 2 MRSA cases were reported and even though community acquired they count against UHD numbers. • The medical devices replacement programme continues to make positive progress and there is clarity about what actions still need to happen. • The GIRFT work and outputs are being systematically integrated into the work of care groups and individual specialities.

	• Maternity and Neonatal safety data continues to show improvements in several measures. Sickness rates remain high, though improvement is expect shortly.
ADVISE	The Committee wishes to advise the Board that: • A discussion about whether duty of candour applies in relation to patients receiving care in a non-clinical area simply by fact of the location as opposed to a specific failure of care. • Clinical Governance Committee continues to work effectively.
Review of Risks	• The Risk Register was reviewed and several of them discussed and scores challenged.
Celebrating Outstanding	• The GIRFT review of Vascular Services show outcomes in the top 10% of the country.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Quality Committee – Chair's Report
Presented by:	Michael Marsh, Chair of the Quality Committee
Agenda items discussed:	At its meeting held on **3 March 2026**, the Committee received the following: • Service Deep Dive: Intensive Care Unit • Risk Register: risks rated 12 – 25 (Quality & Safety) • Integrated Performance Report • Antimicrobial resistance • Maternity and Neonatal Safety Champions Report: • Safeguarding Report • Complaints and Patients Experience Report • Terms of Reference • Governance Cycle • Report from the Clinical Governance Group
ALERT	The Committee wishes to alert members of the Board that: • A high number of critical care patients are on Non-Invasive Ventilation (NIV), and the care could be better provided in a different facility. Split site working provides some challenges including to elective surgical activity. The service requests that critical care discharges are given priority by wards.
ASSURE	The Committee wishes to assure members of the Board that: • The medical and nurse lead for critical care presented data supporting that the service is of high quality overall with good risk adjusted mortality (12-14%) statistics. The ICNARC quality indicator board is largely positive with exception of unplanned readmissions. • The integrated performance report was scrutinised and NCTR remains a real challenge with over 200 patients. The 4-hour target continues to deteriorate. There have been 2 new MRSA cases. • The HSMR has risen marginally for the 3rd consecutive month so a review on cases and coding has been started. The SHMI remains below expected at 0.87. An audit of practice against the Learning from Deaths Policy has commenced. • There is evidence that UHD has good practice in relation to use of antimicrobials, performing well against national

	targets (total use of antibiotics and use of broad-spectrum antibiotics). Though future targets are not yet known, UHD is in a good position to achieve the likely ambition. • Maternity and neonatal data was reviewed as usual and no concerns were raised. • The quarterly safeguarding report was reviewed and changes in training approach for level 3 discussed. UHD's performance on the Oliver McGowan training shows we are not an outlier. • The quarter 3 patient experience report was reviewed, and complaints performance remains a challenge. • The work of the Clinical Governance Committee continues to be positive and proactive.
ADVISE	The Committee wishes to advise the Board that: • Critical care moved into the Beach building nearly a year ago and has adjusted to the work environment with adopting new ways of working. This has been a positive experience and staff feel safe. Discharges to the word frequently experience delays. • The Maternity Incentive Scheme Compliance submission has been accepted by NHSE. • The PLACE report will be reviewed next month. • The revised Terms of Reference were accepted in principle, though some discussion is required outside of the meeting about attendance. • The Governance cycle was approved for the committee.
Review of Risks	• Work continues addressing issues on the risk register with some focused work on the governance of point of care testing we should see a reduction in the next 2-3 months.
Celebrating Outstanding	• The Critical Care teams successful move into BEACH Building and high quality outcomes national audit programme (ICNARC).

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 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 extraordinary meeting held on **23 January 2026,** which had a single item business agenda, the Committee received a report on the following: • HealthSet Full Business Case ("FBC") which was recommended to the Board to approve.
ALERT	N/A
ASSURE	The Committee undertook a detailed review of the FBC, noting it had also reviewed an initial draft of the benefits case at a recent F&PC meeting. The FBC had been developed in line with the HM Treasury Green Book and NHS Five Case Model (Strategic, Economic, Commercial, Financial and Management Cases), together with NHS England Assurance Guidance for Digital Technology Business Cases (Apply to Supply). The scope changes since the Outline Business Case were clearly outlined and appropriate. The Committee was assured that the case met the necessary requirements and was in the best interests of the Trust, aligning well with its overall strategy and that of the ICS. Given the complex governance arrangements associated with the implementation on an EPR system across the NHS provider trusts in Dorset and Somerset the Committee recommended the Board consider the need for independent assurance reporting on the implementation phase.
ADVISE	N/A
Review of Risks	N/A
Celebrating Outstanding	The Committee recognised the outstanding work undertaken by the CDO and the entire project team in bringing a complex, multi-organisation FBC to approval stage within a very challenging timescale.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Alastair Matthews, Chair of the Finance and Performance Committee.
Agenda items discussed:	At its meeting held on **2 February 2026**, the Committee received reports on the following: • Update from ICS • Board Assurance Framework • Risk Register: risks rated 12-25 (Finance and Performance) • 2025/26 Financial Performance Month 9 • Efficiency Improvement Programme • New Hospitals Programme: Cashflow and Contract • Operational Performance Month 9 • HealthSet Programme and EPR Stability • Deep Dive: Fire Safety • Estates Compliance Report • Medium Term Plan In addition, the Committee approved the following contract awards: • Supply of Furniture, Fixtures and Fittings for new builds and refurbishments. The Committee also recommend the Board approve the following: • Shaftesbury House CDC construction phase. At its meeting held on **10 February 2026**, the Committee received a report on: • 2026/27-2028/29 Medium Term Plan which was recommended to the Board for approval.
ALERT	1. Emergency Department performance remains a significant concern. Whilst ongoing improvement cycles continue, sustained high levels of demand and poor flow from ED contributed to the Trust remaining behind the revised performance trajectory in December and into January. 2. No Criteria to Reside continued at high levels in December and into January. There are actions in place within the Trust and with system partners with a

	challenging trajectory to reduce the level to 110 well before the emergency/planned care site transition in the Summer. Moving performance to the agreed trajectory remain high risk.
ASSURE	1. The Committee reviewed and was assured that the latest full year financial forecast, which includes a range of pressures and mitigating actions, remains on Plan. Non-recurrent support in respect of the decision to not proceed with the Wholly Owned Subsidiary has been confirmed. The main financial risk at this stage is the financial impact of the ongoing demand and capacity pressures. There remain some pressures at ICS level that are being managed.
ADVISE	1. The “deep dive” into Fire Safety highlighted a number of areas requiring improvement action, including compliance with monthly reporting from local areas across sites. An improvement trajectory, linked to new electronic processes has been agreed. The level of available capital for backlog maintenance will require careful monitoring as part of the planning processes. The Trust is in the process of reviewing various governance arrangements, including fire safety as part of overall health and safety governance. 2. The Trust requested approval some time ago to re-phase some elements within the capital programme, this has recently been escalated by the CFO - at the time of the meeting formal approval had not been received. 3. The Committee was updated on progress on the 3 year Operating Plan but with ongoing negotiation with Commissioners was not in a position to review a final plan. An additional F&P meeting was scheduled for 10 February. As previously highlighted, it is clear that the level of the Efficiency Improvement Programme for 2026/7 and beyond will be extremely challenging, particularly in 2026/27 with major transformation activity taking place and the impact of a high level of schemes delivered in 2025/6 being non-recurrent. The Committee reviewed and recommended the Board approve the Operating Plan at its 10 February meeting.
Review of Risks	1. The Committee reviewed the aspects of the Board Assurance Framework and Risk Register relevant to its terms of reference. There were no new items to highlight to Board, although the risk rating related to No Criteria to Reside required reconsideration (see Alert 2 above)
Celebrating Outstanding	The Committee thanked the Executives and their teams for the clear way they had triangulated and presented the Operating Plan through several stages under what was a demanding timeframe.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Alastair Matthews, Chair of the Finance and Performance Committee.
Agenda items discussed:	At its meeting held on **2 March 2026**, the Committee received reports on the following: • 2025/26 Financial Performance Month 10 • Efficiency Improvement Programme • Key Areas of Judgment and Estimation within the Annual Accounts • Going Concern • Operational Budget • New Hospitals Programme: Cashflow and Contract • STP Wave 1, and BEACH building project out turn report • Operational Performance Month 10 • HealthSet Programme and EPR Stability • Private Patients update The Committee recommend the Board approve the following: • 3rd Surgical Robot business case • Laproscopic energy devices & consumables contract • Committee's Terms of Reference The Committee approved: • EPR Graphnet extension contract
ALERT	(1) Emergency Department performance continues to be a significant concern with 4 hour performance having fallen every month for the last 6 months and with a widening of the gap between the revised agreed trajectory and actual for the last 4 months. Various internal and external reviews have been undertaken and action plans developed/reports awaited. However, as yet those actions have not been effective in addressing the overall performance. With the planned transformation in the Summer to a single ED at RBH this is an increasing concern. (2) The level of No Criteria to Reside bed occupancy also continues to be a significant concern. There are actions being taken across the health and care system to help address this but the level remains well above 200 beds, making the trajectory needed to reduce this to 140 by mid 2026 look more and more challenging. (3) The Trust will fall c£36m short of its recurrent savings target for 2025/6 which has resulted in the need for a

	very high level savings requirement for 2026/7 in order to deliver a breakeven plan.
ASSURE	(1) The Trust remains in line with the financial plan at January 2026. Whilst there continue to be significant operational and directly related financial pressures the Trust has identified mitigations delivery of which are expected to offset the financial risk and enable the Trust to end the year at the planned breakeven position. (2) Progress has been made towards finalising the operation plan for 2026/7. F&PC has requested that the Care Group sign-offs include the operational as well as financial plans. There remain a number of allocations that will need to be made to the Care Group plans in the first quarter of the year and the CFO will progress these and update F&PC once completed. The key risks identified were: (1) the level of efficiency requirement; (2) the requirement to reduce the NCTR level to 140; (3) a new contractual requirement to significantly improve the timeliness of coding of activity; (4) the risk that UEC activity will significantly exceed the commissioned level; and (5) there is a high level of operational productivity improvement in the plan. FPC reviewed the mitigations and will continue to focus on these as we move into the financial new year.
ADVISE	(1) Having the new wards (COAST) available to the Trust in early June is a critical enabler to delivering the major transformation planned July/August 2026. (2) The recently submitted 2026/27 Operating Plan includes an efficiency requirement of £69m. This will be challenging in a year when there is major transformational activity planned, including the move to make RBH the Emergency Care site and Poole the Planned Care site. At this stage many of the identified schemes are at an early stage of development and there remain £21m yet to be identified. The rapid identification and progression of these schemes to deliver early in the new financial year will be critical to underpin delivery of the plan. F&PC will be tracking this closely, looking to understand how the forecast monthly delivery of the developing plans matches the monthly delivery profile in the plan, noting that there is a significant increase in that profile for the second half of 2026/27. (3) The Committee were briefed on c£3m of funding being made available at short notice by NHSE to provide a new discharge facility at RBH. Due to the timing this case will come direct to the Board at its March meeting.
Review of Risks	(1) The Committee reviewed the aspects of the Risk Register relevant to its terms of reference.
Celebrating Outstanding	(1) The Committee noted that whilst performance in UEC remained very challenging there were a large number of areas where performance if strong, including the cancer targets, diagnostics and several aspects of the waiting lists.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

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

Agenda items discussed:	At its meeting on **2 March 2026**, The Committee received the following:
	• Chief People Officer's Report, including:
	  o Dorset Provider Collaborative
	  o ICS System Collaboration
	• Board Assurance Framework and People and Culture risk register
	• Integrated Performance Report – People Breakthrough Objective
	• People and Culture SLA & KPI:
	  o Occupational Health
	  o Recruitment
	• People service improvement projects:
	  o Band 5 Nurses
	  o On call
	• Audit and fraud report action plans
	• Communications: a well-informed workforce
	• Workforce Operational Efficiency and Reduction Plan (WORP)
	• Guardian of Safe Working Hours
	• Resident Doctors Plan
	• Gender Pay Gap
	• Safe staffing: Maternity
	• Freedom to Speak Up Report
	• Staff Survey Report
	• Committee Terms of Reference
	• Committee Governance Cycle
	• HR policies
	• People and Culture Group Escalation Report
	• Health and Safety Group Escalation Report
	• Mandatory Learning Oversight Group Escalation Report

ALERT	The Committee wishes to alert members of the Board that: **Sickness across UHD** UHD has continued to experience increased sickness rates, remaining above the upper control limit for the past four months. While seasonal fluctuations are expected, current data shows a

	sustained level of sickness compared with previous years. The top three causes are anxiety, stress, depression and other psychiatric illness; back problems; and other musculoskeletal (MSK) issues. The committee discussed this in detail and reviewed the findings from the Staff Survey, which provided insight into potential contributory factors. Care Groups are examining this through the A3 lens and are working through prioritised sickness cases with HR support. A range of actions including upskilling line managers, improving clarity around policies, developing SLAs for Occupational Health, utilising tools to address work-related stress, and strengthening the management of sickness absence are contributing to improvements. Some of these approaches have already resulted in positive reductions, including in Maternity where sickness decreased from 7.8% in December to 5.3% in January. The committee will continue to monitor and review the position. **Workforce Operational Efficiency and Reduction Plan** As of M10 UHD is not achieving a balanced plan with an adverse variance against M12 (March 2026) plan: • Total WTE: 173.29 • Substantive WTE: 215.89 • Bank WTE: -9.09 • Agency WTE: -33.51 There is limited assurance UHD will achieve the reduction plan – which is symptomatic of the current operational position aligned to winter pressures, no criteria to reside, industrial action, higher than expected front door demand, additional elective activity to meet targets and opening of escalations beds. Additionally, there is an increasing volume of A&C vacancies being brought through the Trust Vacancy Review Panel creating pressure against delivery of agreed A&C workforce reduction targets.
ASSURE	The Committee wishes to assure members of the Board that: **Internal Communications Channels and Engagement** The committee received assurance from James Donald regarding the effectiveness of internal communications channels and the plans to improve engagement across UHD. The scale of reach and the number of initiatives supported by the team are impressive. The UHD App is a standout product, downloaded by more than 9,000 users, and is due for an agreed upgrade that will further enhance the user experience and engagement.
ADVISE	The Committee wishes to advise the Board that:

	Appraisals – Completion and Quality The committee has noted improvements to the appraisal completion rate and were reassured about plans to address this using the A3 approach. **People Service Improvement Project – Band 5 Nurses** Following the recent letter from Jo Lenaghan, Director General for People at NHS England and DHSC (Interim), regarding *Actions to deliver the Agenda for Change uplift and a fairer deal for nurses*, the committee received a verbal update on the ongoing collaborative work with the Trust Partnership Forum to progress this programme. A more detailed progress update will be presented to the committee in May. There remains a significant scale of work required to ensure completion by the summer, and the Board is reminded of its responsibility for overseeing the implementation and management of the Agenda for Change (AfC) system. **Safe Staffing – Maternity and Guardian of Safe Working Hours** The committee reviewed both these reports, and it will be presented at the Board meeting for further discussion. There were no items for escalation noted on these reports. Rachael Ford has now taken on the role of Guardian of Safe Working Hours from Paul Froggatt. The committee noted its thanks to Paul for his dedication to this role.
Review of Risks	The committee reviewed the risks currently on the register, with discussion focused on Risk 1202 – *Understaffing in the Obstetrics and Gynaecology medical rota* (score 12). Lorraine Tonge provided an update on the actions undertaken to date and highlighted the gaps that still need to be addressed. The committee recognised that people-related risk - specifically those linked to the People function are not yet fully articulated or presented within the risk register. Two new risks were referenced: *Capacity and skills within the Temporary Staffing Team* (score 12) and *WTE staffing controls and Workforce Plan* (score 12). These risks were not included in the circulated papers and will be reviewed and discussed at future meetings.
Celebrating Outstanding	None to be raised from this meeting.

University Hospitals Dorset
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BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 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 **16 February 2026**, the Committee received reports on the following: • Investment Update • Finance Report – Q3 • Fundraising Report – Q3 • Fundraising Strategy • Fundraising Policies • Committee's Terms of Reference • Committee's Governance Cycle • Risk Register In addition, the Committee received various proposals and business cases for approval and three business cases for recommendation to Board to approve.
ALERT	There is nothing to alert the Board.
ASSURE	1. The charity's financial performance is excellent, with a total income of £3.4 million to the end of the 3rd quarter against a plan of £2.7 million, a positive variance of £0.7 million. The charity is on track to raise more than £4 million for the full financial year 2025-2026. 2. Given the healthy balance of total charity funds (£19 million as of 31st Dec 2025) it is reassuring to see that the number of charity funding applications have increased along with the amounts being requested. The Charitable Funds Committee is reviewing the fundraising and spending strategy to ensure that the initiatives that have the biggest impact on improving patient care and staff experience are prioritised. 3. The Committee wishes to assure the Board that while onsite lottery canvassing was approved (within the scope of the Board's 2024 decision to establish a UHD lottery), we remain acutely mindful of the ethical sensitivities of fundraising within a hospital environment. Robust safeguards are in place, including the use of fully regulated providers, strict adherence to the Code of Fundraising Practice and Gambling Commission requirements, and hospital-specific protocols to protect patients, relatives and staff in vulnerable circumstances. The Committee will maintain rigorous oversight, with defined KPIs, regular reviews, and the ability to pause or amend activity should any ethical, reputational or

	operational concerns arise, ensuring the lottery is managed responsibly and in keeping with the values of University Hospitals Dorset NHS Charity.
ADVISE	The Charitable Funds Committee wishes to advise the Board that: • The Charitable Funds Committee recommends that the Board approve funding for *Return to Wellbeing*, an 18-month, evidence-based rehabilitation programme to reduce long-term sickness absence related to stress and mental ill-health. The £309,884 non-recurrent investment is primarily staffing-based, funding a defined multidisciplinary team and programme delivery, evaluation and sustainability planning, with costs fully scoped, time-limited and including a 5% contingency. Additional in-kind support from the Psychological Support and Counselling Service enhances value for money. Given the current £3.28m annual cost of stress-related absence, even modest reductions would offset the investment, with a realistic prospect of positive return.
Review of Risks	Review of the charity risk register did not show any major risks.
Celebrating Outstanding	N/A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 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 **2 February 2026**, the Group received the following: • Programme Risks • Service Ready Update o Phase 3 Move Planning • Build Ready Update • People Ready Update • TCT Digital Update • Communications and Engagement Update • Consolidated EIP benefits stocktake
ALERT	The Committee wishes to alert that: • Ten unresolved programme risks remain under active management; several relate to high-risk clinical areas and require continued scrutiny. • Workforce consultations remain a pressure point for HR capacity, with remaining gaps in COAST and respiratory high-care areas creating potential delays to readiness. • Transport for oncology and haematology patients remains an unresolved and material system risk. ICB commitment to non-emergency transport is impacting pathway assurance and causing some public concern. • Achieving system-wide alignment on communications continues to be challenging due to organisational changes and limited engagement from some partners; further strategic communications resource may be required. • Building Safety Act approval delays now projected at 60 weeks (previously 13) pose a threat to Phase 4 timelines and costs, with escalation to NHSE and government ongoing. • Some assumptions underpinning the reconfiguration business cases require revision, and real-time cost pressure capture is essential to avoid embedding inefficiencies.

ADVISE	The Committee wishes to advise: • Single-room model staffing uplift confirmed at 6-7% nationally, dispelling assumptions of significantly higher requirements. Early infection-rate increases are possible post-implementation due to isolation effects. • Mitigations for potential patient social isolation include enhanced volunteer engagement and digital enablement such as interactive camera technology. • Move planning continues with Healthcare Relocations: site surveys, move champions and detailed move calendars are in progress, including ward decluttering ahead of July 2026. • Gateway reviews are underway across all care groups with targeted focus on high-risk areas such as ED and workforce readiness. • Work is ongoing to finalise emergency and planned transfer pathways, including out-of-hours arrangements and necessary impact assessments. • Public engagement continues via targeted events, interviews, surveys and heatmap-guided outreach; internal communications remain active in preparing staff for major change. • Savings realisation continues to be tracked by care group and financial year, with a focus on productivity, estates rationalisation and income opportunities. Digital/IT teams are actively managing global supply chain pressures and aligning resource with the move schedule; proactive equipment ordering is underway.
ASSURE	The Committee wishes to assure that: • National evidence and Liverpool experience continue to demonstrate strong benefits of the single-room model: improved pandemic preparedness, enhanced privacy/dignity, improved sleep quality and better patient-experience outcomes. • Infection control benefits anticipated include faster room turnaround, reduced mixed-sex breaches and more efficient bed management. • Clear governance, reporting and escalation routes are in place for all unresolved programme risks with defined ownership and tracking mechanisms. • 84% of workforce plans are expected to be signed off by the end of January, following targeted interventions to unblock issues. • Progress continues delivering cash-releasing and cost-avoidance benefits from STP Wave 1 and New Hospital Programme business cases, with ongoing Finance and Performance Committee oversight. • Digital workstream remains closely aligned with clinical and operational teams to support transition and readiness despite external supply constraints.
Review of Risks	There are significant *programme-level* risks including unresolved workforce gaps, delays in some consultations,

	critical dependencies in transport arrangements, and major delays in Building Safety Act approvals that threaten construction timelines. System-wide communication alignment and external partner engagement remain inconsistent.
Celebrating Outstanding	The programme has achieved substantial progress in workforce planning, with 84% of workforce plans on track for sign-off; demonstrating strong cross-team collaboration and problem-solving. The move-readiness work is also advancing well, with structured gateway reviews and detailed move planning already underway.

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

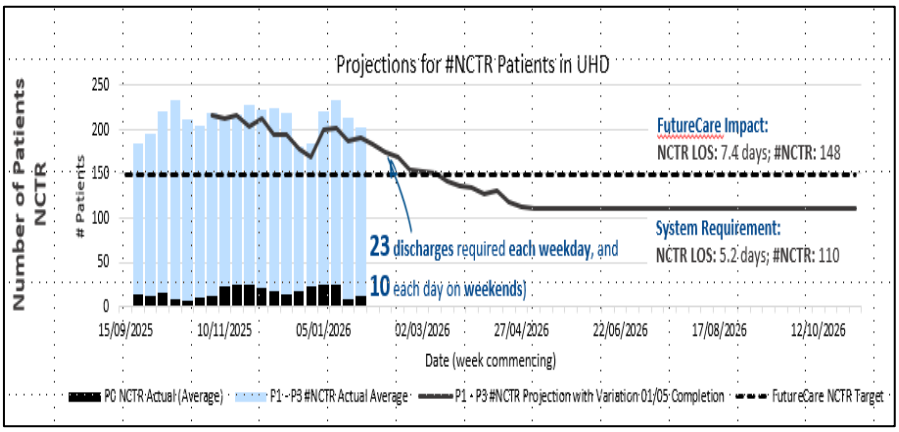
Agenda item: 9.3

Subject:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Adam Morris, Mark Major, Judith May, David Mills, Irene Mardon, Jo Sims, Viv Alividza and Adrian Tron.
Presented by:	UHD Chief Officers

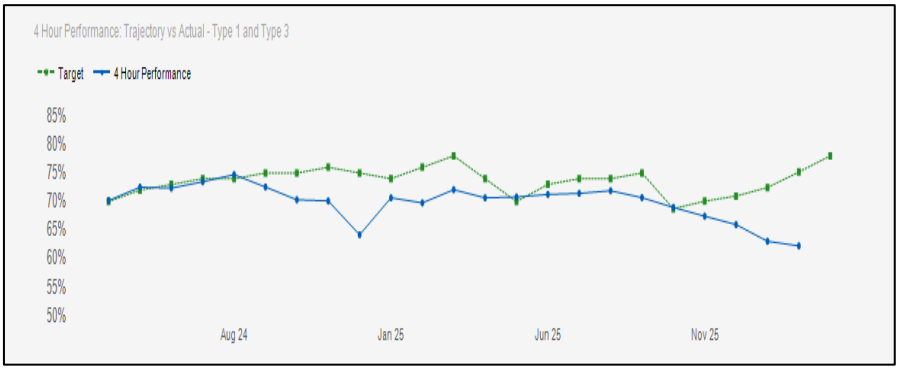
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report for January 2026 - Appendix A
Purpose of paper:	Information
Executive Summary: (Alerts: 7)	**Forward Look: Prepared and Focused** January has been a challenging month across the organisation with high occupancy impacting on UEC pathways with two Business Continuity Incidents and one Critical Incident being stood up in response. We recognise the challenging operational environment that winter brings for both patients and staff. We have a winter plan guided by our Trust strategic deployment reviews and are confident that our focused actions and continued prioritisation will ensure we deliver against our key objectives **Population & People (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:** Increase in the number of NCtR in January 26 **Alert 2: Performance against the 4-hour Organisational standard:** The standard was finalised at 63%, failing to meet the improvement trajectory of 72.5% **Quality Outcomes and Safety (1)** **To *reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture*** **Alert 1: Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia: 2 cases of hospital associated MRSA bacteraemia in January** **Our People (3)**

	Strategic goal: To significantly improve staff experience, engagement, and retention. **Alert 1: Resident Doctor Mandate:** The British Medical Association (BMA) has announced that following a ballot, the Resident Doctor strike Mandate for strike action over national pay and jobs has been extended to August 2026. **Alert 2: A&C recruitment** - An increasing volume of A&C vacancies is being brought through the Trust Vacancy Review Panel creating pressure against delivery of agreed A&C workforce reduction targets. **Alert 3 High-cost off-framework** usage continues to rise month on month partly driven by ongoing operational pressures. **Sustainable Services – Finance (3)** ***Strategic goal: To return to recurrent financial surplus from 2026/27*** **Alert 1: Revenue Position** At the end of January, the Trust reported a deficit of £3.1million, being and improvement of £2.1 million from the December position and £38,000 better than plan. Good progress continues to be made in relation to planned mitigations, providing confidence that these will deliver the expected benefits by the end of March. **Alert 2: Efficiency Improvement Programme** Efficiency improvement delivery to the end of January is £7.9m million behind plan. **Alert 3: Capital Programme** The Trust has reported capital expenditure of £105.8 million, being £20.2 million below plan year to date.
Background:	The integrated performance report (IPR) includes a set of indicators covering the key aspects of the Trust's performance relating to safety, quality, experience, workforce, and operational performance. As part of our commitment to the CQC Well-Led Framework, we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts. • Maintaining and updating the indicators that are most relevant to our patients. • Greater focus on key indicators as part of our Patient First roll-out programme linked to the Trust Strategic priorities and the Trust refreshed Strategy Deployment Review process. • Include the Metrics that are part of the National Oversight Framework denoted in bold in the metrics summary tables. • Providing SPC training to operational leads who compile the narrative against the data included within the report. We recognise as an organisation that behind every single metric discussed in this paper there is a patient.
Population & Systems **Urgent & Emergency Care** **(2 Alerts, 2 Advise, 2 Assure)**	**Strategic goal: To meet the national constitutional standards for Planned and Emergency care, supporting reducing inequalities in outcome and access and improving productivity and value.** **Alert (1): No Criteria to Reside:** Following a shortfall in delivery against the complex discharge weekly requirement, the No Criteria to Reside (NCtR) position reported in December deteriorated reporting an average of 220 a material difference of c30 patients against the agreed system plan. This has increased occupancy, impacting flow across emergency pathways. In response a set of additional focussed actions has been agreed:

- Agreement reached on commissioning of non- core capacity gaps across the system. (Un commissioned pathways to leave hospital)
- Agreement on additional domiciliary pathway capacity to support Pathway 1 discharges
- Additional social worker support in response to increasing workload
- Additional support to reduce pressure across mental health beds.
- Pan Dorset complex discharge panel chaired by an independent chair.



Alert (2): Performance against the 4-hour Organisational standard
The Trust's position against the standard was finalised at 63%, failing to meet the improvement trajectory of 72.5%. The national target (78%) remains outside of process control limits, therefore, will not be achieved without change or intervention to underlying processes.



The Emergency Department continues to run improvement activity in parallel to managing the high demand and acuity. The cycles remain focussed on underlying processes:

- SDEC (Same day emergency care) Streaming; Rapid Assessment Treatment (RAT)
- Ambulatory Care (ACA) with a broader PDSA focussed on effective escalation.
- Standardisation of roles and reduction of variation.

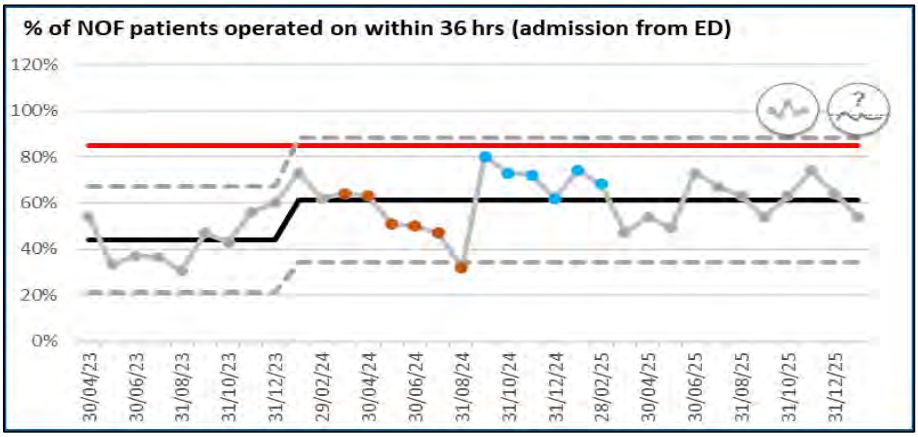
The team is part of a national NHS 4-Hour Sprint focused, on a short-term improvement initiative to improve performance by rapidly testing targeted interventions these will include additional funding has been allocated:

- Re-modelling front end of the emergency department to more effectively stream to alternative care settings, earlier in the pathway utlising GP in ACA,
- Acute Physician in RATS and senior nurse
- Ringfenced transfer team to reduce time from DTA to transfer.
- New model of bed management to reduce variation and ambiguity with greater clarity around roles and accountability.

- Greater visibility on early flow and use of SDECs to decompress Emergency Department.
- Greater visibility of P0 pathways to help reduce number of P0 patients that fail discharge.
- Accelerating the implementation of a Trusted assessor model to up-skill wards in undertaking assessment

Advise (1): Trauma: December performance for time to theatre for fractured neck of femur (#NoF) patients saw 54% of patients operated on within 36 hours from ED admission.

January fell below the process mean but the target continues to fall within the process limits, indicating it is achievable. 72.7% achieved surgery within 36 hours of being fit for surgery.



The key areas of focus to further improve this position are:

- Improving trauma theatre start times using data for procedure times and raising awareness of the Live on the Day Theatre Tool with the Trauma Wards
- Optimising the responsiveness from T&O with theatres, noting theatre staffing shortfalls at Poole.
- Continued focus on maximising trauma theatre efficiency and mitigating periods of escalated service demand.
- Embedding protected 1st patient on the theatre list to improve start times.

Advise (1): Ambulance Performance:

Average handover times for UHD increased to 31 mins during January 26 due to outflow from EDs. This has not triggered special cause variation, and target remains within process limits. Continued focus on handover times and supporting ambulance partners should see recovery in February.

Assure (1): Alternatives to Admission:

The number of Same Day Emergency Care (SDEC) starts has continued to demonstrate strong performance ahead of the improvement trajectory.

Assure (2): Non-Elective Length of Stay (LOS):

Despite the current NCtR position, the non-elective length of stay reduced by 0.4 day as compared to December and the occupied bed day usage is tracking well against the improvement trajectory and continues to track favorably against 2024/2025.

Advise (1) Cancer Waiting Times: All operational plan trajectories met

The 28 Day Faster Diagnosis standard for December 2025 performance was above the national standard (75%) and the Trust's Operational Plan (79%). The 31 Day standard achieved the 96.0% national standard for the eleventh consecutive month, achieving 97.2%. The 62 Day standard exceeded the Trust operational plan (73.6%) and met the March 2026 national recovery target (75%).

Population & Systems

Planned Care including Cancer standards

(2 Advises, 2 Assures)

The Trust has exceeded every operational planning trajectory in December 2025 for Cancer, showing the strongest performance since October 2023 and since the new standards were introduced. It is known that January 2026 will be a challenging month for cancer performance and additional actions are in place for February and March to support Trust's position.

Assure (1) Elimination of waits on an RTT pathway exceeding 65 week was achieved for the second consecutive month and the percentage of >52 week waits as a proportion of the waiting list (2.3%) has also reduced.
The Trust reported no patients on an active RTT waiting list with a wait over 65 weeks for the second consecutive month in January 2025 and is seeking to maintain this position in Quarter 4.
The percentage and actual number of patients waiting >52 weeks is also reducing. NHSE has launched an RTT sprint for Outpatients and 52-week waits in Quarter 4, which has provided additional funding to increase capacity for first OPAs and treatments. Focused actions include:

- Delivering an increase of c.2600 Outpatient first appts. before March 2026.
- Increasing treatments by implementing plans in UHD and with in/outsourcing providers during Quarter 4.
- Continued targeted validation of the waiting list to ensure patients who no longer need to be seen are discharged.

Advise (2) The % of patient waiting >52 weeks for Community Health (neurodevelopmental) services remains high
Following discussion with ICB and System partners on agreed interventions to address the increasing waiting list the Trust will commence the transfer of the longest waiting Children on a neurodevelopmental pathway to local Right to Choose providers for assessment in March 26. Additional Capacity is being brought online, through the implementation of a Neurodiversity Exploration and Strengths Tool (NEST) led through Dorset Health Care.

Assure (2) 18-week Referral to Treatment (RTT) performance shows a reduced variation (0.8%) to the operational plan trajectory.
A 1.3% improvement in RTT performance has been delivered in January compared to December reducing the variation to plan (63.2% versus plan 64%). This is being supported by reduced waits for a first attendance with 74% of patients seen under 18 weeks, enabling them to be placed on the correct pathway or discharged sooner.

The Planned Care Improvement Group has oversight of the improvement projects supporting elective performance.

Planning requirement	Dec 25	January 2026	
Referral to treatment 18-week performance	61.9%	63.2% ↑	National standard 92% trajectory 64.0% Jan 2026
Eliminate >65 week waits	0	0 ←	Plan trajectory 0 by Jan 2026
Reduce >52+ weeks	1674	1529 ↓	Plan Trajectory 1.3%, 856 by Jan 2026
Reduce Waiting List size	63,335	65,960 ↑	Plan Trajectory 67,170 Jan 2026
Waits for first activity <18 weeks	73.5%	74.0% ↑	Plan trajectory 71.8% Jan 2026

Population & Systems

Health Inequalities and Primary Prevention

(1 Advise)

Advise (1) The DM01 (Diagnostic) standard performance was 5.7% of patients waiting more than 6 weeks for a diagnostic test, moving the Trust above the operational planning ambition (5%).

Standard: No more than 1% of patients should wait more than 6 weeks for a diagnostic test.

January 2026	Total Waiting List	< 6 weeks	> 6 weeks	Performance
UHD	11,243	10,602	641	**5.7%**

Diagnostic waiting times performance remains strong, with the Trust performing in the top quartile nationally. However, performance in January was impacted by reduced outsourcing capacity and a depleted bookings admission team. Imaging achieved the national constitutional standard (<1%) but endoscopy, cardiology and physiological measurement each exceeded 10%.

Population & Systems

Operational Productivity

(2 Advise, 1 Assure)

Advise (1) Capped theatre utilisation performance was maintained at 80.8% in January.

Capped theatre utilisation is comparable to the process mean at 80.8% and there is reduced variation in performance, nevertheless it remains below the national target (85%). Contributing factors:

- Bed capacity during UEC critical incident, impacting day case and ITU bed capacity
- Pre-op assessment capacity
- Ward capacity prioritised for OPS/medical patients

The 4 key actions are:

- Reducing the impact of cancelations by specialities, particularly for pooled lists; including back filling short notice cancelations.
- Undertake list profiling reviews at speciality level.
- Review capacity at Wimborne ensuring fully utilised
- Optimisation of pre-op assessment capacity, including additional insourced capacity during Q4 to support the RTT sprint.

Advise (2) The Trust's performance against the British Association of Day Surgery (BADS) day surgery rate (target 85%) remains variable at 83.7%.

The latest published data is October 2025, and the Trust is performing at 83.7%, a reduction compared to September and below the national target. An improvement project working group is in place.

Assure (1) The Trust has delivered 115.4% (provisional value weighted activity) year to date compared to the same period in 2019/20.

- Elective activity is above the operational plan trajectory in January (108.6%).

Maternity
(1 Advise)

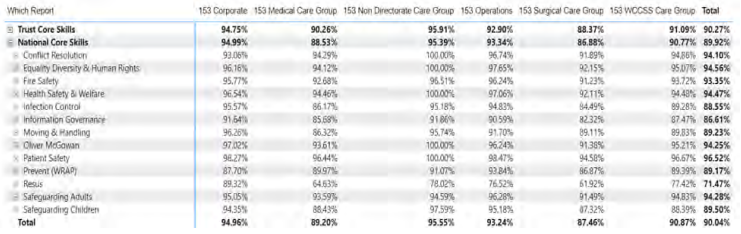
Advise (1): These are areas currently identified for focus

- Workforce –sickness rates and staff morale improving however remains a focus.
- Readmitted babies to hospital within the first 30 days of life- well-being clinic now commenced in November however increase in admissions in December and January
- Apgar score less than 7 at 5 minutes – quality improvement commenced.

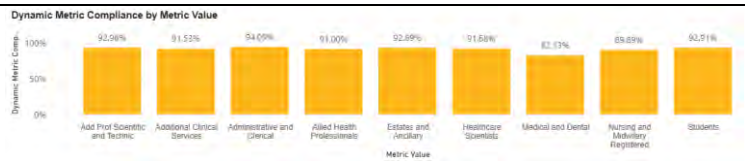
	Improvement actions are detailed within the IPR.
Infection Prevention and Control: ***(1 Alert, 6 Advise)***	**Quality, Safety, & Patient Experience Key Points** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture** • **Alert (1): Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia: 2** cases of hospital associated MRSA bacteraemia in January 2026. Both cases Community Onset, healthcare associated (COHA). One in Medical Care group, one in Surgical Care Group. Case investigations underway with Amber triage and requests for AAR. • **Advise (1) Clostridioides *difficile* cases**: 6 cases of hospital associated *C.diff* cases were reported and investigated in January 2026. This is a reduction compared to December 2025. • **Advise (2) *E.coli* bacteraemia: 8** cases of *E.coli* bacteraemia were identified in January 2026, a reduction compared to December 2025. • **Advise (3) *Klebsiella* bacteraemia**: 4 cases reported in January 2026, an increase of one compared to December 2025. • **Advise (4) *Pseudomonas* bacteraemia:** 0 cases reported in January 2026. • **Advise (5) Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia:** 4 cases identified in January 2026, an increase of 1 compared to December 2025. **Advise (6): Outbreaks/cohort of infectious disease:** 12 outbreaks identified in January 2026: • Two Influenza A outbreaks on Poole site • Three Covid-19 outbreaks on Poole site • Six Influenza A outbreaks on RBH site • One outbreak of Norovirus on RBH site
Clinical Practice Team ***(1 Advise)*** ***(2 Assure)***	**Clinical Practice Team:** **Falls prevention & management**: **Advise (1)**: Inpatient falls remain within expected variation. January 2026 rate: **6.9 per 1,000 bed days**. Ten inpatient falls resulted in moderate or greater physical harm, equating to **0.3 per 1,000 bed days**. **Assure (1)**: PSIRF SWARM reviews complete except one for all moderate+ harm falls; **inconsistent neuro observation documentation** as Trust-wide learning identified. Falls Steering Group: February 2026 meeting held; attendance improved but not quorate. **Assure (2): Fundamentals of Care Safer Activity** launch scheduled for March 2026, focusing on L&S BP, promoting appropriate footwear, and highlighting the importance of movement for recovery.
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**

Organism	Feb-25	Mar-25	Apr-25	May-	Jun-25	Jul-25	Aug-	Sep-25	Oct-25	Nov-	Dec-25	Jan-26
MRSA	0	2	1	0	0	0	1	0	0	1	0	2
MSSA	7	8	4	4	6	2	6	5	5	3	3	4
C Diff	6	8	10	11	5	8	13	8	12	10	8	6
E Coli	14	19	18	12	14	12	7	7	12	11	11	8
Kleb	5	8	3	6	3	4	4	3	2	2	3	4
Pseudo	2	0	3	2	1	2	2	2	4	6	1	0
Outbreaks	5	0	0	0	0	0	2	0	0	1	8	12

(2 Advise)	**care, which results in a positive experience for them, their families and/or carers.** **Patient Experience and Engagement Team Overview:** **Patient Experience (inc. PALS and Complaints) performance January 2026** **Advise (1) The number of open complaints over 35 days** is currently at 55. The complaints team continue to prioritise, with further measures to reduce the number of outstanding complaints in place and developing SOPs to ensure efficient processes within the service. **Advise (2) Average complaint response timescale** January 2026 was a 41.37 working day average for a final response.
Nurse Staffing: ***(2 Advise)*** ***(1 Assure)***	**Care Hours per Patient Day (CHPPD):** **Advise (1)** January 2026 CHPPD remained stable at 4.8 for Registered Nurses/Midwives combined and all Registered and non- registered care staff 7.7 The overall percentage rota fill rate against planned staffing (day and night all nursing/care staff) was 94.8%. **Red Flag Reporting:** **Advise(2) 12 Red Flags** on Adult in patient wards for January 2026. 50% (6) which occurred on inpatient wards and ED are due to "Unable to Provide Enhanced Care", 25% (3) Inability to record patient vital sign as planned, 16.6% (2) - Omission of fundamental care and 8.40% (1) RN shortfall of great than 8hours or 25% versus shift demand. **Workforce Controls:** **Assure (3)** 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.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement, and retention.**
CPO Headlines ***(1 Advise)***	**No items to alert** **Advise (1)** - Staff Survey 2025 – Trust level data shared at TMG and Board, and IQVIA management report received. Results are still embargoed and full comparison against our sector not available yet. Care Group and Directorate data packs being created and HRBPs to be briefed on how to use the packs. People & Culture Champions are preparing to share their finding and recommendations with clinical leaders on two areas – Communication (achieving a well-informed workforce) and progress against our Staff Rest spaces improvement project. People Pulse January 2026 survey closed with 625 respondents which is lower than usual. Data being collated in detail. Employee engagement score for January 2026 is 6.11 which is also lower this quarter.
HR Operations -	**Advise (1) Consultant and SAS Job Planning:** Job Planning Consistency Panels with each Specialty have commenced. The focus is to apply a

(1 Advise, 1 Alert, 1 Assure)	consistent approach across specialties and support the health and wellbeing of our Consultant and Specialty / Associate Specialist Doctor Workforce. To date, meetings with 14/36 specialties have taken place. **Alert (1) Resident Doctor Mandate:** The British Medical Association (BMA) has announced that following a ballot, the Resident Doctor strike Mandate for strike action over national pay and jobs has been extended to August 2026. **Assure (1) Exception Reporting Arrangements – Resident Doctors:** New exception reporting arrangements for doctors in training in England, came into effect from 4 February 2026. The aims of the changes are revisions to the process to increase transparency of the process and to reduce barriers to exception reports being raised. UHD has worked with the Guardian of Safe Working and other key stakeholders to ensure it is compliant with the new arrangements.
Blended Education & Training (2 Advise)	**Advise (1) – Oliver McGowan Training:** **Oliver McGowan eLearning** (all staff) compliance – 94.25% **Part 2 Tier 1** (webinar - all non-clinical staff, non-patient facing clinical staff and HCSWs) launched Nov 2025 – 13% Issues – training provided by Dorset Council with available sessions all fully booked. No train the trainer in the Dorset ICS/ council to be able to bring delivery in house and offer more sessions. Solution: Currently using NHSE funding to buy in tier 1 training from Oliver McGowan hub based in Somerset between now and March. **Part 2 Tier 2** (full day face to face - all clinical staff who are patient facing (apart from HCSWs) including medical staff of all grades – 16% In-house team delivering training (funded by Dorset Council). On track to reach 30% compliance across Dorset by end March 2026 with additional course capacity added. Discussions have begun regarding Framework agreement to facilitate the ongoing delivery beyond March 2026. Part 2 tier 1 and 2 issues involve capacity for delivery (resource intensive) and scale of staff to be trained – 5500-6000 versus challenge of being released with persistent OPEL 4 levels in January. **Advise (2) – Overall Training Compliance as of end of Jan 2026:** Overall Trust Training Compliance – 85.13% Compliance with Oliver McGowan Part 2, tier 1 and 2 removed – 88.72% Compliance with Safeguarding Level 3 also removed (recent increased rollout, full-day training – compliance for this 27%) – 90.04% Table shows compliance by Care Group per topic and in total.  Resus now includes Paediatric courses which have affected total compliance. Areas of reduced compliance for Resus and Safeguarding have been identified, and bespoke sessions arranged. Table shows compliance by staff group.

Which Report	153 Corporate	153 Medical Care Group	153 Non Directorate Care Group	153 Operations	153 Surgical Care Group	153 WCCSS Care Group	Total
Trust Core Skills	**94.75%**	**90.26%**	**95.91%**	**92.90%**	**88.37%**	**91.09%**	**90.27%**
National Core Skills	**94.99%**	**88.53%**	**95.39%**	**93.34%**	**86.88%**	**90.77%**	**89.92%**
Conflict Resolution	93.08%	94.29%	100.00%	96.74%	91.89%	94.86%	**94.10%**
Equality Diversity & Human Rights	96.16%	94.12%	100.00%	97.65%	92.15%	95.07%	**94.56%**
Fire Safety	95.77%	92.68%	96.51%	96.24%	91.23%	93.72%	**93.35%**
Health Safety & Welfare	96.54%	94.46%	100.00%	97.06%	92.11%	94.48%	**94.47%**
Infection Control	95.57%	86.17%	95.18%	94.83%	84.49%	89.28%	**88.55%**
Information Governance	91.64%	85.68%	91.86%	90.59%	82.32%	87.47%	**86.61%**
Moving & Handling	96.26%	86.32%	95.74%	91.70%	89.11%	89.83%	**89.23%**
Oliver McGowan	97.02%	93.61%	100.00%	96.24%	91.38%	95.21%	**94.25%**
Patient Safety	98.27%	96.44%	100.00%	98.47%	94.58%	96.67%	**96.52%**
Prevent (WRAP)	87.70%	89.97%	91.07%	93.84%	86.87%	89.39%	**89.17%**
Resus	89.32%	64.63%	78.02%	76.52%	61.92%	77.42%	**71.47%**
Safeguarding Adults	95.05%	93.59%	94.59%	96.28%	91.49%	94.83%	**94.28%**
Safeguarding Children	94.35%	88.43%	97.59%	95.18%	87.32%	88.39%	**89.50%**
Total	**94.96%**	**89.20%**	**95.55%**	**93.24%**	**87.46%**	**90.87%**	**90.04%**

	
Workforce Systems ***(1 Advise)***	**Advise (1) Medical Rostering** - a plan has been drawn up detailing the 7 Specialties selected for the external support being provided for the project to ensure the March 2026 deadline is met for DCC's for Consultants and SAS Doctors to be on an electronic rostering system.
Resourcing ***(1 Alert)*** ***(1 Advise)***	**Advise (1) The Admin and Clerical (A&C) Transfer Window (TW)** remains embedded as the default route for all A&C permanent vacancies, with continued growth in the talent pool and sustained engagement from colleagues. Use of the TW is becoming more consistent across services, supported by refreshed guidance and ongoing recruitment advice to hiring managers. Additional targeted hiring manager support is being developed as the process continues to mature. **Alert (1) A&C recruitment** - An increasing volume of A&C vacancies is being brought through the Trust Vacancy Review Panel. While these are routed through the Transfer Window, the volume presents a risk that the TW becomes over-stretched and that vacancies may progress to external recruitment where role redesign or redeployment cannot be accommodated. This continues to create pressure against delivery of agreed A&C workforce reduction targets and requires close monitoring and active management.
Temporary Staffing ***(1 Advise, 1 Alert)***	**Advise (1)** The NHSE directive to stop the use of Band 2 and 3 agency workers took effect on Monday 2 February. As a result, UHD has ceased the use of Band 3 Mental Health and Security Workers, with a break-glass process in place to maintain patient safety. Ongoing recruitment activity is underway to increase Bank pool. Strengthening governance around the break-glass use of an off-framework Security Agency providing Band 3 workers, is in progress. **Alert (1)** High-cost off-framework usage continues to rise month on month, with 300 hours filled in M10, partly driven by ongoing operational pressures.
Organisational De velopment ***(2 Advise)***	**Advise -** 384 FTSU concerns raised since April 2025 with 48% relating to behaviours and 30% relating to process and systems. Learning includes leadership and management (51%) and developing a civil and respectful culture (22%), **Advise -** The Trust hosted a number of events with Yvonne Coghill, including a Board development session and a panel discussion with the Diverse Ethnicity Network.
Trust Finance Position ***(3 Alerts)*** ***(1 Advise)*** ***(1 Assure)***	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert (1): Revenue Position** At the end of January, the Trust reported a deficit of £3.1million, being and improvement of £2.1 million from the December position and £38,000 better than plan. Good progress continues to be made in relation to planned mitigations, providing confidence that these will deliver the expected benefits by the end of March. However, the Trust is currently experiencing significant operational pressures, including caring for 240 patients who no longer require acute care (significantly more than the ICS agreed trajectory) which is putting considerable pressure on

	the forecast outturn. If this pressure continues there will be a further, unmitigated risk to the delivery of the full year plan. **Alert (2): Efficiency Improvement Programme** Efficiency improvement delivery to the end of January is £7.9m million behind plan. The trust has identified savings opportunities of £55.0 million, however when adjusted to reflect the risk of delivery in year, this is reduced to £54.2 million. This risk adjusted shortfall has been factored into the forecast outturn noted above. However the recurrent savings shortfall results in a significant underlying deficit, which places significant pressure (£35.8 million) on the 2026/27 financial plan. **Alert (3): Capital Programme** The Trust has reported capital expenditure of £105.8 million, being £20.2 million below plan year to date. Whilst the Trust is currently forecasting delivery of the programme within the capital funding envelope, there remains considerable risk pending confirmation of the Trust's reprofiling request in relation to STPW1 funding. **Assure (1): Public Sector Payment Policy** In relation to the timely payment of supplier invoices, the Trust is currently delivering performance of 95.5%, ahead of the national standard of 95%. **Advise (1): Cash** As at December 2025 the Trust is holding a consolidated cash balance of £44.6 million which is fully committed against the Trust's reconfiguration programme. This current balance represents 18 days of operating expenditure. The underlying operational cash balance, including PDC draws expected in January relating to capital spend in December, is £62.6 million or 25 days of operating expenditure. The key mitigations which will deliver a breakeven financial outturn will also improve the cash balance significantly in February and March.
Sustainable Services **Digital** ***(2 Assure)*** ***(1 Advise)***	**Advise (1) The rate of Advice and guidance requests per 100 first attendances demonstrate significant improvement however the target sits outside the current process control limits** A task and finish group involving clinical and operational leads supporting the development of a standard operating procedure for Advice and Guidance pathways and the roll out of the use of the Consultant Connect solution. The roll out continues to progress well with an ongoing roll out moving specialty by specialty. **Assure (1) Did not attend or missed appointment rates are above the Trust's 5% target at 5.6%.** DNA rates (5.6%) is demonstrating normal variation but fell below the process mean in January. The Trust continues to expand its use of DrDoctor to support patient's self-management of appointments. **Assure (2) ICE for Ordering vs paper - agreed locations to move paperless during February and March and feedback.** The Task and finish group continues to work up the Trust wide roll out plan and the equipment needed to achieve chat. It has been agreed that pilot areas will move paperless for requesting during February and March as agreed with the care groups. Trust wide a new Add-on form will be launched for any add on

	test requests to an existing request. All paper Radiology and Pathology reports will also cease Trust wide at the end of February, and communications are being sent out to raise awareness of this.
Key Recommendations:	Members are asked to note the content of the report.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒ Please select above each that applies and for all selected, explain the implications of each here
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	
Finance & Performance Committee (Operational / Finance Performance)	02/03/2026	Pending
Trust Management Group	26/03/2026	Pending
Quality Committee	03/03/2026	Pending

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

University Hospitals Dorset
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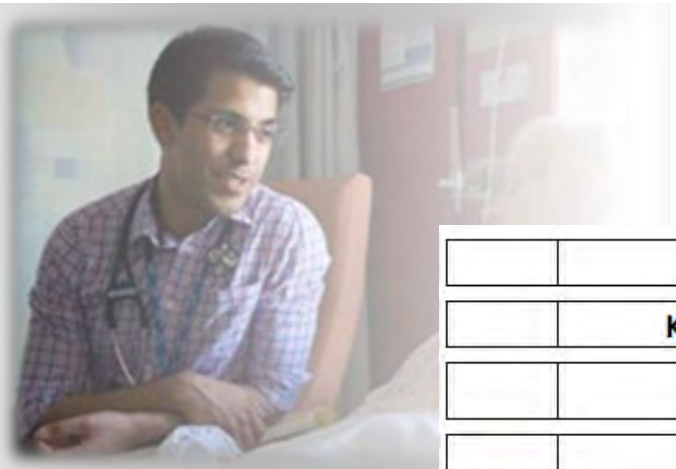
Integrated Performance Report

Reporting month: January 2026

Meeting Months : February/March 2026



Contents

University Hospitals Dorset
NHS Foundation Trust

Executive Summary

University Hospitals Dorset
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Proactive Management of Risks.
We are actively mitigating the potential impacts of constrained patient flow across our key domains:

- **Quality & Safety:** Our priority is to safeguard patient safety and experience. We are implementing targeted flow initiatives to minimise the risk of increased waiting times and protect our elective procedure rates from cancellation.
- **Financial**: We are maintaining financial discipline by managing capacity escalation costs. Our focus remains on delivering our elective and cancer recovery programme efficiently to mitigate any financial and patient waiting times impact risk from activity shortfalls.
- **People & Wellbeing:** Protecting our workforce is paramount. Our winter planning prioritises sustainable rostering and the wellbeing support needed to manage demand without over-reliance on high-cost temporary staffing.
- **Strategic Performance:** Our elective recovery programme remains on track, demonstrating our resilience. We are strategically balancing capacity to protect this progress while responding to urgent care needs, thereby safeguarding our reputation for both planned and emergency care.

Forward Look: Prepared and Focused
January has been a challenging month across the organisation with high occupancy impacting on UEC pathways with two Business Continuity Incidents and one Critical Incident being stood up in response.

We recognise the challenging operational environment that winter brings for both patients and staff. We have a winter plan guided by our Trust strategic deployment reviews and are confident that our focused actions and continued prioritisation will ensure we deliver against our key objectives

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

Key to KPI Variation and Assurance Icons

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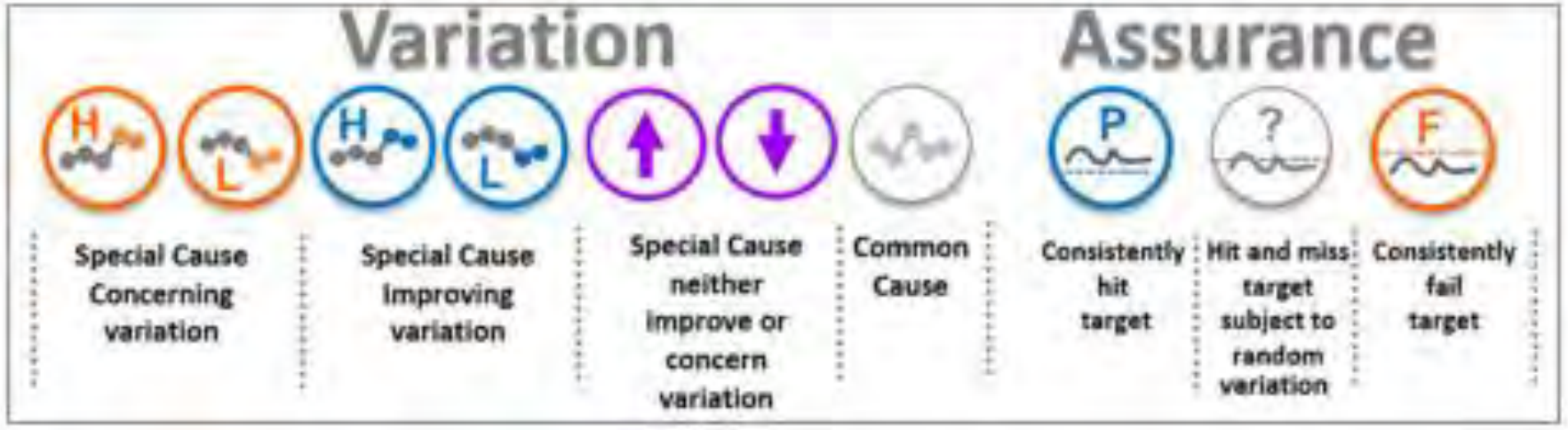

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

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

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

Matrix Summary

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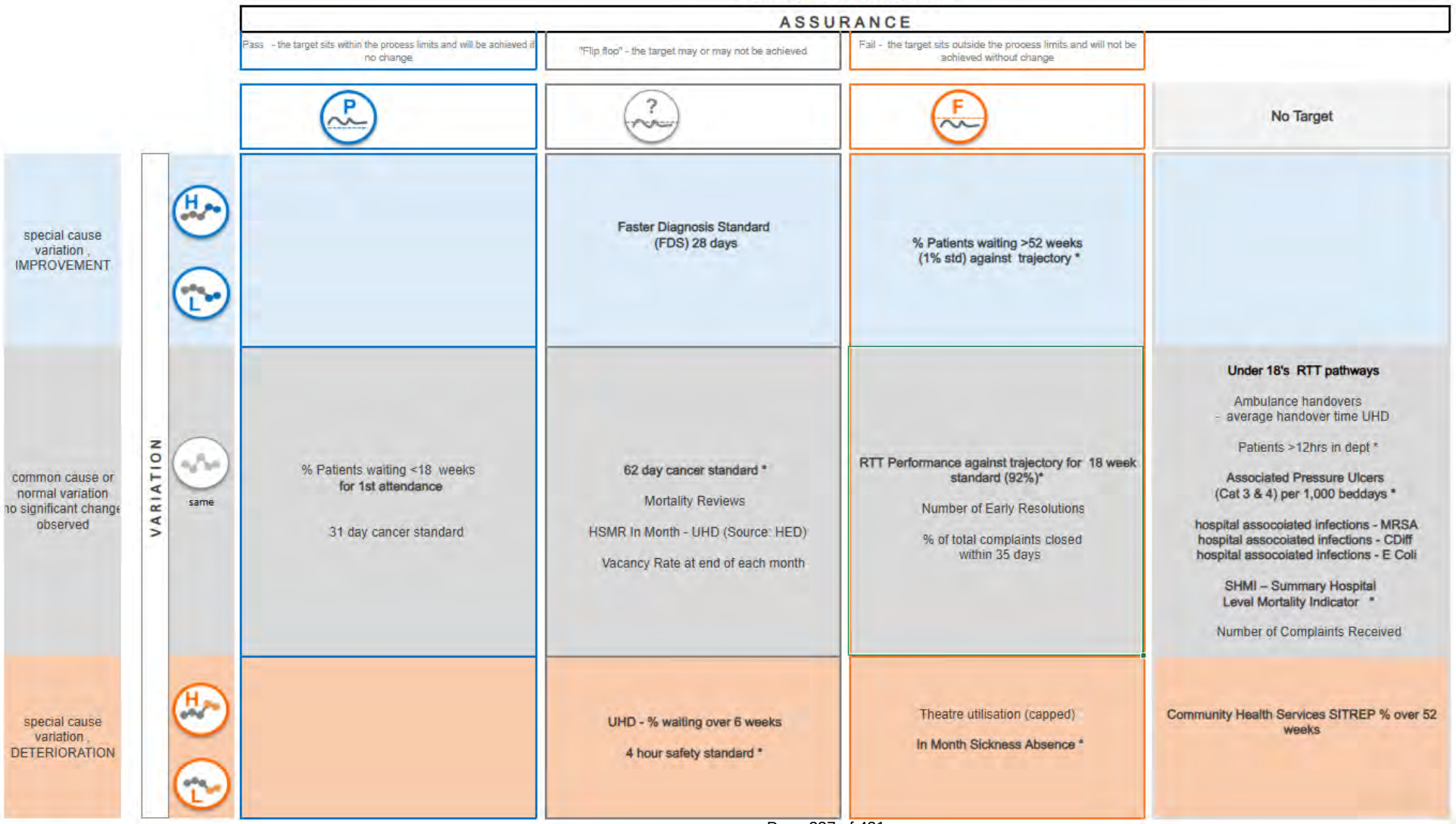
2025/26 IPR Matrix



National Oversight Framework

University Hospitals Dorset
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UHD has been placed into **segment 3** of the NHS Oversight Framework (NOF) in the September 2025 NHSE ranking (pub 11/12/25), with a rank of #71/134 acute and specialist providers and an average metric score of 2.37 (previous quarter 2.36)

Scores and ranks are refreshed quarterly (Segment 1 is best)

Domain	Domain Score (September 2025)	Segment	Direction of Travel since last segmentation	Prevoius score (initial segmentation July 2025)
Access to Services	2.68	3	⟷	Domain score 2.68 / Segment 3
Effectiveness and Experience of Care	2.43	3	⟷	Domain score 2.44 / Segment 3
Patient Safety	2.40	2	⟷	Domain score 2.49 / Segment 2
People and Workforce	2.22	2	⟷	Domain score 2.13 / Segment 2
Finance and Productivity	1.20	1	⟷	Domain score 1.07 / Segment 1

Population & System

Mark Mould
Chief Operating Officer

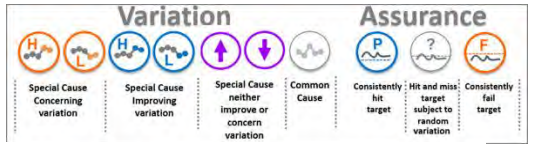
Operational Leads:
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Lisa Clarke – Group Director of Operations – Women's, Children, Cancer and Support Services
Adam Morris – Interim Group Director of Operations – Medical

Committees:
Finance and Performance Committee

Performance at a Glance

Population & System

University Hospitals Dorset
NHS Foundation Trust



UHD Elective Care

KPI	Latest month	Measure	Target	Variation	Assurance
RTT Total Waiting List Size	Jan 26	65960	67170		
RTT Performance against trajectory for 18 week standard (92%)	**Jan 26**	**63.2%**	**64.0%**		
Patients waiting >52 weeks	Jan 26	1529	856		
% Patients waiting >52 weeks (1% std) against trajectory	**Jan 26**	**2.3%**	**1.3%**		
Patients waiting >65 weeks	Jan 26	0	0		
% Patients waiting <18 weeks for 1st attendance	Jan 26	74.0%	71.8%		
Under 18's RTT pathways	**Jan 26**	**4722**	-		
UHD - Total Diagnostic Waiting List	Jan 26	11243	-		
UHD - % waiting over 6 weeks	**Jan 26**	**5.7%**	**5.0%**		
UHD - % waiting over 13 weeks	Jan 26	0.3%			
Community Health Services SITREP % over 52 weeks	**Jan 26**	**69.4%**	-		
Faster Diagnosis Standard (FDS) 28 days (75% std)	**Dec 25**	**79.4%**	**79.25%**		
31 day standard (96% std)	Dec 25	97.2%			
62 day standard (85% std)	**Dec 25**	**75.0%**	**73.6%**		
Trauma Admissions	Jan 26	338	-		
% of NOF patients operated on within 36 hrs (admission from ED)	Jan 26	54.0%	85.0%		
% Outpatient appointments with procedures	Jan 26	23.1%			
UHD - Total Outpatient - Virtual (%)	Jan 26	16.5%	25.0%		
UHD Outpatient DNA rate	Jan 26	5.6%	5.0%		
Theatre utilisation (capped)	Jan 26	80.8%	85.0%		
UHD Theatre case opportunity	Jan 26	9.0%	15.0%		

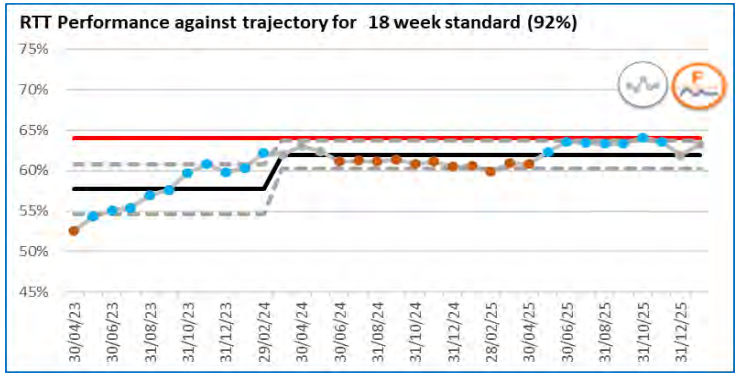
UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance
Arrival time to initial assessment	Jan 26	21	15		
Clinician seen <60 mins %	Jan 26	29%	-		
Patients >12hrs from DTA to admission	Jan 26	746	0		
Patients >12hrs in dept	**Jan 26**	**2007**	-		
4 hour safety standard	**Jan 26**	**63.0%**	**72.5%**		
Ambulance handovers - average handover time UHD	Jan 26	32.3	-		
Ambulance handovers - average handover time RBH	Jan 26	35.8	-		
Ambulance handovers - average handover time Poole	Jan 26	28.2	-		
Ambulance handover >60mins breaches	Jan 26	195			
Ambulance handovers	Jan 26	4446	-		
Bed Occupancy (capacity incl escalation)	Jan 26	95%	85%		
Stranded patients: Length of stay 7 days	Jan 26	546	-		
Stranded patients: Length of stay 14 days	Jan 26	348	-		
Stranded patients: Length of stay 21 days	Jan 26	243	108		
Non-elective admissions	Jan 26	6890	-		
> 1 day non-elective admissions	Jan 26	4027	-		
Same Day Emergency Care (SDEC)	Jan 26	2862	-		
Conversion rate (admitted from ED)	Jan 26	29.2%	30.0%		
Patients placed in Temporary Escalation Spaces in ED (average daily)	Jan 26	49.65	-		

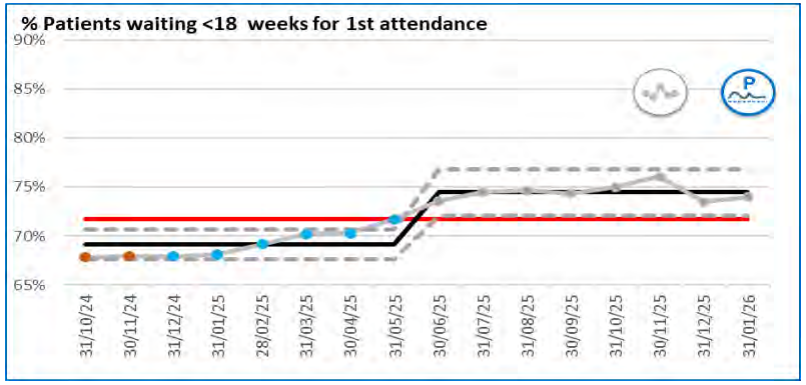
Elective Access - RTT

University Hospitals Dorset
NHS Foundation Trust

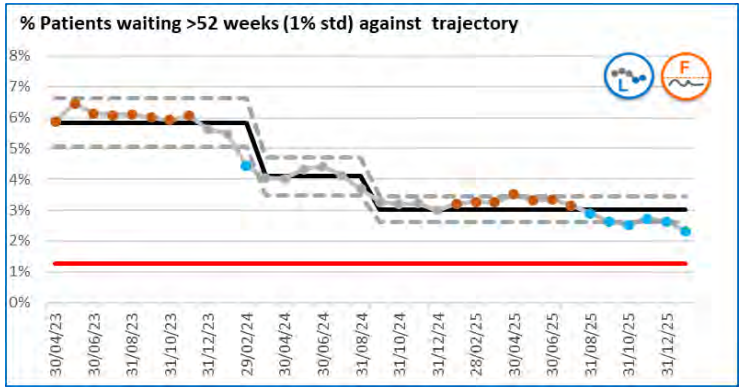
January 26
63.2%
Variance/Assurance
F
Targeting (Internal)
64.0%
Business Rule
Full CMS



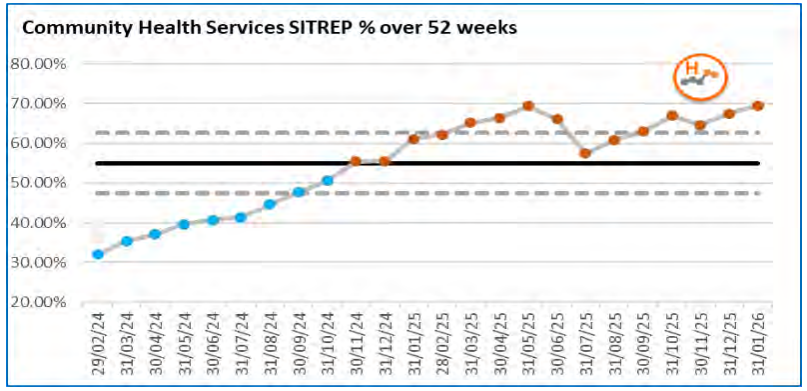
January 26
74.0%
Variance/Assurance
P
Targeting (Internal)
71.8%
Business Rule
Note performance



January 26
2.3%
Variance/Assurance
L F
Targeting (Internal)
1.3%
Business Rule
Full CMS



January 26
69.4%
Variance/Assurance
H
Targeting (Internal)
Business Rule
Note performance



Summary

- **RTT performance** variance to plan has reduced to 0.8% in January. The March 2026 target is currently outside of the process control limits; however, the Trust has scheduled additional activity in Quarter 4 to meet this performance target. This includes First OPAs and treatments.
- **Waits for first OPA or diagnostic test** within 18 weeks of referral, continue to exceed the planned trajectory; supporting early identification of treatment pathways.
- Elimination of waits on an RTT pathway exceeding 65 week was achieved for the second consecutive month and **% of waits over 52 weeks** is reducing; whilst the 52ww target is outside of the process control limits, January's performance was below the lower process control threshold indicating special cause improvement. Winter pressures has had a significant impact on elective capacity in month to deliver against the trajectory.
- **>52 weeks for Community Health (neurodevelopmental) services** remain above the upper process control limit.

Actions

- Deliver an increase of c.2600 Outpatient first appts. during the national RTT Sprint in Q4 2025/26.
- Increase treatments by implementing plans with in/outsourcing providers supported by additional national funding to reduce 52 week waits in February/March.
- Continue targeted validation of the waiting list to ensure patients who no longer need to be seen are discharged.
- Commence the transfer of the longest waiting Children on a neurodevelopmental pathway to local Right to Choose providers for assessment.

Assurance & Timescale for Improvement

Planned Care Improvement Group providing oversight and weekly performance huddle in place.

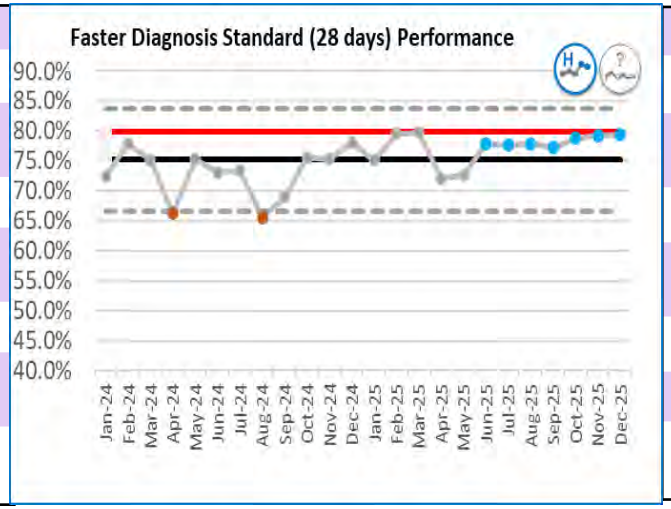
Timescales:

- On track to maintain 0 65 week waits for the remainder of 2025/26
- Reduce variation to plan for % of waiting list >52 week waits, to 0 by end March 2026 and return to RTT performance planned trajectory by March 26 with a 1% improvement against the Q4 RTT national sprint funding.
- Currently exceeding March 2026 target for waits for 1st activity and no known risks.
- Reduction in longest waits for patients waiting neuro-developmental assessment commencing March 26

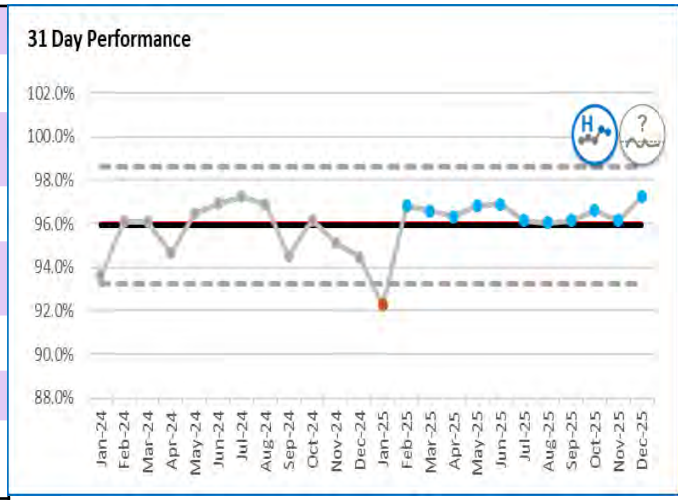
Elective Access - Cancer

University Hospitals Dorset
NHS Foundation Trust

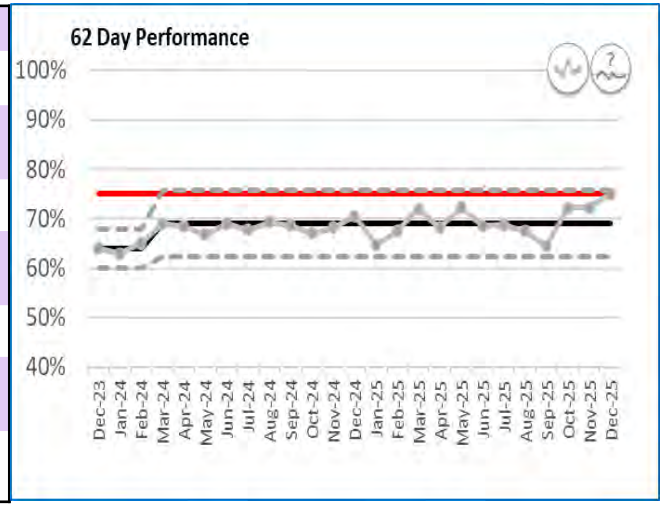
Dec 25
79.4%
Variance/ Assurance
Targeting (Internal)
79.25%
Business Rule
Note performance



Dec 25
97.2%
Variance/ Assurance
Targeting (Internal)
96.0%
Business Rule
Note performance



Dec 25
75.0%
Variance/ Assurance
Targeting (Internal)
73.6%
Business Rule
Full CMS



Summary

FDS Performance for Dec-25 was above the national standard (75%) and the Trust's Operational Plan (79%). The process is showing special cause improvement, suggesting a significant upward shift in the process mean and evidence of sustained improvement. Performance was above the mean for 7 consecutive months.
31 Day Dec-25 performance achieved the 96.0% national standard for the eleventh consecutive month, achieving 97.2%. The SPC chart indicates special cause improvement, signifying a statistically significant upward shift in the process mean and evidence of sustained improvement.
62 Day Dec-25 performance achieved the Trust operational plan (73.6%) and the national recovery target (75%). The SPC chart shows common cause variation, suggesting that the variation observed is inherent to the current process, however the target is within the process limits and therefore achievable.

Actions

- **Colorectal** – enhanced support in place and rapid improvement plan in progress in conjunction with the Wessex Cancer Alliance.
- **Breast** – additional Radiology Saturday sessions in Q4 to support Breast Radiologist shortages alongside insourcing support from 18 weeks. Finalisation of plans to launch a Breast Pain service from Q1 of 26/27.
- **Skin** – an extension in Q4 of the insourcing plan with 18 weeks to provide additional fast track and treatment capacity.
- **All sites** – investment in additional treatment capacity in February and March 26 to support the March 26 target.

Assurance & Timescale for Improvement

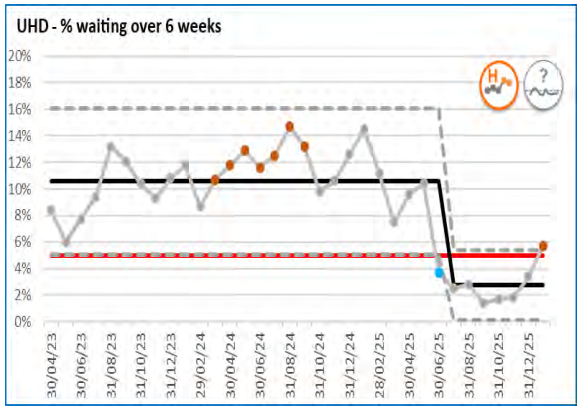
- On track to meet the 80% target for the 28 Day Faster Diagnosis Standard by March 2026.
- 11 consecutive months of achieving the 31 Day standard.
- Expecting a challenging January position but recovery plans are in place for February and March.
- The over 62 Day PTL has remained below 220 patients throughout 2025/2026 with the end of January position reporting 185 patients. A trajectory is in place by tumour site to reduce this to 80 by March 2026.
- Submission made to SW Regional team for additional funding in Q4 for 62 Day performance.
- The performance in December 25 for UHD is the strongest position across all of the cancer standards since the new metrics were established in October 2023.

Health Inequalities and Primary Prevention

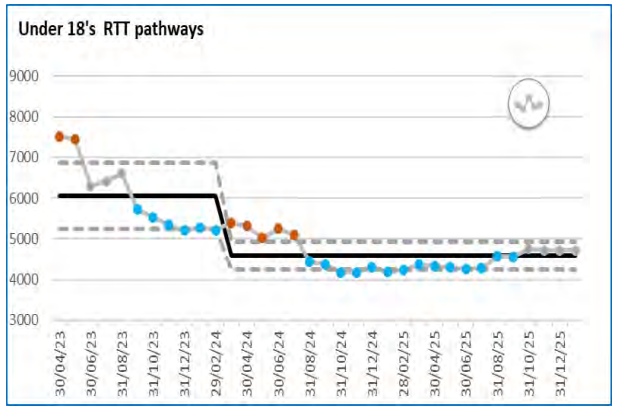
Diagnostic Access , RTT Under 18's waiting and Smoking Referrals

University Hospitals Dorset
NHS Foundation Trust

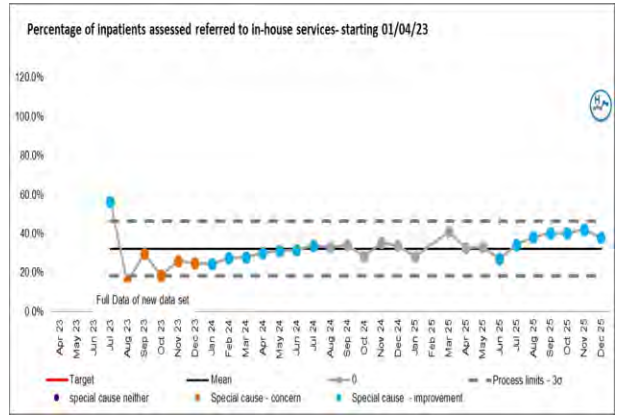
Jan 26
5.7%
Variance/ Assurance
Targeting (Internal)
5%
Business Rule
Note Performance



Jan 26
4,722
Variance/ Assurance
Targeting (Internal)
Business Rule



Jan 26
37.9%
Variance/ Assurance
Targeting (Internal)
Business Rule

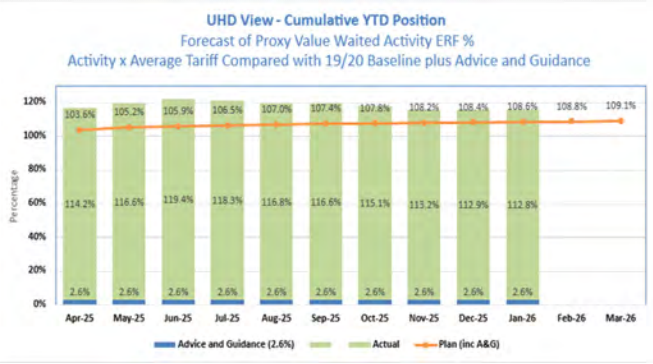


Summary	Actions	Assurance & Timescale for Improvement
DM01 (Diagnostics) performance showed special cause variation at 0.7% above the target. Performance in January was impacted by reduced outsourcing capacity and a depleted bookings admission team. Imaging achieved the national constitutional standard (<1%) but endoscopy, cardiology and physiological measurement all exceeded 10%. The RTT waiting list size for patients <18 yrs demonstrates common cause variation and remains within process control limits. RTT performance however at 64.8% is better than plan and 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 3 2025/26 (latest data). Children within the 20% most deprived groups, on average have 2 weeks less to wait compared to those in IMD 3-10. No variation exists in wait times when analysing by ethnicity for all age groups. However, children from community minority groups are waiting an average of 6 weeks. In contrast, waiting times for White British children is on average 11 weeks. UHD Tobacco Service –The latest data is December 2025 - referrals 300 with 71% of patients seen 2 following referral. 28 Day Quit Outcomes – Dec 2025 –23%	Diagnostics: • Increase capacity for endoscopy, cardiology and physiological measurement in the short term to clear backlog • Recruit to endoscopy bookings team • Continue use of 18 Weeks Support for endoscopy pending opening of the new Endoscopy build in 2026.	The target for DM01 performance had been achieved for seven consecutive months but faltered last month, aim is to recover by year end.

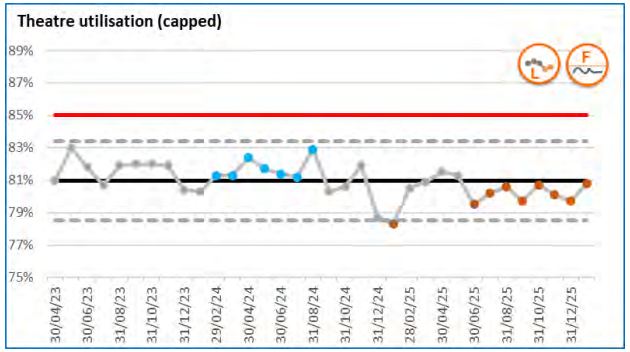
Operational Productivity

University Hospitals Dorset
NHS Foundation Trust

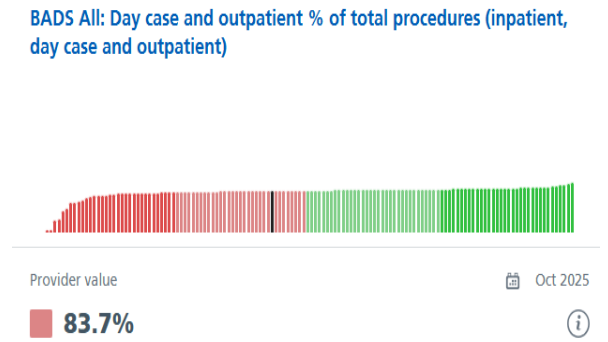
Jan 26
115.4% YTD
Variance/ Assurance
Targeting (Internal)
108.8%
Business Rule
Note Performance



Jan 26
79.7%
Variance/ Assurance
Targeting (Internal)
85%
Business Rule
Verbal CMS



Oct 25
83.7%
Variance/ Assurance
Targeting (Internal)
85%
Business Rule
Note Performance



Summary

- Year to date 115.4% (value weighted) **elective activity** has been delivered compared to the 2019/20 baseline period. This is above the operational plan trajectory (108.6%).
- **Capped theatre utilisation** is comparable to the process mean at 80.8% and there is reduced variation in performance, nevertheless it remains below the national target (85%). Contributing factors:
  - Bed capacity during UEC critical incident, impacting day case and ITU bed capacity
  - Pre-op assessment capacity
  - Ward capacity prioritised for OPS/medical patients
- **BADS Daycase rate** is 83.7%, marginally below the national target (85%), noting latest data reported is October 2025. Within this, Day cases were above National average (59.25% vs 47.2%) and outpatient procedures below (24.5% vs 36.6%).
- **Implied productivity growth:** The month 7, 25/26 implied productivity growth (latest nationally reported data) compared to month 7 2024/25 is 2.4%, maintaining an improved position.

Actions

Theatre improvement programme – key areas of focus:

- Reducing cancellations by specialities, particularly for pooled lists
- Undertake list profiling reviews at speciality level.
- Back filling short notice cancelations and locking lists in advance
- Review capacity at Wimborne ensuring fully utilised
- Optimisation of pre-op assessment capacity, including additional insourced capacity during Q4 to support the RTT sprint.
- Winter plan and Hospital Flow programmes in place to manage winter pressures on capacity and flow; supported by conversions to daycase surgery where possible to reduce dependency on inpatient beds.

- All BADS procedures are being listed as day case by default to improve the data capture of procedures.
- The first procedure through the St Mary's procedural suite is due to take place in Quarter 4 in Urology with further specialties expected to use the facility before the end of March 26.

Assurance & Timescale for Improvement

The Planned Care Improvement programme provides oversight to elective activity, and Theatre Improvement and Daycase programmes.

Theatre improvement programme relaunched in September 2025 and A3 improvement plans developed for each specialty performing below the national target to affect delivery of the planned capped theatre utilisation target.

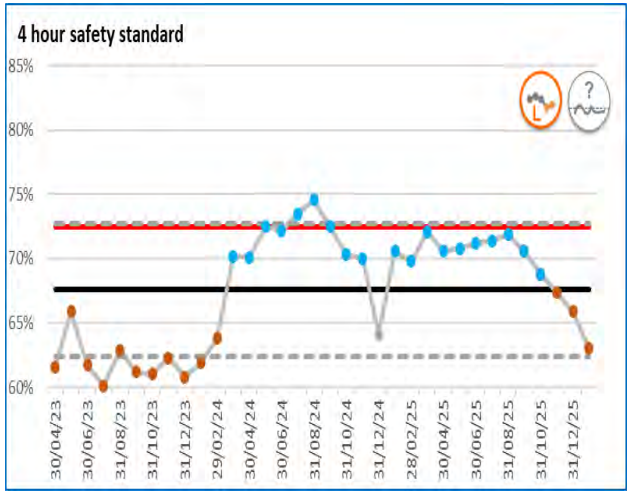
Maintain BADS day case rate – Quarter 4, with a focus on reducing variation.

Chief Operating Officer review of the theatre and day case programmes is to take place in Q4 2025/26.

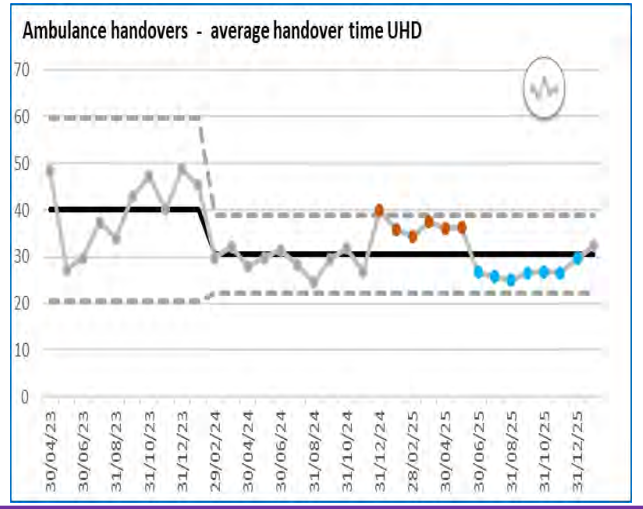
Urgent and Emergency Care

University Hospitals Dorset
NHS Foundation Trust

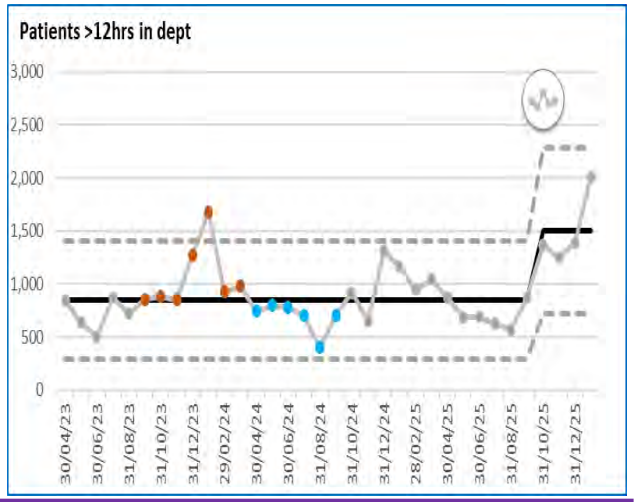
Jan 26
63.0%
Variance/ Assurance
Targeting (Internal)
72.5%
Business Rule
Verbal CMS



Jan 26
32.3 minutes
Variance/ Assurance
Targeting (Internal)
Business Rule
Note performance



Jan 26
2,007
Variance/ Assurance
Targeting (Internal)
Business Rule
Full CMS



Summary

- The Trust's position against the standard was finalised at 63%, failing to meet the improvement trajectory of 72.5%. The national target (78%) remains outside of process control limits, therefore, will not be achieved without change or intervention to underlying processes.
- Following a period of non-delivery against the complex discharge target, the improved No Criteria to Reside position reported in December deteriorated reporting an average of 220 (+c30). This has increased occupancy impacting flow across emergency pathways.
- Average handover times for UHD increased to 31 mins but has not triggered special cause variation and target remains within process limits. THP demands that the trust has sufficient occupancy to maintain outflow to avoid corridor care.
- Number of patients within the department for more than 12 hours increased to 14% in January 26. There is strong correlation between the bed occupancy associated with increased NCtR. In addition, a lack of community provision of acute mental health beds and high prevalence of patients presenting with mental health difficulties, has contributed to the increase.
- Overcrowding within the emergency department has challenged progress with some deterioration across several of the ED metrics.

Actions

- Improvement cycles continuing SDEC, RATs, and escalation focusing on process – streaming earlier in pathway, fewer hand-offs, timelier seen times.
- Earlier streaming to SDEC to increase overall % performance by c4%.
- Standardised EPIC role within Emergency Departments.
- Refresh and re-launch of the Internal Professional Standards including early escalation.
- Planning underway for 6-week system reset and sprint through late Feb and March 26.
- Ongoing focus on NCtR recovery actions including increasing social worker provision and focus on pathway 1; additional D2A bed capacity; and spot booking beds to support pts needing services beyond the core offer i.e. delirium. Decision regarding establishing an intermediate care budget and a 12-week recovery programme.
- Work is being accelerated as part of Better Care Fund planning to ensure long term commissioned solutions to pathway gaps.
- Care Coordination Programme focusing on ward processes as a key enabler to discharge planning across all pathways and ensuring effective interface with the TOC.
- Continue to develop underlying processes within the Transfer of Care Hub.
- Pursuing a nationally procured discharge module to enhance action and patient tracking.
- Multi-agency system meetings looking at a Pan-Dorset policy including DCH to ensure a robust mechanism for escalation relating to MH. Mapping exercise against the ED MH Action card.

Assurance & Timescale for Improvement

- Live discussion underway regarding a proposal for 12 – week NCTR recovery programme with aim of reducing LOS attributable to pathways 1&2 and 50% reduction of NCTR number > 21 days.
- Focused work to stream earlier to SDEC to realise 4% performance benefit.
- Sustained improvement in fewer patients on a P0 pathway at midnight.
- Non-elective LOS remains below same period 25/26
- Actual Occupied Bed Day Usage tracking well against improvement trajectory
- Improved transfer times from DTA to left department
- All driver metrics linked to underlying processes are aligned to outturn 78% by March 2026
- MDT Huddles in place and consistent
- Med/OPS SDEC attendances hitting targets
- Type 1 seen in 60 mins improved
- DTA in 110 a 4% improvement from last year
- Non-elective LOS remains below same period 25/26
- Actual Occupied Bed Day Usage tracking well against improvement trajectory.
- Increased MCN referrals through January 26.

University Hospitals Dorset
NHS Foundation Trust

Our People

Melanie Whitfield
Chief People Officer

Operational Leads:
Irene Mardon- Deputy Chief People Officer

Committees:
People and Culture Committee

Performance at a Glance
Our People

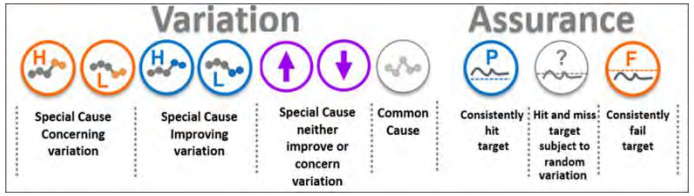
University Hospitals Dorset
NHS Foundation Trust

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Dec 25	7.4%	7.5%			7.3%	5.1%	9.4%
In Month Sickness Absence	Jan 26	5.3%	4.0%			4.7%	4.1%	5.3%
Mandatory Training Compliance at end of each month	Jan 26	85.1%	90.0%			89.5%	88.2%	90.7%
Agency Pay as Proportion of Total Pay	Jan 26	0.9%	3.2%			2.7%	2.0%	3.4%

NHS Staff Survey Results will be reported annually

- "Staff engagement score >7/10"
- "I would recommend my organisation as a place to work" > 62% by March 2024
  National Education and Training Survey overall satisfaction score



Workforce monitoring - Actual vs plan

University Hospitals Dorset
NHS Foundation Trust

Operational Plan Monitoring

Staff Type	Plan/Actual	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Substantive	Actual	9098.1	9070.4	9085.4	9039.3	9106.2	9094.1	9143.9	9176.6	9155.3	9183.9		
	Plan	9086.0	9099.0	9072.3	9064.3	9055.3	9095.4	9057.3	9035.0	9012.7	8990.3	8968.0	8968.0
Bank	Actual	643.3	647.5	669.5	678.2	651.2	627.6	636.0	672.2	644.0	580.1		
	Plan	609.0	591.0	564.0	565.0	560.0	640.9	630.5	620.2	609.9	599.5	589.2	589.2
Agency	Actual	135.8	148.1	129.3	83.4	87.8	90.7	101.4	85.5	90.0	83.2		
	Plan	158.0	135.0	135.0	136.0	135.0	139.0	141.0	146.0	151.0	144.0	128.0	116.7

Staff Type	Plan/Actual	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Staff	Actual	9877.2	9866.1	9884.2	9800.9	9845.2	9812.3	9881.3	9934.3	9889.3	9847.2		
	Plan	9853.0	9825.0	9771.3	9765.3	9750.3	9875.3	9828.8	9801.2	9773.5	9733.9	9685.2	9673.9

Summary

- In M10 UHD total workforce was 113.35 whole time equivalent (wte) behind in month plan. Against M12 plan, the adverse variance is 173.29wte.
- M10 substantive workforce was 193.56wte behind in month plan. Against M12 plan, the adverse variance is 215.89wte.
- Bank usage reduced and was 19.44wte ahead of in month plan.
- Actual bank use against M12 plan shows a favorable variance of 9.09wte. NHS Infrastructure Support are the only workforce group with an adverse variance against M12 plan (31.38wte)
- Agency usage reduced in M10 to 83.23wte, against an in-month plan of 144wte. Agency use shows a favorable variance of 33.51wte against M12 plan. NHS Infrastructure Support are the only workforce group with an adverse variance against M12 plan (4.25wte)

Actions

Continuous review of the '*Workforce Operational Efficiency and Reduction plan*' and the six project and 38 workstreams to support delivery of the workforce reductions through improved controls and processes.

Inaugural meeting of the '*Workforce Controls*' project group with presentation and review of A3's.

Noted M10 bank wte reduction but increase in spend: M10 was a 5-week month, but with a final payroll date of 25/01/2026. The discrepancy means the spend profile will not fully match hours profile. Further review required to determine impact on reported bank WTE aligned with increase in bank spend.

Assurance & Timescale for Improvement

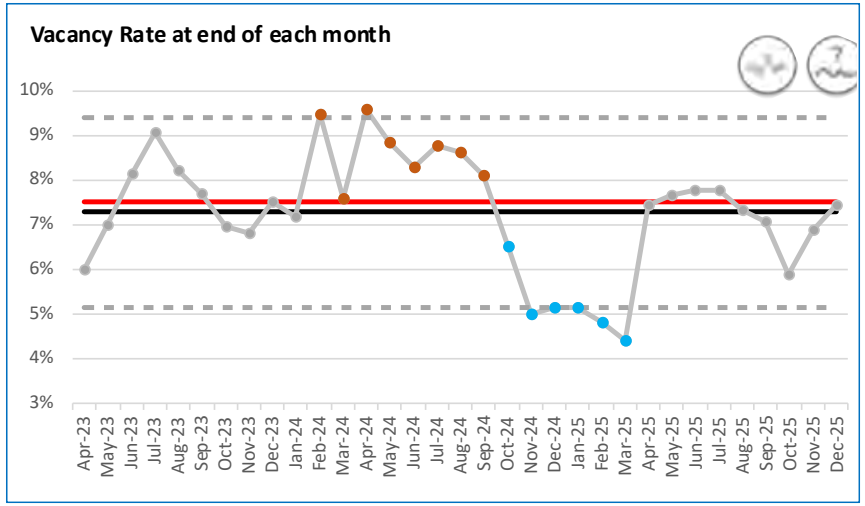
Ongoing monitoring against H2 trajectory for remaining 2-months of 2025/26.

Review and updating of risks aligned to achieving 25/26 operating plan and escalations at appropriate Care Group Boards. SDR meetings and Sustainability Services Meetings.

Workforce monitoring - Vacancy Rate

University Hospitals Dorset
NHS Foundation Trust

December 25
7.4%
Variance/ Assurance
Targeting (Internal)
7.5%
Business Rule
Verbal CMS



Summary

Vacancy position – December 2025

- Reporting against establishment shows a vacancy rate of **7.42% (718.69 WTE).**
- When aligned with the **Workforce Operational Plan,** the vacancy rate is **0.41% (37.48 WTE),** demonstrating that the majority of vacancies are **planned and funded rather than unplanned gaps.**

Actions

- Work is underway to strengthen alignment between the Workforce Operational, Efficiency and Reduction Plan (WORP) and establishment, improving the quality of vacancy approval decisions and providing clearer assurance on funded, planned and unplanned vacancies.
- The Vacancy Review Panel (VRP) design improvements continue to support enhanced vacancy approval decision making. In parallel, targeted Time to Hire improvement actions are being implemented.
- Development of Recruitment Service Level Agreements (SLAs), setting out clear responsibilities, standards and escalation routes, is in progress.

Assurance & Timescale for Improvement

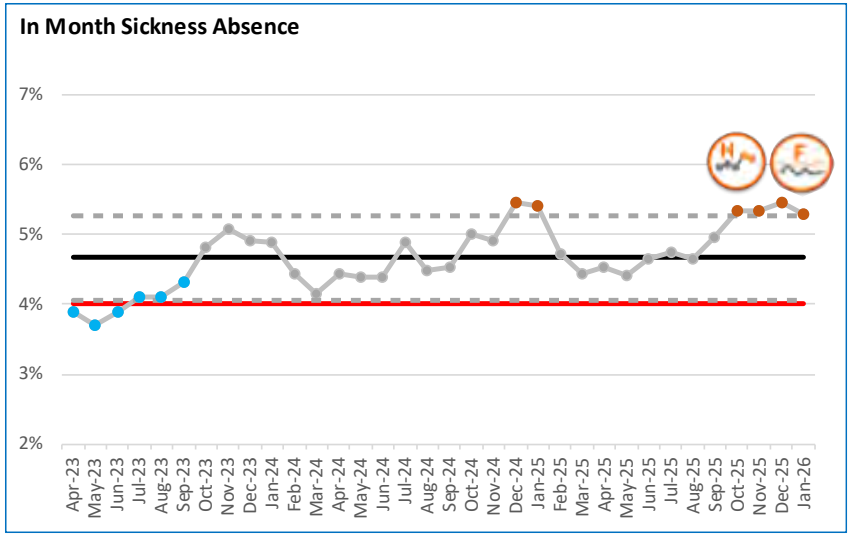
- 30-day Time to Hire target to be achieved by March 2027, in line with NHS England expectations.
- Refreshed Trust and Care Group Vacancy Review Panels to launch April 2026.
- Recruitment SLA, KPIs and SOPs to be agreed and published by 31 March 2026.

Sickness Absence Rate / Turnover

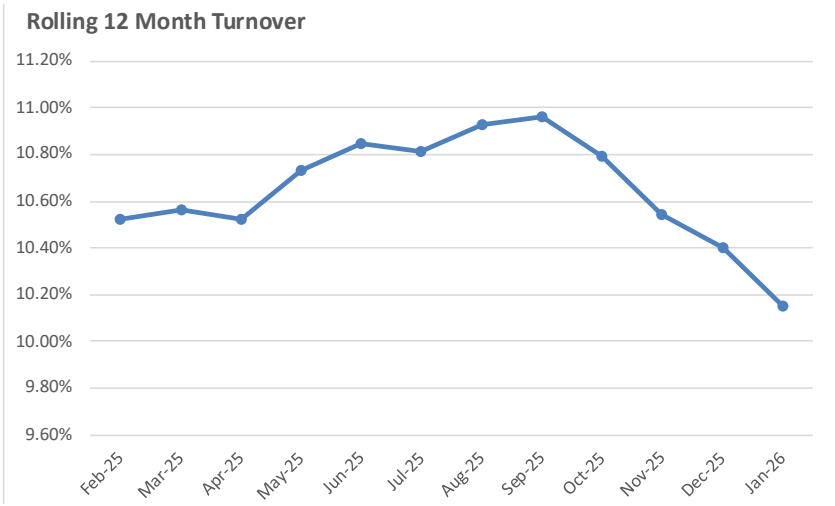
University Hospitals Dorset
NHS Foundation Trust

January 26
5.3%
Variance/ Assurance

Targeting (Internal)
4.0%
Business Rule
Verbal CMS



January 26
10.2%
Variance/ Assurance
N/A
Targeting (Internal)
10%
Business Rule
Verbal CMS



Summary

M10 sickness absence rate is comparable to M09 2024 (5.46%).

Areas of highest sickness absence rates include Maternity, ED, Critical Care, Pharmacy, Portering and Housekeeping.

The top three reasons for sickness absence continues to be anxiety/stress/ depression/ other psychiatric illness, back problems and other musculoskeletal (MSK) problems.

Each Care Group and Corporate / Operations functions has a carried out a review of sickness absence using the Patient First A3 methodology, identifying the areas of focus with attention to be paid to particular 'hot spots' or where there are themes emerging. This ranges from particular areas e.g. Maternity in WCCSS Care Group or staff groups e.g. Nursing and HCSW workforce in the Surgical Care Group.

Turnover for M10 (Jan 26) saw a slight decline on the previous month at 10.06%. Some of the areas with highest turnover were in the Corporate / Operations areas e.g. Outpatients.

Actions

The highest 50 short-term and 30 longest term sickness absence cases with each Care Group and Corporate/Operations functions are continuing to be worked through with each area, and progress continues to be made in support and conclusion of some cases.

Work has started to review the policy and process to support with reducing the absence rate. This includes how teams manage absence and support wellbeing work collaboratively, particularly around the more challenging cases.
Ongoing engagement with managers of all levels is underway supported by HR Business Partners and the Employee Relations team, focusing on upskilling in the absence management policy and process and targeting Band 7 leads through workshops and development days.

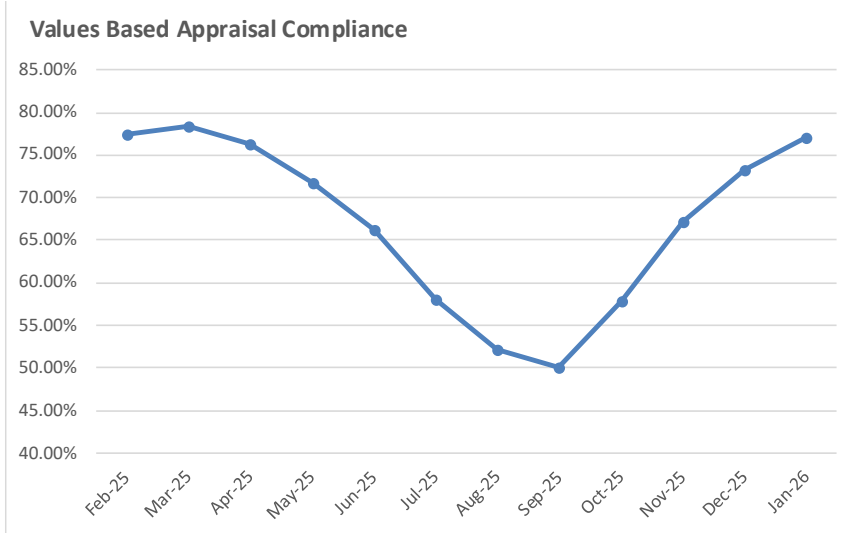
Assurance & Timescale for Improvement

All Trusts are required to demonstrate progress to reduce sickness absence rates to 4.1% by March 2027. UHD is working with NHSE to set out how the Trust will achieve this level, with associated trajectory.

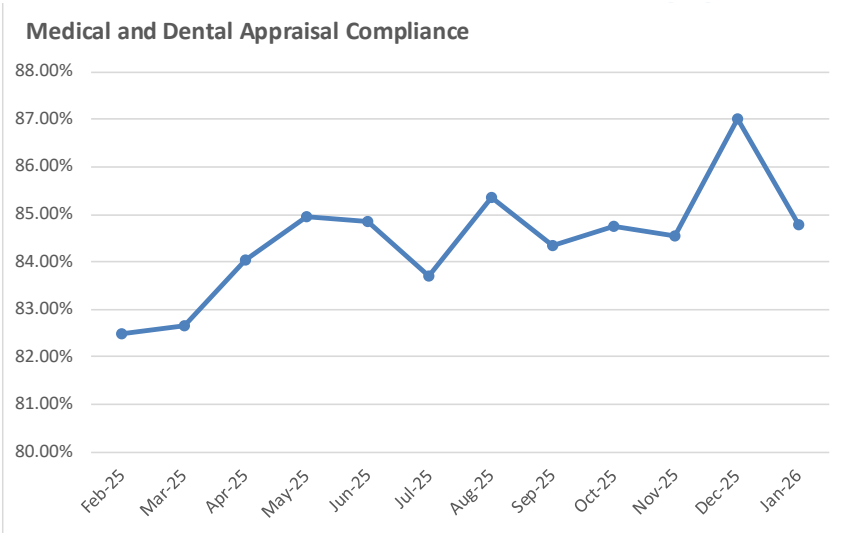
Appraisal Rates

University Hospitals Dorset

January 26
77.0%
Variance/Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS



January 26
84.8%
Variance/Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS



Summary

Appraisal rates have continued to improve significantly since autumn. While challenges remain, the trajectory is positive and we continue to offer and promote support and resources for both appraisers and appraisees.
The following breakdown shows care group compliance, from highest completion to lowest. All care group compliance has improved since January.

- Operations 83.5%
- WCCSS 82.8%
- Corporate 80.4% - biggest improvement in the past month, by almost 8%
- Surgical 78.7%
- Medical 68.4%

Actions

An A3 problem solving exercise is currently underway to critically review the current state and look at opportunities and recommendations for improvement. This is inclusive of an in-depth review of the 2025 Staff Survey results to understand hotspots and areas of concern and best practice.
On-going monitoring of care group compliance by HR BPs is supporting completion.

Assurance & Timescale for Improvement

Completion of an Appraisal A3 will inform next steps and provide further clarity on timescales for improvement. Currently awaiting further guidance on the launch of an NHS-wide Standard Appraisal Framework which will also inform our in-house process.

University Hospitals Dorset
NHS Foundation Trust

Quality Outcomes & Safety

Sarah Herbert
Chief Nursing Officer

Dr Peter Wilson
Chief Medical Officer

Operational Leads:
Vivian Alividza – Deputy Chief Nursing Officer

Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Performance at a Glance
Quality Outcomes & Safety

University Hospitals Dorset
NHS Foundation Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Patient Safety Incidents (All) per 1,000 beddays	Jan 26	41.60	-			37.41	30.98	43.83
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	Jan 26	0.20	-			0.49	0.11	0.86
Medication Incidents (All) per 1,000 beddays	Jan 26	4.80	-			5.05	3.19	6.90
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	**Jan 26**	**0.40**	-			**0.37**	**0.13**	**0.61**
Inpatient Falls (Moderate +) per 1,000 beddays	Jan 26	0.30	-			0.17	-0.04	0.38
Hospital Associated Infections - MRSA	**Jan 26**	**2**	-			**1**	**-2**	**3**
Hospital Associated Infections - MSSA	Jan 26	4	-			5	0	10
Hospital Associated Infections - C Diff	**Jan 26**	**6**	-			**9**	**-1**	**19**
Hospital Associated Infections - E Coli	**Jan 26**	**8**	-			**11**	**2**	**21**
Hospital Associated Infections - Kleb	Jan 26	4	-			5	-2	12
Hospital Associated Infections - Pseudo	Jan 26	0	-			2	-2	6
Hand Hygiene Compliance	Jan 26	93.4%	-			95.7%	93.7%	97.6%
Infection Control Mandatory Training Compliance	Jan 26	88.6%	-			89.4%	88.7%	90.2%

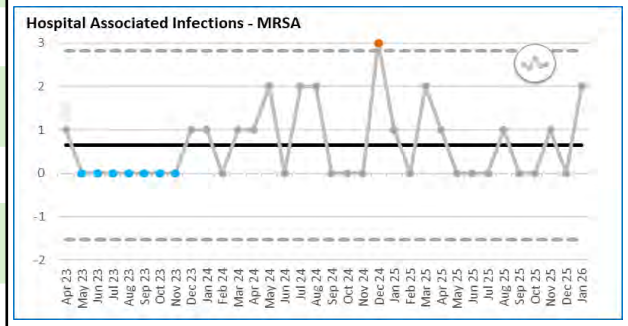
NHS Staff Survey Results will be reported annually

- **Improved NHS Staff Survey culture questions by 5% - raising concerns sub-score**

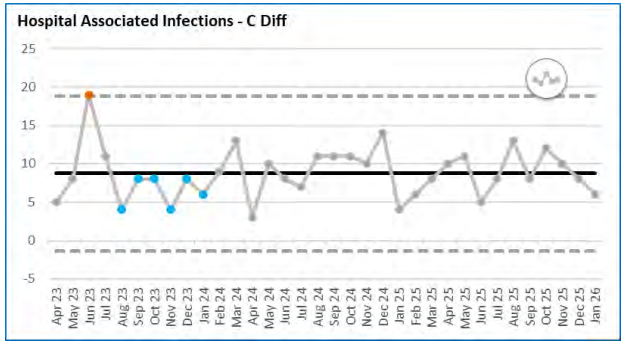
Hospital Associated Infections

University Hospitals Dorset
NHS Foundation Trust

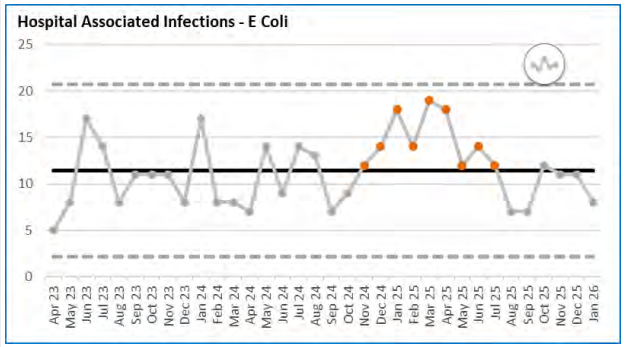
January 26
2
Variance/ Assurance
Targeting (Internal)
-
Business Rule
N/A



January 26
6
Variance /Assurance
Targeting (Internal)
-
Business Rule
N/A



January 26
8
Variance /Assurance
Targeting (Internal)
-
Business Rule
N/A



Summary

January 2026:
Hospital associated MRSA bacteraemia – 2 x COHA
Hospital associated MSSA bacteraemia – 4 (2 x COHA, 2 x HOHA)
Clostridiodes difficile hospital associated cases – 6 (3 x COHA, 3 x HOHA)
Escherichia coli bacteraemia cases – 8 (2 x COHA, 6 x HOHA)
Klebsiella cases – 4 (3 x COHA, 1 x HOHA)
Pseudomonas cases – 0
Outbreaks – 12

Actions

IPC led management of outbreaks identified across both sites with minimal disruption to flow, maintaining patient safety

Ongoing ward Hand Hygiene audits and feedback

MSSA cases under investigation
Gram-negative bacteraemia – case reviews underway.
Trend analysis to commence through LERN/PSIRF pathway

Assurance & Timescale for Improvement

Respiratory panel LFD testing remains in use with wider dissemination across Trust areas. Note reporting through ICE at ward level is inconsistent, creating risk of no formal record of diagnosis. Escalated to care groups

Learning shared at the monthly care group IPC meetings.

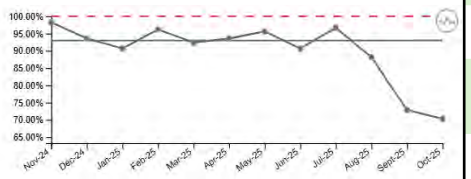
Catheter improvement programme addressing catheter insertion and ongoing care as integral aspect of Fundamentals of Care.

eMortality Consultant Review Compliance
HSMR < 100

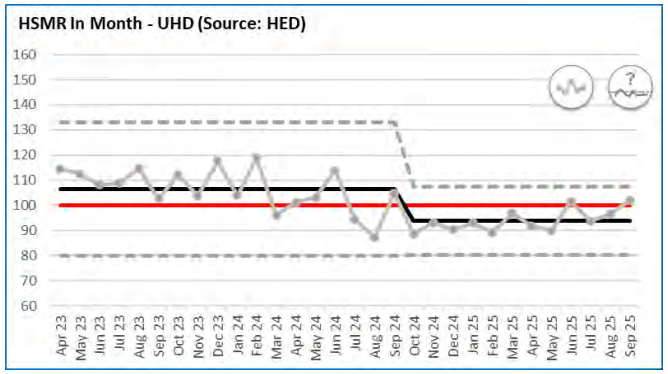
University Hospitals Dorset
NHS Foundation Trust

October 25
70.3%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Full CMS

Consultant Mortality Reviews

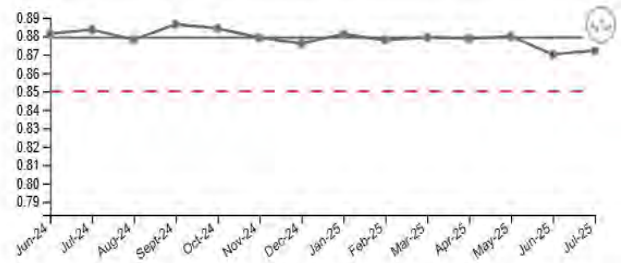


September 26
102.0
Variance /Assurance
Targeting (Internal)
100
Business Rule
N/A



July 25
0.87
Variance /Assurance
Targeting (Internal)
1
Business Rule
Verbal CMS

SHMI – Summary Hospital Level Mortality Indicator



Summary

E-Mortality review compliance remains below target at 70.3%. 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 September 2025 has remained within expected variation at 102.0.
SHMI remains below target and stable at 0.87.

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. Internal audit identified issues with coding and new risk (2302) agreed around coding accuracy and potential impact on HSMR
Flow chart to use to address HED alerts in design.

Assurance & Timescale for Improvement

Significant improvement noted, particularly in medicine. Barriers to surgical teams are being worked through with good effect by working with individuals with lower compliance. 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.

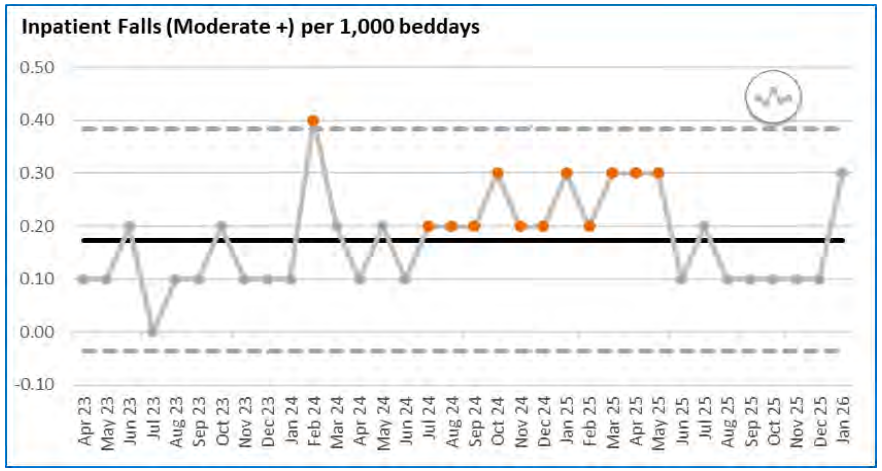
UHD is in the top 15 trusts of the 119 trusts included in the SHMI reporting.
New flowchart will ensure that all alerts are assessed for accuracy and to identify concerns within that patient cohort.

Patient Safety – Falls

University Hospitals Dorset
NHS Foundation Trust

January 2026
0.30
Variance/ Assurance

Targeting (Interna)
–
Business Rule
N/A



Summary

- **Falls remain within the expected range.**
- Overall inpatient fall rate in January 2026: **6.9 per 1000 bed days.**
- Decrease of 15 reported inpatient falls compared to December 2025.
- **Ten inpatient falls resulted in moderate or greater physical harm, equating to 0.3 per 1,000 bed days. No fatalities.**
- 91% of falls were recorded as low or no harm.
- **5% of LERNs submitted on incorrect forms or without harm level.**
- Second month with unusually high night-time falls, possibly linked to January's staffing and operational pressures. Peak fall times remain 13:00 and 15:00.

Actions

PSIRF Learning: SWARM reviews complete execpt for one related to incidents causing moderate or greater harm; inconsistent Neuro Observation documentation discussed at falls steering group. LERNs remain pending Matron sign-off and final Duty of Candour completion.
Falls Steering Group: Meeting held in February 2026. Attendance improved but was not fully quorate.
Falls Policy Review: Discussed at the Falls Steering Group: the UHD Falls Policy and associated SOPs need to be completely rewritten to separate the SOPs from the main policy.
Safer Activity Launch: Central L&S eObs BP functionality launch has been delayed due to technical issues. The Safer Activity launch will proceed in March 2026, with a focus on L&S BP, promoting appropriate footwear reducing unnecessary reliance on hospital provided non-slip slipper socks.

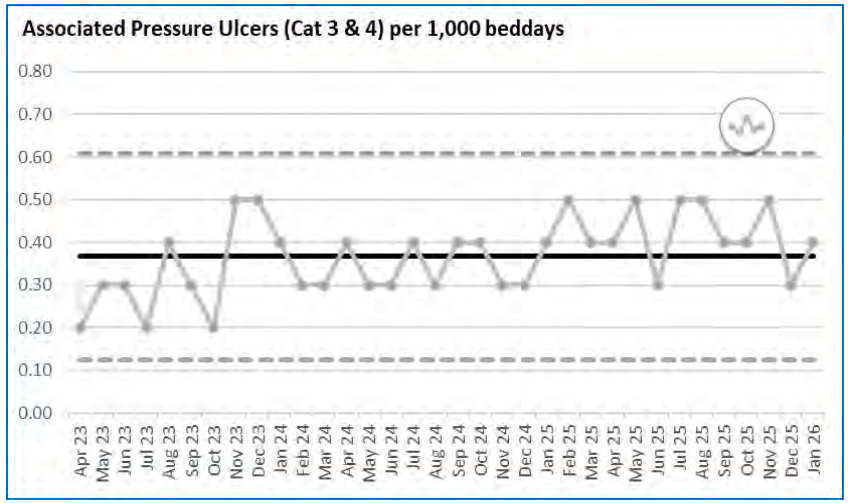
Assurance & Timescale for Improvement

- **Falls Steering Group:** Monthly meetings scheduled and attendance improved.
- **Falls Assessment Redesign:** An SBAR on Falls Assessment options aligned to NG249 was discussed at the Falls Steering Group. Further scoping is needed to explore digital options that prevent duplication and remains accessible to all clinical staff.
- **Digital Integration:** eObs functionality for lying/standing BP recording launch delayed due to technical issues.
- **Footwear Initiative:** Safer Activity launch to reduce reliance on non-slip socks. Slippers available for purchase from the stock shop for public.
- **Walking Aid Access:** Currently on hold – focus Q1 2026.

Patient Safety – Pressures Ulcers

University Hospitals Dorset
NHS Foundation Trust

January 2026
0.40
Variance/ Assurance
Targeting (Internal)
Business Rule
N/A



Summary

Statistical process control remains within usual variation during December 2025

- Category 3: 10 patients acquired a Category 3 pressure ulcer (one of which was medical device related)
- One patient (admitted with category 2 damage and known to have previous category 3, deteriorated significantly during admission to category 4 damage)

- 0.3/1000 bed days

Actions

- Fundamentals of Care: The 'Be a Zero Hero' campaign has launched throughout January, highlighting the importance of Zero Pressure to sacrum and heels
- aSSKINg bundle roll out to Surgical Care Group delayed (date awaited to implement)
- Systems now in place for ordering of Air Supply Units for therapy mattresses- Medical Equipment Library will hold stock
- Posters shared for advice re: Medstrom mattresses ordering and cancellation
- Issues regarding Medstrom contract escalated and raised via Category Manager following walk rounds and review of equipment on site

Assurance & Timescale for Improvement

Learning response significant harms following PSIRF methodology

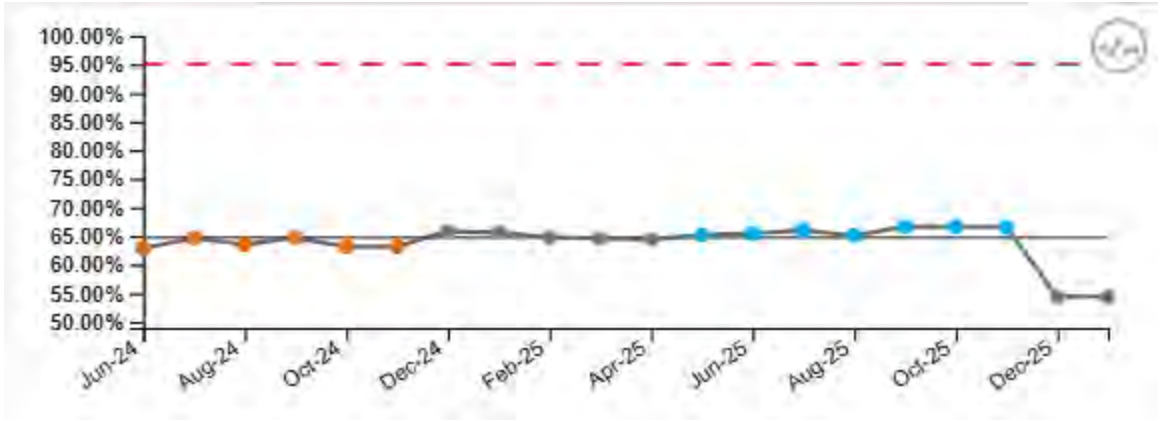
- AAR convened for significant Category 3 damage acquired
- PSII ongoing
- After Action Review completed regarding Category 4 pressure damage (Medical Device Related)

Patient Safety – VTE Prophylaxis

University Hospitals Dorset
NHS Foundation Trust

January 2026
54.4%
Variance/ Assurance
Targeting (Internal)
95%
Business Rule
Full CMS

VTE Prophylaxis Prescribing Compliance



Summary	Actions	Assurance & Timescale for Improvement
• 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	• 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	• 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

Group	Metric Id	MetricName	Provider Latest Date	UHD Value	UHD Target	UHD Variation	UHD Assurance
Birth	1	No. of women delivered (all births)	Jan 26	322			
	2	No. women delivered (unregistrable baby/babies only)	Jan 26	5			
	3	Number of women delivered (multiple births where at least one unregistrable and one registrable)	Jan 26	0			
	6	Number of babies born	Jan 26	328			
	7	No. of registrable babies born	Jan 26	321			
Booking	15	Total number of bookings	Jan 26	407			
	16	% bookings completed <10 weeks gestation	Jan 26	100%	65%		
Continuity of Carer	17	% of women on continuity of carer pathway by 29 weeks' gestation	Jan 26	5.95%			
	18	% of Black and Asian women on continuity of carer pathway by 28 weeks' gestation	Jan 26	90%			
	19	% of women (IMD-1) placed on a continuity of carer pathway	Jan 26	0%			
Infant Feeding	35	% of babies receiving breast milk at first feed	Jan 26	76.1%	72%		
	36	% babies receiving breast milk at discharge from midwifery care to HV/GP (10 - 28 days PN)	Jan 26	71.1%			
Maternal Morbidity & Mortality	13	Rate per 1,000 Women with >= PPH 1500ml(previous 3 months aggregated)	Jan 26	27.7	30		
	14	Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated)	Jan 26	14.9	28		
	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)	Jan 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)	Jan 26	0			

Data and Target

The national PQS Diis Scorecard is rated based on SPC methods and comparison to national targets.

Performance

Areas to note improvement :

- **Bookings** completed ,10 weeks 100%
- Avoidable term admissions to Neonatal unit **ATAIN** slight increase noted this month
- Rate per 1000 of women with 3rd and 4th degree tears

Key Areas of Focus

- **Workforce –sickness** rates and staff morale improving however remains a focus.
- Readmitted babies to hospital within the first 30 days of life- well-being clinic now commenced in November however increase in admissions in December and January
- Apgar score less than 7 at 5 minutes – quality improvement commenced.

Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

			Provider	UHD			
Group	Metric Id	MetricName	Latest Date	Value	Target	Variation	Assurance
Perinatal Morbidity	8	% of term babies admitted to NNU	Jan 26	5.52%	5%		
	22	% of babies <3rd birthweight centile, born >37+6 weeks	Jan 26	0%			
	62	Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar)	Jan 26	19.5	13		
Perinatal Mortality	11	No. of still births per month	Jan 26	0			
	12	No. of neonatal deaths < 28 Days	Jan 26	0			
	20	Annual rate of stillbirths per 1,000 births - rolling 12mths	Jan 26	2.92	2.5		
	41	Rate per 1,000 of live birth babies who died within 28 days of birth - rolling 12mths	Jan 26	2.93			
Preterm Birth Data	23	No. of singleton babies born <27 weeks' or multiples born <28 weeks' gestation or birthweight <800g	Jan 26	1			
	33	Rate per 1,000 births which are preterm (< 37 week's gestation)	Jan 26	96.6	60		
Treating Tobacco Dependency	9	% of women smoking at booking	Jan 26	4.67%			
	10	% of women smoking at delivery (previous month)	Jan 26	4.84%	6%		
	37	% of women with a CO measurement at time of booking	Jan 26	92.1%	95%		
	38	% of women with a CO measurement at time of 36 weeks' gestation	Jan 26	87.0%	95%		

Maternity and Neonatal Care

University Hospitals Dorset
NHS Foundation Trust

CQC Maternity Ratings UHD Assessment 2019 and Oct 2022.	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	Inadequate	Inadequate	GOOD	OUTSTANDING	OUTSTANDING	Inadequate

National position & overview

- **The Perinatal Quality Surveillance Dashboard describes a standard data set for Trust Board overview**
- **The dashboard implementation using the Perinatal Quality Surveillance Tool forms part of our Maternity Safety Self -Assessment and Ockendon 1 requirements**
- **There are several items which require narrative rather than graphic benchmarking and these are described below**

Findings of review of all perinatal deaths using the national monitoring tool	Matters for Board information and awareness	Progress in achievement of maternity improvement plan
MBRRACE reportable cases: There was no reportable cases to MBRRACE in January. **MNSI** There were no new MNSI cases in January 2026 and no ongoing or outstanding MNSI cases.	**Patient Safety Incident Response Framework** (PSIRF) has been implemented in maternity. In January there was four incidents requiring escalation through PSIRF and discussed in rapid review . No further learning opportunities identified. Ongoing PSII Major Obstetric Hemorrhage (MOH) following a Cat 2 EMCS (Emergency caesarean section) and Hysterectomy in theatre, then transfer to ITU. After Action Review (AAR) carried out by the Patient safety team in October. Feedback and questions have been received from the patient and her partner. Currently graded as 'Moderate physical harm' pending review and PSII commenced **Top incidences LFPSE:** • Post partum hemorrhage >1500mls • Term admission to NICU • Re-admission of babies **Safety champions reviews this month:** • Quarterly 3 Maternity and neonatal quality and safety Trust Board report.	CQC action plan - **Advise** Recent inspection in September – Awaiting draft report – initial recommendations action plan in place for baby abduction/security and safe staffing rosters. Maternity incentive scheme year 7 - Release of year 8 awaited and expected in April. All standards from year 7 continue . 2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022. 2025 survey showed a stable position and with greatest improvement for patient satisfaction in the maternity advice line Staff survey shown overall staff satisfaction -action plan in place for each area to individualize the improvements in 2025. Staff survey for 2025 closed end of November –good maternity response rate. Results received and currently being analysed. Culture improvement plan – Focus on behaviour charter work underway with perinatal leadership team in updating plan for 2026

University Hospitals Dorset
NHS Foundation Trust

Patient Experience

Sarah Herbert
Chief Nursing Officer

Operational Leads:
Vivian Alividza – Deputy Chief Nursing Officer

Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Performance at a Glance
Patient Experience

University Hospitals Dorset
NHS Foundation Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Friends & Family Test	Jan 26	93.2%	-			93.9%	92.4%	95.4%
Complaints Received	Jan 26	80	-			76	33	118
Complaint Response Rate (Grade Based Target)	Jan 26	40%	100%		F	47%	19%	75%
Mixed Sex Accommodation Breaches	Jan 26	0	-	L		7	-5	20

Survey Results will be reported annually

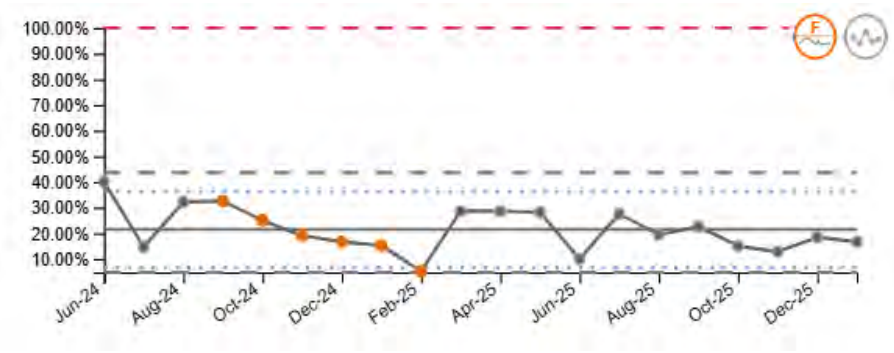
- To increase Have Your Say Survey feedback rates by 30%
- 5% improvement in employees who see patient care as a top priority for UHD

Patient Experience

University Hospitals Dorset
NHS Foundation Trust

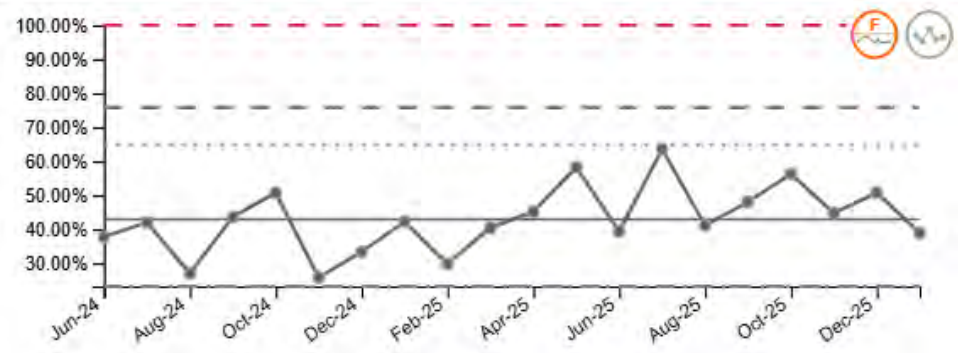
January 26
16.7%
Variance/ Assurance
F
Targeting (Internal)
100%
Business Rule
Verbal CMS

% of Early Resolutions closed within 10 days



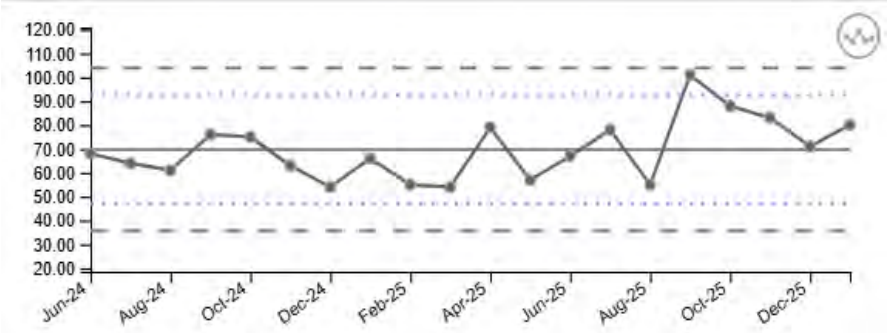
January 26
38.9%
Variance/ Assurance
F
Targeting (Internal)
100%
Business Rule
Full CMS

% of total complaints closed within 35 days



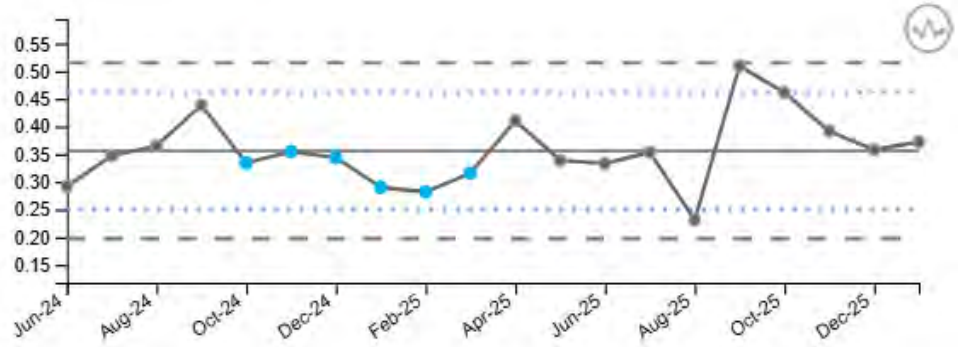
January 26
80
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Note Performance

Number of complaints received



January 26
0.37
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Verbal CMS

Number of complaints per 1000 contacts for clinical services



Summary

PALS concerns received = 639
Formal complaints = 49
Early Resolution Complaints = 31
Average Complaint response time = 41.37 days

Actions

Number of PALS concerns logged in month has increased.
Focus on reducing complaint response timescales continues

Assurance & Timescale for Improvement

Complaints manager continues to meet weekly with the care groups. A review of the complaints process, including working SOPs in progress.

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Finance

Pete Papworth
Chief Finance Officer

Operational Lead:
Adrian Tron, Deputy Chief Finance Officer

Committees:
Finance and Performance Committee

Performance at a Glance

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Finance

All values £'000 Driver Metric	Latest Month	In Month Plan	In Month Actual	In Month Variance	Year To Date Plan	Year To Date Actual	Year To Date Variance	Forecast Outturn Plan	Forecast Outturn Actual	Forecast Outturn Variance
Revenue Control Total	Jan-26	2,147	2,153	6	(3,124)	(3,086)	38	0	0	0
Capital Control Total	Jan-26	13,231	8,594	4,637	125,975	105,821	20,154	190,156	190,156	0
Efficiency Programme	Jan-26	7,798	4,366	(3,432)	53,999	46,113	(7,886)	69,625	54,237	(15,388)
Cash Balance	Jan-26	67,814	44,588	(23,226)	67,814	44,588	(23,226)	74,976	133,271	58,295
Better Payment Practice Code	Jan-26	95.0%	93.4%	-1.6%	95.0%	95.5%	0.5%	95.0%	95.0%	0.0%

Efficiency Improvement Programme

University Hospitals Dorset
NHS Foundation Trust

January 25
78%
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	(7,088)	4,417	(2,672)	(8,551)	5,636	(2,915)	66%	4,760	56%	1,799	2,464	(4,288)	50%
Medical	(10,294)	8,335	(1,959)	(12,524)	9,919	(2,605)	79%	9,836	79%	6,114	1,517	(4,893)	61%
WCCSS	(9,412)	6,768	(2,644)	(11,318)	8,453	(2,865)	75%	8,576	76%	5,168	443	(5,707)	50%
Operations	(1,588)	3,365	1,777	(1,875)	3,634	1,759	194%	3,447	184%	1,157	139	(579)	69%
Corporate	(3,263)	5,380	2,117	(3,875)	6,095	2,220	157%	5,888	152%	3,152	254	(469)	88%
Trust Wide	(17,030)	17,207	177	(23,497)	19,860	(3,637)	85%	21,764	93%	11,285	322	(11,890)	49%
Dorset wide schemes	(5,324)	640	(4,684)	(7,986)	640	(7,346)	8%	640	8%	0	0	(7,986)	0%
UHD	**(53,999)**	**46,113**	**(7,886)**	**(69,625)**	**54,237**	**(15,388)**	**78%**	**54,911**	**79%**	**28,674**	**5,139**	**(35,812)**	**49%**

Summary

Efficiency improvement delivery to the end of January is £7.9 million behind plan. The trust has identified savings opportunities of £55.0 million, however when adjusted to reflect the risk of delivery in year, this is reduced to £54.2 million. Whilst this representing an improvement in month of £0.3 million; it remains £15.4 million short of the full year savings requirement.

Actions

Further enhancing of local controls following a detailed review of the national 'grip and control' checklist in September has, and will continue to, support improvements in this forecast. NHS England undertook a deep dive into our efficiency programme in October, to provide additional external assurance and to learn from the output of similar reviews undertaken elsewhere in the South West. The final report has now been received and is positive overall. It included a small number of recommendations which are being progressed.

Assurance & Timescale for Improvement

Monitoring of improvements in the identification and delivery of efficiency schemes will continue weekly through the executive team meeting and monthly through Care Group SDR meetings, the Sustainable Services Group and Trust Management Group.

Financial Management – YTD Variance to budget -

University Hospitals Dorset
NHS Foundation Trust

January 25
£0
Variance/ Assurance
P
Targeting (Internal)
£0
Business Rule
Verbal Update

Summary I&E	Year to date			Mitigated Forecast		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Patient Care Income	701,816	713,586	11,769	840,062	858,664	18,602
Other Operating Income	48,943	50,740	1,796	56,869	55,375	(1,494)
Charitable Income	3,130	2,760	(370)	3,581	3,324	(257)
Total Income	**753,890**	**767,085**	**13,196**	**900,512**	**917,364**	**16,852**
Employee expenses	(502,460)	(503,415)	(955)	(602,199)	(602,556)	(357)
Clinical supplies expenses	(60,245)	(61,899)	(1,654)	(72,310)	(75,169)	(2,859)
Drugs expenses	(74,984)	(75,577)	(593)	(88,913)	(89,858)	(945)
Purchase of healthcare and social care	(12,063)	(18,021)	(5,959)	(13,598)	(20,592)	(6,994)
Depreciation and amortisation expense	(29,771)	(30,423)	(652)	(36,025)	(37,076)	(1,050)
Clinical negligence expense	(15,748)	(15,637)	111	(18,898)	(18,049)	849
Premises & fixed plant	(28,366)	(27,775)	591	(34,337)	(32,729)	1,608
Other operating expenses	(105,846)	(34,946)	70,900	(109,326)	(81,114)	28,212
Operating Expenses	**(829,483)**	**(767,693)**	**61,790**	**(975,607)**	**(957,143)**	**18,464**
Net finance costs	(10,169)	(10,140)	30	(11,603)	(9,287)	2,316
Other adj to control total basis	82,639	7,662	(74,977)	86,698	49,067	(37,631)
Control Total Surplus/ (Deficit)	**(3,124)**	**(3,086)**	**38**	**0**	**0**	**0**

January 25
£190,156
Variance/ Assurance
P
Targeting (Internal)
£190,156
Business Rule
Verbal Update

Capital	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Estate Schemes	12,815	12,671	144	19,189	19,189	0
IT Schemes	7,087	6,486	601	10,844	10,844	0
Medical Equipment	4,170	732	3,438	6,053	6,053	0
Total Operational CDEL	**24,072**	**19,889**	**4,183**	**36,086**	**36,086**	**0**
Total Donated Assets	**1,412**	**1,197**	**215**	**1,540**	**1,540**	**0**
CDC - Endoscopy Hub Build	6,000	6,819	(819)	6,999	6,999	0
CDC - Outpatient Assessment Centre	5,000	320	4,680	8,465	8,465	0
CIR - Critical Infrastructure Funding	1,865	1,407	458	3,450	3,450	0
DDC - Digital Diagnostics	203	227	(24)	203	203	0
DDP - Digital Pathology	1,491	1,352	139	1,891	1,891	0
ELR - Elective Recovery	816	508	308	2,776	2,776	0
EPR - Front Line Digitisation	0	0	0	12,253	12,253	0
DCR - Dorset Care Record (MOU)	0	0	0	1,200	1,200	0
NHP - FBCA & Enabling Works	55,837	53,576	2,261	60,418	67,989	(7,571)
NHP - FBCB	11,092	10,492	600	30,327	22,756	7,571
SOL - Renewables - Solar Partnership	1,369	1,240	129	3,210	3,210	0
STPW1 - Beach Building & PH Theatres	16,818	8,794	8,024	21,141	21,141	0
WYFDR - IT NHS App	0	0	0	197	197	0
Total Central PDC	**100,491**	**84,735**	**15,756**	**152,530**	**152,530**	**(0)**
UHD Capital Total	**125,975**	**105,821**	**20,154**	**190,156**	**190,156**	**(0)**

Summary

I&E : The Trust reported deficit is £3.1 million at Month 10, £38,000 better than plan.
The Trust now has a detailed plan to recover the year-to-date deficit and deliver within the full year budget with this shown in the mitigated forecast position above.
Capital : The Trust reported capital expenditure of £105.8 million, being £20.2 million lower than plan year to date. We are forecasting delivery of the programme within the funding envelope but there remains risk within this due to the delays to the COAST building.

Actions

I&E : The plan requires acceleration of identified efficiency schemes currently expected to deliver in 2026/27, a further tightening of workforce controls including considerable reduction in bank expenditure, together with a range of smaller mitigations.

Capital : A re-profiling request has been submitted and is currently being considered in relation to the STP Wave 1 funding.

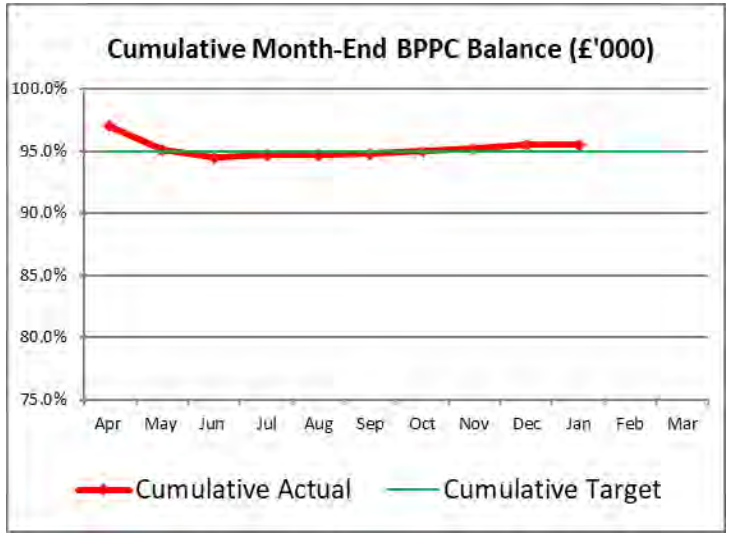
Assurance & Timescale for Improvement

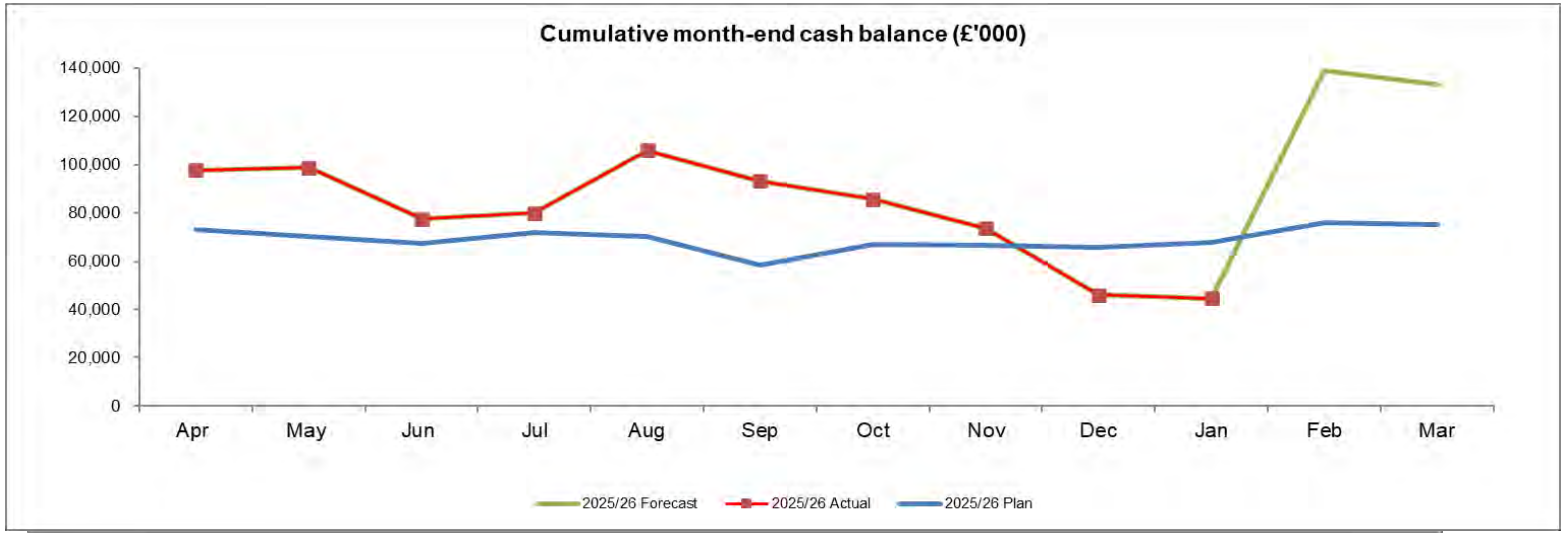
I&E : The Trust has a detailed plan to deliver within the full year budget. The mitigating actions that deliver this will be monitored through the Sustainable Service Group, Care Group SDR meetings, and weekly executive meeting.

Capital : Discussions continue to take place with NHS England regarding the re-profiling request. Confirmation is expected in February.

Working Capital

University Hospitals Dorset
NHS Foundation Trust





Summary	Actions	Assurance & Timescale for Improvement
Public Sector Payment Policy : In relation to the timely payment of supplier invoices, the Trust is currently delivering performance of 95.5%, above the national standard of 95%. **Cash :** As at January 2025 the Trust is holding a consolidated cash balance of £44.6 million which is fully committed against the Trust's reconfiguration programme. This current balance represents 18 days of operating expenditure. The underlying operational cash balance, including PDC draws expected relating to capital spend in December, is £62.6 million or 25 days of operating expenditure.	**Public Sector Payment Policy :** It is anticipated that this will be maintained above the target, with ongoing support to areas with slow invoice approvals to ensure performance moves above the target in future months. **Cash :** With the increasing system and regional focus on the forecasting of cash flow we are strengthening our internal processes around the forecasting and internal reporting of cash flow. The key mitigations which will deliver a breakeven financial outturn by year end will improve the cash balance significantly in February and March.	**Public Sector Payment Policy :** It is expected that the actions ongoing to support BPPC performance will result in performance above the target 95% to the end of the financial year. **Cash** : Revenue mitigations and planned capital draws will improve the cash position in February and March, as shown in the forecast chart above.

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

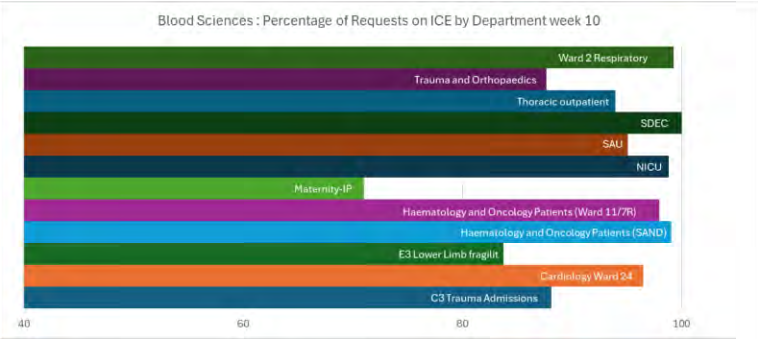
Digital

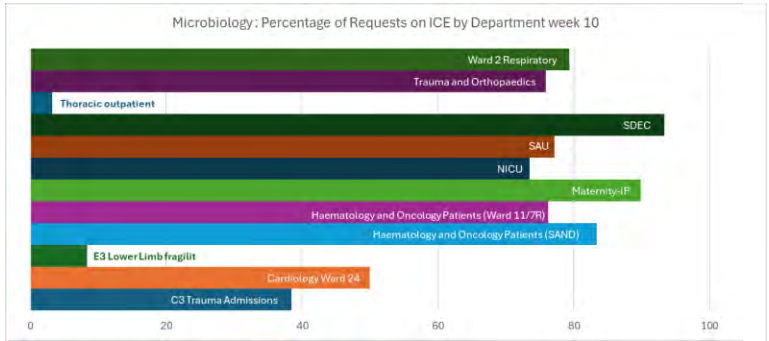
Beverley Bryant
Chief Digital Officer

Digital : Outpatient Transformation & Care Coordination

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
DNA rate against SMS sent	Target needs to be defined - need to review all work related to DNA rate and impact of Dr Doctor							
Digital letters vs paper	Target for all patient letters to go via Synertec so 100% for that but then this is patient choice for Digtial vs Paper							
Uptake of 'Advice & Guidance'		100%	Dec 26		This is to monitor move of A&G to Consultant Connect			
ICE for Ordering vs paper		95%	Mar 26		This is move of ICE to paperless requesting			
ICE results acknowledgement	49%	90%	Mar 26		This is the ICE filing position			
No. of attendances streamed away via NHS S&R tool	Target for this to be calculated as many different measures in this space							

Digital





University Hospitals Dorset
NHS Foundation Trust

Summary	Actions	Assurance & Timescale for Improvement
DNA rates (5.6%) is demonstrating normal variation and fell below the process mean in January. The target is marginally outside of the process control limits indicating further intervention is required.	Evaluation of the Trust's pilot of DrDoctor DNA predictor to take place in Quarter 4 prior to full roll out. A review of best practice toolkits is taking place in February.	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.	Communications being sent out to progress further use of Synertec and Dr Doctor for patient correspondence. Essential system review is confirming the systems that send letters to patients to ensure all are under review.	This is a project under Transforming and Valuing Administration.
Advice & Guidance is the take up of Consultant Connect as the new process for A&G through ERS. Currently there are 9 specialties live with consultant connect.	The roll out of Consultant Connect for Advice & Guidance has 9 specialties live, with 3 imminent to go live. This will leave 10 specialties left to deploy and we are deploying 3 or 4 specialties a month.	Advice & Guidance Task & Finish Group progressing this project. The project roll out continues to progress well to meet the end of March date but a lot of setup on smartcards which may add a slight delay in.
ICE Ordering and Results Acknowledgement – Single Task & Finish Group to focus on moving this to electronic only. Week 10 % ICE for Blood science and Microbiology shown above	Pilot areas are now being scheduled to move paperless for requesting during February and March 2026. There will be a new Add on form for Trust wide requests in February. All Pathology and Radiology paper reports will cease to be produced from the end of February. The Plan for Trust wide roll out being worked up.	Task & Finish Group for ICE Paperless Reporting and Reporting to Monitor and Track this. Overall target for paperless reporting & requesting is being reviewed due to the setup required to facilitate the roll out Trust wide.
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: 11 March 2026

Agenda item: 10.1

Subject:	Board Committees Terms of Reference
Prepared by:	Klaudia Zwolinska, Deputy Company Secretary
Presented by:	Judy Gillow, Interim Trust Chair

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☒ ☒ ☒ ☒ ☒
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Decision/Approval	
Executive Summary:	The purpose of this document is to present updated Terms of Reference for the following Committees as part of the annual review: • Appointments and Remuneration Committee • Audit Committee • Charitable Funds Committee • Finance and Performance Committee • People and Culture Committee • Quality Committee The Terms of Reference have also been refreshed using the new corporate template introduced through the *Organising for Success* corporate project, which aims to streamline and standardise governance arrangements across the Trust.	
Background:	Annual review of the Board Committees Terms of Reference.	
Key Recommendations:	The Board is asked to approve the Board Committees Terms of Reference.	
Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation	☐ ☐ ☐ ☐ ☐ ☐ ☐

	Quality	☐
	Regulatory	☒
	Strategy/Transformation	☐
	System	☐
CQC Reference:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	13/02/2026	The Committee endorsed the Terms of Reference with recommendation to the Board to approve (distributed by email on 13 February 2026)
Charitable Funds Committee	16/02/2026	The Committee endorsed the Terms of Reference with recommendation to the Board to approve.
Finance and Performance Committee	02/03/2026	The Committee endorsed the Terms of Reference with recommendation to the Board to approve.
People and Culture Committee	02/03/2026	The Committee endorsed the Terms of Reference with recommendation to the Board to approve.
Quality Committee	03/03/2026	The Committee endorsed the Terms of Reference with recommendation to the Board to approve.

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

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset
NHS Foundation Trust

Appointments and Remuneration Committee

DOCUMENT DETAILS

Author:	Klaudia Zwolinska
Job Title:	Deputy Company Secretary
Signed:	
Date:	11/03/2026
Version No: (Author Allocated)	1.0
Next Review Date:	10/03/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow, Interim Chair
Signed:	
Date Approved:	11 March 2026
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
March 2026	1.0	March 2027	[11 March 2026]	Director of Corporate Governance	New Terms of Reference Template. Adding reference to NHSE Exit Payment Guidance

TERMS OF REFERENCE

COMMITTEE:	**Appointments and Remuneration Committee**
PURPOSE *(1.2)*:	The primary purpose of the Committee is to identify and appoint candidates to fill the Executive Director positions on the Board and to determine the remuneration and other conditions of service for the Chief Officers and Very Senior Managers. In exercising delegated authority from the Board, the Committee oversees the process for the appointment and removal of the Chief Executive (subject to the Council of Governors' approval), oversees the process for the appointment and removal of the Trust's Chief Officers. Sets remuneration, allowances and other terms and conditions of office of the Trust's Chief Officers.
RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following: **Board Composition, Evaluation and Succession Planning** • Regularly review the structure, size and composition of the Board, including skills, knowledge, experience and diversity, and make recommendations for change. • Use the findings of the Board evaluation process to inform recommendations for change. • Work with the Council of Governors' Nominations, Remuneration and Evaluation Committee in relation to Non-Executive Director appointments. • Consider succession planning for the Chief Executive and other Chief Officers. • Keep under review the leadership needs of the Trust at executive level to ensure organisational effectiveness. • Provide input into the formation or continuation of Very Senior Manager roles **Appointment of Chief Officers and Executive Directors** • Identify and appoint candidates to fill roles within the Committee's remit as vacancies arise. • Ensure a formal, rigorous and transparent recruitment process, including: o considering candidates from diverse backgrounds on merit and objective criteria o using open advertising or external advisers where appropriate o evaluating required skills, knowledge, experience and diversity for each appointment. • Ensure proposed appointees disclose: o significant commitments before appointment o any conflicts of interest prior to or during appointment. **Continuation in Office, Suspension or Termination** • Consider matters relating to the continuation in office of Chief Officers, including suspension or termination, consistent with law and contractual terms.

- Report to and seek approval from the Council of Governors for the appointment or removal of the Chief Executive.

Remuneration Policy and Reward Framework

- Establish and review the remuneration policy for Chief Officers and Very Senior Managers, aligned with:
    - the Trust's wider reward and benefit strategy
    - NHS arrangements
    - extant Treasury guidance.
- Determine remuneration and terms/conditions for those within scope, including:
    - market positioning
    - base salary and salary increases
    - pensions and car benefits
    - allowances
    - expenses
    - compensation payments
    - performance-related incentives and associated targets.
- Consult the Chief Executive when considering remuneration of other Chief Officers.

Ensuring Fair, Transparent and Accountable Pay Decisions

- Set remuneration levels sufficient to attract, retain and motivate high-quality leaders without paying more than necessary.
- Ensure decisions:
    - reflect national guidance and benchmarking
    - avoid increases unless justified by Trust or individual performance
    - remain sensitive to wider staff pay and employment conditions.

Contractual Arrangements and Termination Payments

- Oversee and advise on contractual arrangements for the Chief Executive and Chief Officers, including the scrutiny and calculation of termination payments, ensuring alignment with:
    - HM Treasury guidance
    - National guidance
    - the Code of Governance for NHS Provider Trusts
    - the principle of avoiding rewarding poor performance
- Ensure that all termination, severance, settlement, MARS (Mutually Agreed Resignation Scheme) or other non-contractual exit payments fully comply with the NHS England severance processes.
- Ensure compliance with the HM Treasury control framework for Special Severance Payments.
- Agree and review the extent to which a full-time Chief Officer may take on a Non-Executive Director or Chair role in another organisation of comparable size and complexity.

Performance Evaluation

- Monitor and assess performance evaluation outputs for individual Chief Officers and consider findings when reviewing remuneration.

MEMBERS *(3.1):*	Membership of the Committee comprises: **All Non-Executive Directors**		**STANDING ATTENDEES *(3.2):***	Standing attendees: **Chief People Officer** **Director of Corporate Governance**	
CHAIR (*3.3*):	**Trust Chair**	**DEPUTY CHAIR *(3.3)*:**	**Vice Chair**	**SECRETARY *(5.5)*:**	The **Director of Corporate Governance or** their nominee.
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	The Committee meets **at least once in each year.**		**QUORUM *(5.2)***	Meetings will be quorate if at least **three members** are present, including **Trust Chair** (or Trust Vice Chair in their absence)	
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Committee is accountable to the Board of Directors.		**REPORTING GROUPS *(6.5)*:**	N/A	

University Hospitals Dorset NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

APPOINTMENTS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Committee and how it will achieve its purpose is as set out above.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members shall elect another member to present to chair the meeting (which, in the case of a Board Committee shall be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting. (In the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member shall not count towards the members' attendance. A record of members' attendance shall be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee will normally meet at the frequency set out above and at such other times as the Chair shall require.

5.2 Meetings of the Committee will be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted.

5.4 Meetings of the Committee will be called by the Secretary at the request of the Chair. The Secretary of the Committee will be as stated above.

5.5 The Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee at the next meeting.

5.7 Committee business may be transacted through virtual media (including but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes or notes (as specified above), which will be submitted to the next meeting of the Committee for approval.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committees will be accountable to the group set out above (the Accountable Group), to whom it shall make recommendations in relation to issues that require decision or resolution.

6.2 The Committees will present a report summarising the proceedings of each of its meetings at the next meeting of the Accountable Group. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above.

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Accountable Group detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

APPENDIX A

ATTENDANCE AT COMMITTEE MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee/Group]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

TERMS OF REFERENCE

for the

University Hospitals Dorset
NHS Foundation Trust

Audit Committee

DOCUMENT DETAILS

Author:	Klaudia Zwolinska
Job Title:	Deputy Company Secretary
Signed:	
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Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow, Interim Chair
Signed:	
Date Approved:	11 March 2026
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
March 2026	1	March	[11 March 2026]	Director of Corporate Governance	New Terms of Reference template

TERMS OF REFERENCE

COMMITTEE NAME:	Audit Committee
PURPOSE *(1.2)*:	The Audit Committee is established by the Board to provide independent oversight and assurance to the Board regarding the adequacy and effectiveness of the Trust's governance, risk management and internal control systems across the Trust. It supports delivery of the Trust's objectives by reviewing risk-related disclosures, assurance processes and compliance with statutory, regulatory and code of conduct requirements.

	The Committee follows an annual programme of business but remains flexible to emerging risks and priorities.
RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following: **Governance, Risk Management and Internal Control** • Review the overall effectiveness of governance, risk management and internal control arrangements across the Trust, ensuring they remain fit for purpose and aligned with current regulation and guidance with the intention of supporting Boards in evaluating their assurance systems. • Scrutinise the design and operation of the Board Assurance Framework, ensuring strategic risks are accurately described, controls are effective, and sources of assurance are reliable. • Assess how risk management processes identify, score, monitor and mitigate risks, including the Trust's alignment with system-wide risks where applicable. • Review the interaction between operational, clinical, financial, information and system risks to ensure assurance gaps are addressed. • Receive reports on significant control failures, thematic issues or emerging risks, ensuring that corrective and preventative actions are implemented. **Internal Audit** • Approve the annual internal audit plan and ensure that it provides sufficient coverage of key risk areas, reflecting changes in Trust and NHS system risk profiles. • Assess internal audit's independence, resourcing, skills mix and performance. • Review all internal audit reports, paying particular attention to high-risk findings, overdue actions, and areas of repeated weakness. • Monitor the Trust's responsiveness to internal audit recommendations, ensuring agreed actions are implemented promptly. • Hold private meetings with internal audit to promote openness and discuss any concerns about access, management influence or emerging risks. • Ensure that internal audit contributes effectively to the annual governance statement. **External Audit** • Review and discuss the external audit strategy, scope, and timetable, confirming adequate coverage of key accounting and risk areas. • Monitor the external audit findings, including value-for-money conclusions, and the effectiveness of management responses. • Ensure that audit recommendations are implemented in a timely and thorough manner. • Meet privately with external auditors to explore concerns, independence, emerging audit issues, or limitations in scope. • Advise the Board on the external audit opinion for the Annual Report and Accounts.

Counter Fraud and Anti-Crime Measures

- Oversee local counter-fraud services, ensuring compliance with NHS requirements for the detection, prevention and investigation of fraud.
- Review reports of suspected fraud, financial irregularities or bribery cases and ensure appropriate action is taken.
- Consider thematic fraud risks (procurement, payroll, cyber-enabled fraud, etc.) and monitor how the Trust mitigates them.
- Support the development of a strong anti-fraud culture through training, communication and assurance processes.

Financial Reporting and Annual Accounts

- Review accounting policies, significant judgements, estimates, impairments, provisions and their associated risks.
- Ensure that the Annual Report and Accounts comply with statutory requirements and NHS England guidance before recommending them to the Board.
- Review the narrative content, including performance reporting, governance disclosures and the annual governance statement, ensuring accuracy and transparency.
- Monitor processes for financial reporting throughout the year, not only at year-end.

Other Assurance Functions

- Review the effectiveness of wider assurance functions such as quality governance, workforce, operational performance, estates, IT, information governance and cyber security.
- Ensure all relevant assurance providers (internal audit, external audit, counter fraud, clinical audit, CQC inspections, NHS England reviews, internal compliance audits) contribute to an integrated assurance picture.
- Seek assurance that committees reporting to the Board do not leave unaddressed gaps or duplications in oversight.

Speaking Up, Whistleblowing and Staff Voice

- Review the effectiveness of Freedom to Speak Up arrangements, ensuring they protect the independence and safety of individuals raising concerns.
- Receive reports from the Freedom to Speak Up Guardian on trends, themes and management responsiveness.
- Assess cultural indicators of openness, speak-up climate and psychological safety.

Information Governance, Data Protection and Cyber Security

- Review arrangements for information governance compliance, including Data Security and Protection Toolkit outcomes and internal assessments.
- Oversee cyber-security risk management, ensuring resilience, incident response, penetration testing, and threat intelligence are appropriately managed.
- Monitor data breaches, learning outcomes, and mitigation measures**.**

	Compliance, Regulation and Statutory Reporting • Monitor compliance with NHS England requirements, statutory obligations, financial controls, Standing Orders and the Scheme of Delegation. • Ensure that NHS England and HM Treasury Guidance on Exit-Related Payments is followed • Ensure that compliance reporting is accurate and that non-compliance is escalated appropriately. • Oversee the system for managing regulatory recommendations (CQC, NHSE, internal/external reviews). **System Assurance and Partnership Working** • Review governance arrangements and risks associated with Integrated Care System (ICS) participation, provider collaboratives and joint ventures. • Ensure that system-level controls, risk sharing, data sharing and governance frameworks are adequately designed and operated. • Examine how system working influences Trust risk, assurance and reporting. **Committee Effectiveness and Governance Development** • Conduct an annual self-assessment to evaluate effectiveness and compliance with the current regulation and guidance • Review its skills mix and training needs. • Oversee the quality and timeliness of papers, minutes, action logs and reporting. • Review its Terms of Reference at least annually and recommend updates to the Board.

MEMBERS *(3.1):*	Membership of the Committee comprises: • **Four Non-Executive Directors** (excluding the Trust Chair) At least one must be a qualified accountant with recent and relevant financial experience. At least one must also be a member of the Quality Committee. Membership must collectively include sector-relevant competence	**STANDING ATTENDEES *(3.2):***	Standing attendees: • **External audit representatives** • **Internal audit representatives** • **Local anti-crime service representatives** • **Chief Finance Officer** • **Chief Nursing Officer** • **Director of Corporate Governance** **Chief Executive Officer** attends at least annually.

CHAIR (*3.3*):	**Non-Executive Director** (not the Trust Chair or Vice-Chair)	**DEPUTY CHAIR *(3.3)*:**	**Non-Executive Director Deputy Chair** (not the Trust Chair or Vice-Chair)	**SECRETARY *(5.5)*:**	The **Director of Corporate Governance or** their nominee. They will also be responsible for preparing minutes and updating action log.
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	The Committee will meet at least **quarterly** with additional meetings scheduled as required.		**QUORUM *(5.2)***	Meetings will be quorate if at least **two members** are present: • Chair (or Deputy Chair) • one Non-Executive Director	
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Committee is accountable to the Board of Directors.		**REPORTING GROUPS *(6.5)*:**	The Committee receives reports from sub-groups of the Trust Management Group and Finance and Performance Committee, Quality Committee and People and Culture Committee when matters require escalation.	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Committee and how it will achieve its purpose is as set out above.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members will elect another member to present to chair the meeting (which, in the case of a Board Committee will be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting. (In the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member will not count towards the members' attendance. A record of members' attendance will be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee will normally meet at the frequency set out above and at such other times as the Chair will require.

5.2 Meetings of the Committee will be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business will be transacted.

5.4 Meetings of the Committee will be called by the secretary at the request of the Chair. The Secretary of the Committee will be as stated above.

5.5 The secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The secretary (or their nominee) will collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided no less than seven working days before the meeting and the agenda and papers should be circulated no less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee at the next meeting.

5.7 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair will be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes (as specified above), which will be submitted to the next meeting of the Committee for approval.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee will be accountable to the Board of Directors (the Accountable Group), to whom it will make recommendations in relation to issues that require decision or resolution.

6.2 The Committee will present a report summarising the proceedings of each of its meetings at the next meeting of the Board of Directors. For the avoidance of doubt, where practicable, this will be a written report, with a verbal update being provided as necessary.

6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above.

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board of Directors detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

APPENDIX A

ATTENDANCE AT COMMITTEE MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset
NHS Foundation Trust

Charitable Funds Committee

DOCUMENT DETAILS

Author:	Klaudia Zwolinska
Job Title:	Deputy Company Secretary
Signed:	
Date:	16/02/2026
Version No: (Author Allocated)	1.0
Next Review Date:	15/02/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow, Interim Chair
Signed:	
Date Approved:	11 March 2026
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
March 2026	1	March 2027	[11 March 2026]	Director of Corporate Governance	New Terms of Reference template

TERMS OF REFERENCE

COMMITTEE NAME:	**Charitable Funds Committee**
PURPOSE *(1.2)*:	The Charitable Funds Committee is established as a committee of the Corporate Trustee, with the University Hospitals Dorset NHS Foundation Trust Board acting as the Board of the Trustee (Charity Registration Number 1057366).

	The purpose of the Committee is to provide assurance to the Board regarding the administration, application, investment and stewardship of the charitable funds in accordance with the Charities Acts, external guidance and all applicable legislation. The Committee will ensure that all charitable funds are used in line with donors' wishes and that the Charity is managed effectively, efficiently and with appropriate governance oversight.
RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following: • Monitor and authorise the application of all charitable funds in accordance with the Charities Acts, applicable legislation and donor conditions. • Make decisions regarding the investment of charitable funds in line with legislation, policy and Charity Commission guidance. • Ensure compliance with the Trust's Standing Financial Instructions and Scheme of Delegation as relevant to charitable funds. • Monitor the performance of the investment portfolio, including review of spending plans and balances. • Review and recommend approval to the Board of the Annual Report and Accounts of the Charity for submission to the Charity Commission. • Receive and review quarterly charitable funds income and expenditure accounts and associated reporting. • Ensure expenditure is controlled and utilised on appropriate projects. • Establish and monitor policies and procedures for the effective day-to-day management of charitable funds. • Review detailed business cases relating to major investment decisions and make recommendations. • Ensure legacies are realised completely and in a timely manner. • Safeguard donated money and ensure appropriate use. • Review the overall fundraising strategy and projects annually and recommend schemes to the Board for approval. • Enact the strategy for use of charitable funds as set by the Board.

MEMBERS *(3.1):*	Membership of the Committee comprises: • **Three Non-Executive Directors** • **Chief Finance Officer** • **Chief People Officer**	**STANDING ATTENDEES *(3.2):***	Standing attendees: • **Charity Director** • **Deputy Chief Finance Officer** • **Deputy Chief People Officer**

CHAIR *(3.3)*:	**Non-Executive Director**	**DEPUTY CHAIR *(3.3)*:**	**Non-Executive Director Deputy Chair**	**SECRETARY *(5.5)*:**	**The Director of Corporate Governance** or their nominee. An **Executive Assistant/ Business Manager** will be responsible for preparing minutes and updating action log.
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	The Committee will meet on a **quarterly basis** with additional meetings scheduled as required.		**QUORUM *(5.2)***	Meetings will be quorate if at least **three members** are present: • the Chair (or Non-Executive Director Deputy), • one other Non-Executive Director • one Executive Director.	
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Committee is accountable to the Corporate Trustee, with the Trust Board acting on behalf of the Trustee in making trustee decisions.		**REPORTING GROUPS *(6.5)*:**	N/A	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. PURPOSE

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1.2 The purpose of the Committee and how it will achieve its purpose is as set out above.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members will elect another member present to chair the meeting (which, in the case of a Board Committee will be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting. (In the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member will not count towards the members' attendance. A record of members' attendance will be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 The Committee is authorised by the Board to investigate/review any activity within its Terms of Reference.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee will normally meet at the frequency set out above and at such other times as the Chair will require.

5.2 Meetings of the Committee will be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business will be transacted.

5.4 Meetings of the Committee will be called by the secretary at the request of the Committee Chair. The secretary of the Committee will be as stated above.

5.5 The secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The secretary (or their nominee) will collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided no less than seven working days before the meeting and the agenda and papers should be circulated no less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee at the next meeting.

5.7 Committee business may be transacted through virtual media (including but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair will be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes (as specified above), which will be submitted to the next meeting of the Committee for agreement.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee will be accountable to the group set out above (the Accountable Group), to whom it will make recommendations in relation to issues that require decision or resolution.

6.2 The Committee will present a report summarising the proceedings of each of its meetings at the next meeting of the Accountable Group. For the avoidance of doubt, where practicable, this will be a written report, with a verbal update being provided as necessary.

6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above.

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Accountable Group detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

APPENDIX A

ATTENDANCE AT COMMITTEE/GROUP MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee/Group]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Finance and Performance Committee

DOCUMENT DETAILS

Author:	Klaudia Zwolinska
Job Title:	Deputy Company Secretary
Signed:	
Date:	02/03/2026
Version No: (Author Allocated)	1.0
Next Review Date:	01/03/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow, Interim Chair
Signed:	
Date Approved:	March 2026
Target Audience:	Board of Directors

Document History					
Date of Issue	**Version No:**	**Next Review Date:**	**Date Approved:**	**Person responsible for Change**	**Nature of Change**
March 2026	1	March 2027	[11 March 2026]	Director of Corporate Governance	New Terms of Reference template

TERMS OF REFERENCE

COMMITTEE NAME:	**Finance and Performance Committee**
PURPOSE *(1.2)*:	The Finance and Performance Committee exists to support the Trust in achieving its strategic objectives: *See our patients sooner* and *use every NHS pound wisely.* The Committee does so by providing focused assurance, scrutiny and advice to the Board on the planning, delivery and continuous improvement of the Trust's financial and operational performance. In

	particular, the Committee contributes to and challenges the development of: • the Annual Operating Plan • Productivity and Efficiency Plan • Estates Strategy (Masterplan) • Sustainability Strategy (Green Plan) • Digital Strategy • Private Patients Strategy ensuring these plans are coherent, affordable, and deliverable and that they collectively advance the Trust's mission and vision within the Dorset Integrated Care System. To fulfil this purpose, the Committee provides ongoing oversight of strategic initiatives and "breakthrough" objectives delegated to it by the Board, obtains assurance regarding implementation and outcomes against milestones, and monitors the key risks and interdependencies that could affect delivery, particularly those relating to the efficient use of resources (physical and financial), the realisation of post-merger and transformation benefits, and climate change mitigations. The Committee makes recommendations and escalates issues to the Board, in line with its delegated authority.
RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following: **Strategic Objectives and Breakthrough Initiatives** • Receive annual confirmation of the breakthrough objectives and strategic initiatives delegated by the Board, and monitor delivery, identifying barriers and escalating issues as required. **Statutory Requirements** • Review the draft Annual Report and Accounts with the Audit Committee and recommend the final version to the Board following external audit. **Financial Planning and Reporting** • Review and recommend annual, medium-term and long-term financial plans, including capital investment, borrowing and financial risks. • Scrutinise revenue and capital budgets, tenders and business cases above delegated limits. • Monitor financial performance, variances, financial controls, cash flow, efficiency targets and capital programme delivery. • Review the quality and timeliness of financial, operational and analytical information. **Operational Performance** • Monitor performance against constitutional standards and NHS England requirements, including Care Group-level delivery, productivity and recovery plans.

	Capital and Estates • Review major capital business cases, monitor progress on approved schemes and provide oversight of the Estates Strategy and associated risks. **Commercial, Procurement and Private Patients** • Review the Private Patient Strategy and other commercial or partnership initiatives. • Oversee procurement strategy and related risks. **Productivity and Merger Benefits** • Obtain assurance on delivery of productivity, efficiency, transformation and post-merger integration benefits. **Digital and Technology** • Review the Digital Strategy • Monitor progress of digital and technology programmes, including cyber security and system resilience • Oversight of Artificial Intelligence (AI) **Sustainability** • Review and monitor delivery of the Sustainability Strategy (Green Plan) and climate-related commitments, including sustainability sections of the Annual Report. **Integrated Care System and System-Level Reporting** • Receive financial and relevant reports from the Dorset ICS and provider collaborative, assessing implications for the Trust. **Risk Management** • Review the Board Assurance Framework for risks within scope and monitor high-level risks (rated 12–25) and associated action plans.

MEMBERS *(3.1)*:	Membership of the Committee comprises: • **Four Non-Executive Directors** (including at least one with recent financial experience) • **Chief Digital Officer** • **Chief Finance Officer** • **Chief Operating Officer** • **Chief Strategy and Transformation Officer**		**STANDING ATTENDEES *(3.2)*:**	Standing attendees: • **Chief People Officer** • **Deputy Chief Finance Officer**	
CHAIR (*3.3*):	**Non-Executive Director** (not the Trust Chair or Audit Committee Chair)	**DEPUTY CHAIR** ***(3.3)*:**	**Non-Executive Director Deputy Chair-Executive Director Deputy Chair**	**SECRETARY *(5.5)*:**	The **Director of Corporate Governance or** their nominee.

			(not the Trust Chair or Audit Committee Chair)		An **Executive Assistant/ Business Manager** will be responsible for preparing minutes and updating action log.
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	Meetings are usually held **monthly** (not fewer than 10 times per year) with additional meetings scheduled as required.		**QUORUM *(5.2)***	Meetings will be quorate if at least **three members** are present: • two Non-Executive Directors-Executive Director • one Executive Director If the Chief Finance Officer is absent, the Deputy CFO must attend.	
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Committee is accountable to the Board of Directors.		**REPORTING GROUPS *(6.5)*:**	The Committee receives reports from sub-groups of the Trust Management Group and may refer issues to the Audit Committee, Quality Committee and People and Culture Committee.	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

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3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members will elect another member present to chair the meeting (which, in the case of a Board committee will be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting (in the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member will not count towards the members' attendance. A record of members' attendance will be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

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5. CONDUCT OF BUSINESS

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5.8 Proceedings and decisions made will be recorded in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

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6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above.

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7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Accountable Group detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

APPENDIX A

ATTENDANCE AT COMMITTEE MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

People and Culture Committee

DOCUMENT DETAILS

Author:	Melanie Whitfield
Job Title:	Chief People Officer
Signed:	
Date:	02/03/2026
Version No: (Author Allocated)	1
Next Review Date:	08/03/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow
Signed:	Insert e-signature of Chair of Approving Committee/Group
Date Approved:	Insert date of approval of these ToR
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
March 2026	1	March 2027	[11 March 2026]	Chief People Officer	New Terms of Reference Template

TERMS OF REFERENCE

COMMITTEE NAME:	**People and Culture Committee**
PURPOSE *(1.2)*:	The purpose of the Committee is twofold, firstly the provision of assurance for all national workforce actions and secondly to ensure the Trust has a workforce strategy in place to support the Trust strategy in the provision of excellent healthcare and a great place to work. The people strategy supports the recruitment and retention of sufficient people with the necessary knowledge, skills, and experience, working to the values of the organisation to deliver both the Trust strategy and immediate clinical and other operational objectives.

	Particular attention is given to : • A clear understanding of the strategic workforce needs and plans which need to be in place to deliver these. • A comprehensive long-term people plan with supporting specialist strategies and an ability to regularly review the positive impact on our people services • Assurance for the Trust Board that all legislative, regulatory and mandatory requirements relating to the workforce are met. • That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented. To achieve this, the Committee shall: • Support the development and monitoring of a workforce strategy and long-term people plan, particularly our progress against our vision metrics (Increasing staff engagement; A sustainable organistaion, developing and retaining the best people; and Being a Fair and Equitable Employer). • Champion workforce issues through the inclusion and promotion of the non-Executive independent roles such as the Freedom to Speak up Champion and Wellbeing Guardian ensuring adequate oversight of all workforce areas by the Board. • The Committee will discharge this function on behalf of the Board of Directors by: • Monitoring key workforce metrics to ensure that the expected standards are being delivered particularly against our key people indicators. • Receiving reports to not only provide assurance around compliance with legislation and regulations but to demonstrate our commitment and progress as a leading employer in the community. • Considering and challenging workforce plans and improvement plans on behalf of the Board to continue to improve our people practises across an increasingly diverse and professional workforce.
RESPONSIBILITIES *(2.1)*:	Oversee progress on the development and delivery of workforce, organisational development and cultural change strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives. Review and provide assurance on those elements of the Board Assurance Framework , the people risks identified as the responsibility of the Committee, seeking where necessary further action/assurance. The detail of this review will be upwardly reported to the Board to provide oversight.

	Oversight of the delivery of the people plan and associated policy management. Maintaining oversight of the business of the People and Culture Group and associated sub-structure of working groups. Escalation reports will come to the People and Culture Committee summarising the themes and providing assurance on operational decisions affecting workforce performance, organisational change and the implementation of initiatives. Oversight of the development and delivery of the Long-Term People Plan, the people aspects of the Trust and their contribution to the Trust strategy. Monitor effectiveness of compliance with local and National staff surveys and the implementation of action plans to deliver against identified areas of concern. Receipt and review of the Workforce Report prior to submission to Trust Board as part of the Integrated Performance Report. This includes a review of the Trust's workforce performance indicators which reference the Breakthrough objective and watch metrics to provide assurance that mitigating actions are in place where appropriate. Oversee the implementation of Internal Audit recommendations as directed by the Audit Committee. To receive and review quarterly and annual reports of the Guardian of Safe Working on the Board's behalf with a particular focus on the indications of a healthy speak up culture and the encouragement of sharing learnings. Maintaining oversight of the Trust's employment related equality, diversity and inclusion agenda, including assurance of Gender Pay Gap, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) annual reports. Champion the Trust's position as an equitable employer encouraging and maintaining progress against both our strategic commitment and public sector duties . To provide oversight of the management and delivery of education and training within the Trust.

MEMBERS *(3.1):*	Membership of the Committee comprises: • **Three Non-Executive Directors** • **Chief Nursing Officer** • **Chief Operating Officer** • **Chief People Officer**	**STANDING ATTENDEES *(3.2):***	**Standing attendees:** • **Chef Executive Officer** • **Deputy Chief People Officer** • **Chief Medical Officer** • **Associate Director Communications**

				• **Associate Director HR Operations** • **Director Organisational development (including Patient First)** • **Associate Director Education** • **Guardian of Safe Working Hours** • **Freedom to Speak Up Guardian** • **Director of Corporate Governance**
CHAIR *(3.3)*:	**Non-Executive Director**	**DEPUTY CHAIR** ***(3.3)*:**	**Non-Executive Director Deputy Chair**	**SECRETARY *(5.5)*:** The **Director of Corporate Governance** or their nominee. An **Executive Assistant/ Business Manager** will be responsible for preparing minutes and updating action log.
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	The Committee will meet six times, every two months in a twelve month period, complementing the Finance and Performance Committee schedule commencing in January 2026. Additional meetings can be requested where necessary.		**QUORUM *(5.2)***	The Committee will be quorum when: • at least **half** the members are present including at **least two** Non-Executive Director members or nominated deputy
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Chair of the Committee will draw to the attention of the Board any issues that require disclosure or escalation to the full Board		**REPORTING GROUPS *(6.5)*:**	People and Culture Group People Ready project in support of the

	through use of the Board Escalation Report template. The Committee will also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.		Transforming Care Programme

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Committee and how it will achieve its purpose is as set out above.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members will elect another member to present to chair the meeting (which, in the case of a Board Committee will be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting. (In the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member will not count towards the members' attendance. A record of members' attendance will be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee will normally meet at the frequency set out above and at such other times as the Chair will require.

5.2 Meetings of the Committee will be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business will be transacted.

5.4 Meetings of the Committee will be called by the Secretary at the request of the Chair. The Secretary of the Committee will be as stated above.

5.5 The Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The Secretary (or their nominee) will collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee at the next meeting.

5.7 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair will be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes or notes (as specified above), which will be submitted to the next meeting of the Committee for approval.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee will be accountable to the group set out above (the Accountable Group), to whom it will make recommendations in relation to issues that require decision or resolution.

6.2 The Committee will present a report summarising the proceedings of each of its meetings at the next meeting of the Accountable Group. For the avoidance of doubt, where practicable, this will be a written report, with a verbal update being provided as necessary.

6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above.

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 This paragraph 7.2 applies to Board Committees. The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Accountable Group detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

APPENDIX A

ATTENDANCE AT COMMITTEE MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
								F				
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset
NHS Foundation Trust

Quality Committee

DOCUMENT DETAILS

Author:	Klaudia Zwolinska
Job Title:	Deputy Company Secretary
Signed:	
Date:	03/03/2026
Version No: (Author Allocated)	1.0
Next Review Date:	02/03/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow, Interim Chair
Signed:	
Date Approved:	11 March 2026
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
March 2026	1	March 2027	[11 March 2026]	Director of Corporate Governance	New Terms of Reference template

TERMS OF REFERENCE

COMMITTEE NAME:	**Quality Committee**
PURPOSE *(1.2)*:	The purpose of the Quality Committee is to support the Trust in achieving its strategic objectives: *Improve patient experience, listen and act* and *Save lives, improve patient safety*. The Committee fulfils this purpose by providing assurance that robust clinical governance systems, structures and processes are in place; promoting a culture of learning and continuous improvement; obtaining assurance on delivery of the Quality Strategy; receiving and reviewing

	quality performance information; and supporting the Trust in delivering safe, effective, responsive and well-led care across all services. The Committee also contributes input and recommendations to the Board on clinical and quality-related strategies, including Clinical Strategy, Quality Strategy, Risk Management Strategy, Clinical Audit Strategy and End of Life Care Strategy, and acts as an internal assurance mechanism for regulatory compliance, including Care Quality Commission requirements.
RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following: **Strategic Quality Oversight** • Monitor delivery of the Trust's strategic quality objectives and breakthrough initiatives. • Escalate concerns, risks or delays in delivery to the Board when required. **Clinical Governance and Risk** • Assure that systems for patient safety, patient outcomes and patient experience are robust and effective. • Review the Board Assurance Framework and ensure key risks are accurately reflected and well managed. • Monitor significant risks and progress against agreed actions. **Statutory and Regulatory Reporting** • Review statutory reports, including the annual Quality Report, mortality, safeguarding, infection prevention and control, health and safety and claims. • Consider findings from external regulators and ensure actions are implemented. **Patient Safety Assurance** • Review reports on serious incidents, never events, learning from deaths, inquests and other key patient safety areas such as maternity, paediatrics, end-of-life care, dementia, falls, resuscitation and medicines governance. • Review Quality Impact Assessments for cost improvement and transformation programmes. **Clinical Audit and Improvement** • Oversee the annual clinical audit programme and delivery against the Clinical Audit Strategy. • Monitor implementation of improvement plans arising from incidents, audits and reviews. **Patient Experience** • Review themes from complaints, PALS, patient surveys and other feedback sources. • Ensure improvement actions are identified, monitored and completed.

	Compliance and Standards • Monitor compliance with CQC fundamental standards and escalate gaps as needed. • Review compliance with clinical standards, NICE guidance and ensure clinical policies are updated. **Integrated Care System (ICS)** • Review relevant quality-related reports and information from Dorset ICS and provider collaborative.

<table>
<tr><td>MEMBERS (3.1):</td><td colspan="2">Membership of the Committee comprises:
• Three Non-Executive Directors (one of whom is also a member of the Audit Committee)
• Chief Nursing Officer
• Chief Medical Officer
• Chief Operating Officer</td><td>STANDING ATTENDEES (3.2):</td><td colspan="2">Standing attendees:
•

The Chief Executive Officer will attend on an ad-hoc basis or as required.</td></tr>
<tr><td>CHAIR (3.3):</td><td>Non-Executive Director (not the Audit Committee Chair or Finance and Performance Committee Chair)</td><td>DEPUTY CHAIR

(3.3):</td><td>Non-Executive Director Deputy Chair (not the Audit Committee Chair or Finance and Performance Committee Chair)</td><td>SECRETARY (5.5):</td><td>The Director of Corporate Governance or their nominee. An Executive Assistant/ Business Manager will be responsible for preparing minutes and updating action log.</td></tr>
<tr><td>MEETING TIMING (FREQUENCY AND DURATION) (5.1):</td><td colspan="2">Meetings are usually held monthly (not fewer than 10 times per year) with additional meetings scheduled as required.</td><td>QUORUM (5.2)</td><td colspan="2">Meetings will be quorate if at least four members are present:
• Chair (or Deputy Chair)
• Non-Executive Director
• two Executive Director, one of whom must be either the Chief Medical Officer or</td></tr>
</table>

			Chief Nursing Officer
ACCOUNTABLE TO: (the Accountable Group) ***(6)***	The Committee is accountable to the Board of Directors.	**REPORTING GROUPS** ***(6.5)*****:**	The Committee will receive escalation reports and assurance reports from sub-groups of the Trust Management Group and from other Board Committees with responsibilities that intersect with quality and safety domains. The Committee will also receive reports from other defined groups where required for assurance. These include, but are not limited to: • **Safeguarding** • **Infection Prevention and Control** • **Radiation Protection** • **Medicine Optimisation** • **Deteriorating Patients** • **Mortality Surveillance** • **Clinical Governance Group.**

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

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APPENDIX A

ATTENDANCE AT COMMITTEEMEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee/Group]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: 11.1

COVER SHEET – ALERT, ADVISE, ASSURE	
TITLE:	Resident Doctor – 10-Point Plan Update
Prepared by:	John Ward, Head of Medical Staffing
Presented by:	Lisa White, Associate Director of HR Operations and Wellbeing
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Information
Executive summary:	A paper outlining the new NHS 10-Point Plan for Resident Doctors was presented to the People and Culture Committee (PCC), as agenda item 6.3, on 5th January 2026. The 10-Point Plan for Resident Doctors focuses on improving workplace wellbeing. The paper updated on compliance and planned actions against the plan. UHD's compliance was **69%** during September 2025. Following the January 2025 PCC, NHSE Southwest mandated that the 10-Point Plan be presented to Trust Boards before the end of March 2026 for inclusion in the Annual Report. This paper provides an update on the status of the Trust position and NHSE's requirements regarding future focus. The Trust submitted an updated compliance assessment to NHSE in December 2025, reporting further progress and compliance has now increased to **87%**. A detailed action plan with clear ownership and timescales for remaining areas of focus is now developed. Full compliance is anticipated by 31 March 2026, although some elements of the action plan have national NHS dependencies, which may affect the delivery of four actions for NHS Trusts (RD5–RD8 of below action plan). NHSE has further identified three priority areas for all Trusts, against the original 10-Point Plan. UHD is compliant against areas 2 and 3 below, and awaits national guidance to comply with point 1.

	1. Annual Leave: Review the local Leave Policy against forthcoming national guidance, ensure accessibility, and identify a named lead for implementation and appeals. 2. Board-Level Leadership: Maintain senior ownership and nominate a Non-Executive Director to support Resident Doctor Leads. 3. Exception Reporting: Implement updated national processes effective from 4 February 2026, with strengthened communication and induction. NHSE have not provided compliance feedback at the time of writing this report. Support for Resident Doctor Peer Leads remains a priority, with established executive engagement and access to national peer sessions.
ALERT:	Six actions remain outstanding before the Trust can demonstrate full compliance with the 10-Point Plan. Full compliance is anticipated by 31 March 2026, although some elements of the action plan have national NHS dependencies, which may affect the delivery of four actions for NHS Trusts (RD5–RD8 of below action plan). Progress is being monitored through the established AAA reporting cycle, supplemented by the Action Log with clear ownership assigned to each action. The Trust remains focused on achieving full compliance and will continue to update the Committee on progress and any emerging risks. Where external input is required – the CMO and Head of Medical Staffing are engaged in the SW NHS England updates chaired by the Regional Medical Director and will utilise this forum to escalate challenges with meeting actions requiring external input as applicable.
ADVISE:	An action plan has been outlined with clear timeframes for completion as detailed in appendix 2. A key factor to success to date and going forward is ongoing engagement and support from Resident Doctor Peer Leads and other key stakeholders
ASSURE:	Action has been taken within the initial 12-week period. The initial baseline assessment undertaken on 29 September demonstrated 69% compliance. Subsequently a follow up assessment took place, which as at December, compliance was at 87%, demonstrating ongoing progress being made.
Celebrating Outstanding:	Thank you to all involved in progressing meeting the requirements in a collaborative way.
RECOMMENDATION:	The Board is asked to: 1. **Note** the areas self-assessed as compliant and those requiring further exploration or action within UHD. 2. Take **assurance** that work remains ongoing to complete requirements.
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 Cult		
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

1. Introduction

1.1 A paper outlining the new NHS 10-Point Plan for Resident Doctors was presented to the People and Culture Committee (PCC), as agenda item 6.3, on 5th January 2026. The 10-Point Plan for Resident Doctors focuses on improving workplace wellbeing, ensuring fair annual leave allocation, addressing payroll errors, streamlining training requirements, and reducing the impact of rotations. The paper updated on compliance and planned actions against the plan. UHD's compliance was **69%** during September 2025.

1.2 Following the January 2025 PCC, NHSE Southwest mandated that the 10-Point Plan be presented to Trust Boards before the end of March 2026 for inclusion in the Annual Report. This paper provides an update outlining the status of the Trust position, action plan, and NHSE's requirements regarding future focus.

2. Current Status

2.1 On the 10 December, an updated Trust position, against the 10-Point Plan, was submitted to NHS England. The updated assessment demonstrates 18% progress (69% in September 2025 & **87%** in December 2025). Appendix 1.

2.2 An action plan, including ownership and timescales, has been completed (appendix 2) which highlights six outstanding actions. These actions require completion prior to demonstrating full compliance with the 10-Point Plan. Full compliance is anticipated by 31 March 2026, although some elements of the action plan have national NHS dependencies, which may affect the delivery of four actions for NHS Trusts (RD5–RD8 of below action plan).

3. Future Requirements

3.1 Following an update provided by the National Medical Director, Professor Meghana Pandit on the 28 January 2026, there is an expectation that all Trusts focus on three areas of the 10-Point Plan. For UHD 3.1.2 and 3.1.3 are compliant. 3.1.1 awaits national guidance. As outlined below:

3.1.1 Annual Leave – Point 3 National guidance, *A Guide to Good Practice in Annual Leave for Resident Doctors*, will shortly be published. Trusts are expected to:

- Review the Leave Policy for Doctors and Dentists in Postgraduate Training and Locally Employed Doctors against the new guidance.
- Ensure accessibility of the policy for all resident doctors; the current version is available on the Trust intranet and covered at induction.
- Identify a named lead to support implementation and oversee appeals.

Arrangements are in place to complete these requirements promptly once the national guidance is released.

3.1.2 Board Level Leadership: Point 4 National guidance, *Maintaining Board Level ownership continues through regular discussion taking place at the Resident Doctor Forum*. To comply with this, Non-Executive Director, Michael Marsh has been nominated to support the Board and Resident Doctor Leads, respectively.

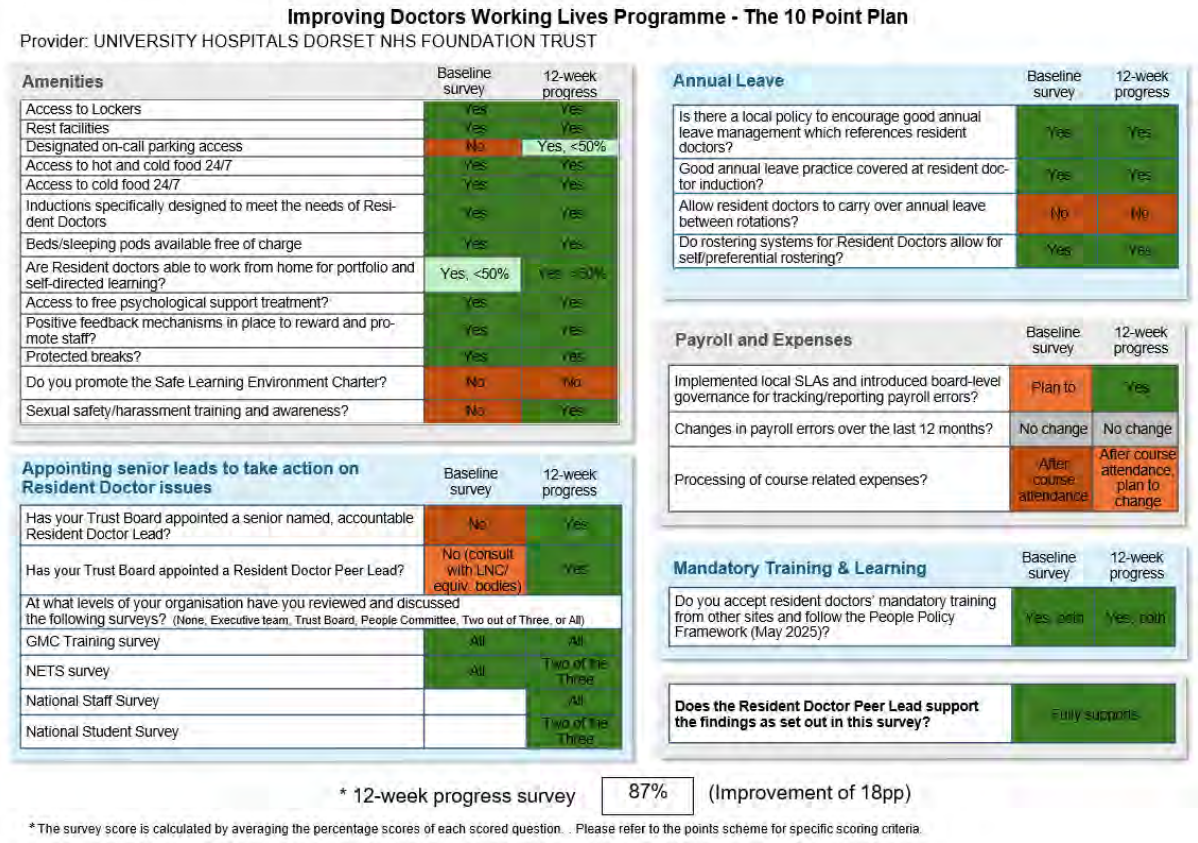
3.1.3 Exception Reporting: Point 7 National guidance, u*pdated national exception reporting processes* came into effect from 4 February 2026. UHD is complaint with the new guidance. Staff communications were cascaded across the Trust on 6 February 2026, highlighting the changes. Internal processes have been strengthened to ensure exception reporting is encouraged, particularly around emphasis at Resident Doctor Induction.

3.2 Resident Doctor Peer Leads: *Support for Peer Leads* remains a priority. Established routes through executive colleagues and deputies ensure their views are represented at the Resident Doctor Forum, and individuals are encouraged to attend national Peer Lead drop-in sessions.

4. Recommendations

- **Note** the areas self-assessed as compliant and those requiring further exploration or action within UHD.
- Take **assurance** that work remains ongoing to complete requirements.

Appendix 1 Updated Baseline assessment December 2025



Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes	Yes
Rest facilities	Yes	Yes
Designated on-call parking access	No	Yes, <50%
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes, <50%	Yes, >50%
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes	Yes
Protected breaks?	Yes	Yes
Do you promote the Safe Learning Environment Charter?	No	No
Sexual safety/harassment training and awareness?	No	Yes

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Yes	Yes
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	No	No
Do rostering systems for Resident Doctors allow for self/preferential rostering?	Yes	Yes

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Plan to	Yes
Changes in payroll errors over the last 12 months?	No change	No change
Processing of course related expenses?	After course attendance	After course attendance, plan to change

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	No	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	No (consult with LNC/ equiv. bodies)	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	All	All
NETS survey	All	Two of the Three
National Staff Survey		All
National Student Survey		Two of the Three

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, both	Yes, both

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey 87% (Improvement of 18pp)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria

Progress - actions completed since the completion of the December baseline assessment

Area	Topic	Update
Amenities	Safe Learning Environment Charter	The Charter is publicised and has a dedicated section available on the intranet.
Amenities	Resident Doctors' ability to work from home for portfolio and self-directed learning.	Resident doctors of all grades can work from home to undertake their self-directed learning time. The only caveat being, if there is an incident, they may be called into work.
Amenities	Sexual Safety/harassment training and awareness	Resident Doctor Induction processes revised with the Consultant Lead in attendance at inductions, to raise awareness and support the visibility of the training available.
Appointment of senior leads	Appoint Senior, named accountable Lead, and nominate a Non-Executive Director to support the Board Lead and Resident Doctor Peer Lead	Chief Medical Officer and Guardian of Safe Working have combined accountable Lead Role. Non-Executive Director (Michael Marsh) has been nominated to provide appropriate support.
Appointment of senior leads	Appoint Resident Doctor Peer Lead	Appointed combined role (Will Jasper & Amna Ali).
Payroll & Expenses	Tracking and reporting of payroll errors	Takes place via Payroll Operational Group meeting monthly.
Payroll & Expenses	Processing of course related expenses	Processes revised and now live to facilitate the processing of course related expenses in line with the stipulated timeframes.

Appendix 2 Action Plan

Action No.	Reference (respective point of 10-point plan)	Action	Owner	Due Date
RD2	1. Trusts should take action to improve the working environment and wellbeing of resident doctors *Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so Trusts can adapt implementation to reflect local needs and operational realities in these and other areas:*	Reflecting the local needs requirements, ensure effective provision of effective lighting on on-site parking, and develop plan for appropriate lighting to be maintained	Travel and Transport Management	13/03/2026
RD3	1. Trusts should take action to improve the working environment and wellbeing of resident doctors *Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so Trusts can adapt implementation to reflect local needs and operational realities in these and other areas:*	Peer Leads to take part in virtual drop-in sessions arranged via NHS England 1: W/c 9 February – sharing best practice Session 2: W/c 23 February – annual leave guidance and exception reporting Session 3: W/c 23 March – review first six months and look forward	Resident Doctor Peer Leads	27/03/2026
RD5	3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing *It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery.*	To comply with requirements as per the ten-point plan, there is recognition at a regional level around the challenge of complying with the stipulations. Await the national guidance currently being produced on the best practice for annual leave management and undertake a further review of the Trusts Leave Policy for Doctors and Dentists in Postgraduate Training and Locally Employed Doctors.	Head of Medical Staffing	31/03/2026

RD6	3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing	Once action RD5 is completed, identify a named individual to support implementation of changes where applicable to the Annual Leave Policy	Resident Doctor Peer Leads & Head of Medical Staffing	31/03/2026
RD7	5. Resident doctors should never experience payroll errors due to rotations	Participate in the roll out of the national NHS England payroll improvement programme.	Head of Medical Staffing	31/03/2026
RD8	10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate	The Trust already acts as Lead Employer for GP Trainees across West Dorset. Also, Foundation placements supported. Await further update on the national position regarding the future of Lead Employers following submission of expression of interest being made by UHD to potentially assume the role of Lead Employer at a regional level.	Head of Medical Staffing & Medical Education Manager	31/03/2026

Antimicrobial Resistance (AMR) and Stewardship (AMS) in Dorset

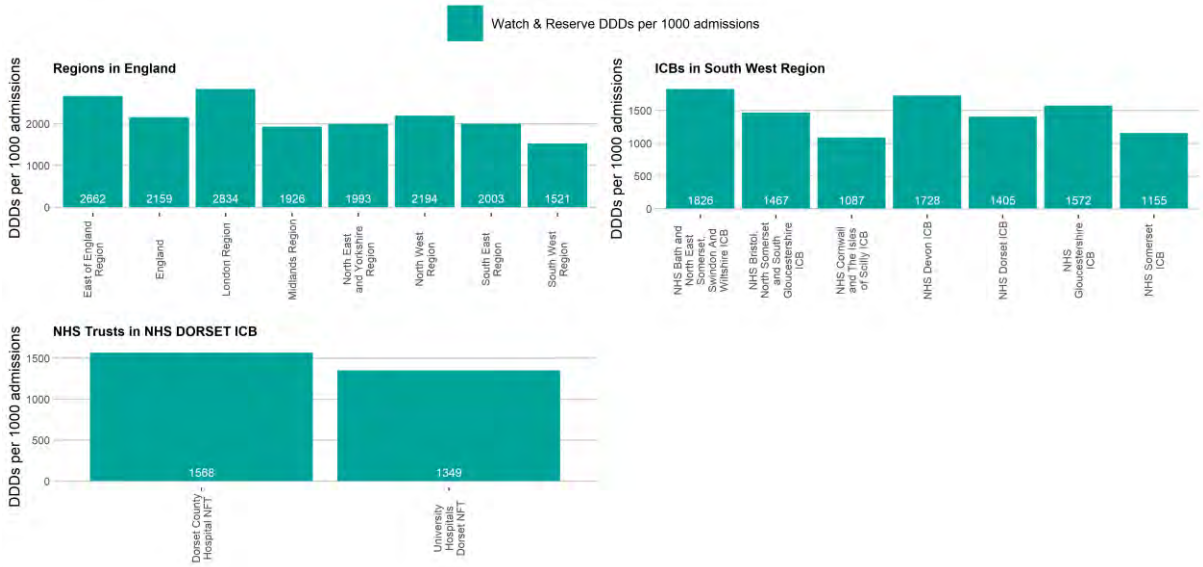
1) National Action Plan 2024 – 2029 (NAP) and Call to Action Letter

The NAP lists 4 themes containing 9 outcomes, 2 of which are health targets applicable to the Dorset health system.

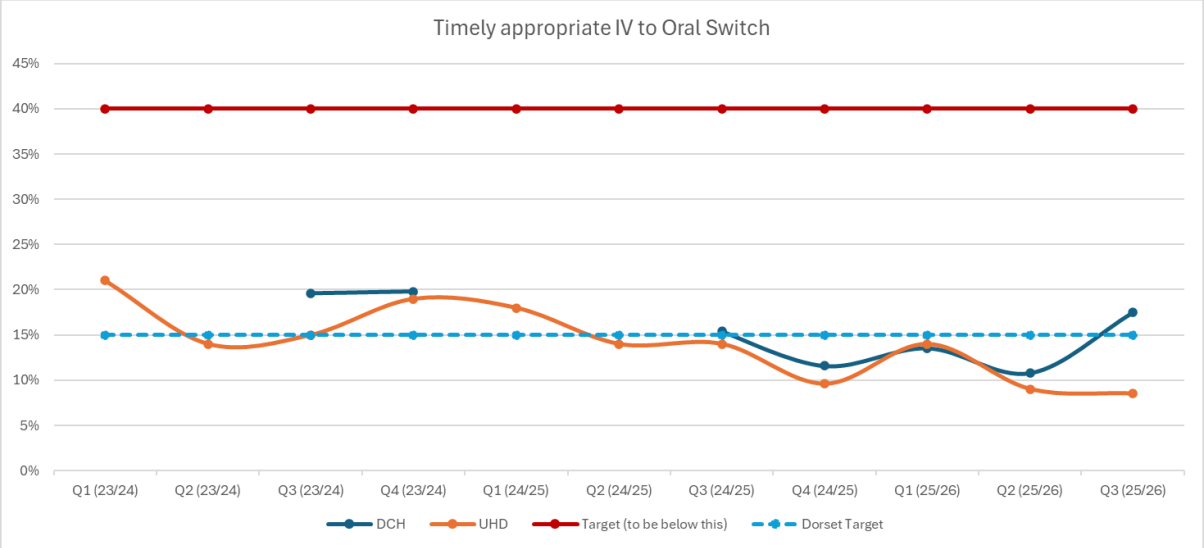
- target 4a: by 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline
- target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system

2) Current targets and performance

Standard contract – use best efforts to optimise antimicrobial use (especially broad spectrum WARE antibiotics) – no formal target



Intravenous to Oral Switch (IVOS) – non-mandatory CQUIN target of <15%



3) Future Targets.....(unpublished)

Total antibiotic use to be reduced to the 2019 baseline (no denominator)

61% of total use to be from the Access category (currently at 63% for UHD and 57% for DCH)

Within primary care the access target is 70% and there are targets looking at the % of certain drugs being prescribed as 5-day courses as well as % of children receiving antibiotic prescriptions.

4) Our plans as a system

a. Continue to roll out the IVOS work across UHD and extend top DCH – aim for a target of <8% - final report march 2027 – interim report sep 2026.
b. Aim to meet the primary care targets for 5-day prescribing (amoxicillin, doxycycline, flucloxacillin) – note final targets not yet published. Quarterly update as per national reporting datasets
c. System wide look at use of urine dipsticks to diagnose and treat UTI (against NICE guidelines) – to cover acute trusts as well as community service providers, care homes and GP surgeries. At UHD the target will be to ensure that no UTI is diagnosed using a urine dipstick alone. Formal report march 2027.

Target b is primary care only. At UHD we may include a target looking at safe use of Fluoroquinolone drugs instead, as a recent audit has concluded these drugs are not being used according to guidelines in almost half of cases – details not finalised yet.

Also recommend more collaboration between the ICT and AMS teams.

5) Workforce

Lack of system wide resource for this work. At UHD we have 1PA microbiologist, 1.0 WTE nurse (shortly to retire), 1.5 WTE pharmacists. DCH have 1PA microbiologist, 0.5 WTE pharmacist, 0.5 WTE pharmacy technician.

Resource across the system unclear but most people have this as an 'add on to' their main job.

2 immediate suggestions: UHD to fund the pharmacy technician at DCH to cover both organisations as a 1.0 WTE.

Is it possible for the AMS team at UHD to control their own set budget?

Darren Wilson – Lead Antimicrobial Pharmacist

27/2/26

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: 11.1

Subject:	Maternity and neonatal safe staffing report July to Dec 2025
Prepared by:	Kerry Taylor Head of Midwifery and Neonatal Services Approved by Lorraine Tonge Director of Midwifery and Neonatal Services Signed off by Sarah Herbert Chief Nursing Officer
Presented by:	Lorraine Tonge Director of Midwifery and Neonatal Services

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	This report is produced bi-annually to enable oversight of midwifery and neonatal staffing for the Board. Within this paper, the data from the Birthrate Plus report (Jan 2025) has been included, which shows that the current funded establishment enables a high midwife to birth ratio. Since the last report, the birthrate has dropped significantly, however the high acuity of patients has increased. Vacancies and turnover have fluctuated in the last six months. Improvement work is planned to help keep vacancy and turnover rates below national average. Sickness rates have increased in the last 6 months, peaking at a rolling rate of 7.8% in December 2025. Improvement plans are in place to reduce the levels to less than 6%. Stress and anxiety remain the main reasons for absence. 4 MSWs have been supported to complete their midwifery apprenticeship and many more would like the opportunity. Supporting this is in line with the 10-year plan; however, it is a challenge to support this development opportunity without the funding to backfill these posts.

	The number of specialist roles has increased since the 2022 Birthrate Plus review – currently some of these are funded by the LMNS and it should be noted that future funding of these roles may be a challenge without LMNS financial support. The number of red flags for delay in transfer to labour ward for induction of labour has risen – partly due to a slight increase in birth rate for this period. Work continues to improve the flow and function of the maternity unit. We have maintained MIS compliant with keeping the LWC supernumerary at the start of a shift and providing 1-2-1 care in established labour. Staff feedback has been included within the report due to the number of concerns raised since moving to the BEACH building – with the geography of the building and staffing concerns being their biggest worry. Neonatal nurses are fully recruited, and we continue to improve the number of QIS trained staff – we intend to be compliant with BAPM standards within 2 years – this is a national issue and we are progressing well. Funding for the current ANNP establishment is not adequate, and this has created a cost pressure. Our general manager is resolving this issue with the support of the care group – these roles are required to ensure full coverage of our neonatal unit. We were grateful for the Trust supporting the back-fill of maternity leave to enable our newly qualified midwives to work for us under fixed term contracts. This should help to reduce some of the staffing challenges raised by staff.
Background:	The purpose of the Maternity and Neonatal Staffing Report (July-Dec 2025) is for the Board to have bi-annual oversight of midwifery and neonatal staffing.
Key Recommendations:	**To note report and record in board minutes for MIS evidence.**
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
Mat Neo Safety Champions	23/01/2026	Discussion and noted reports
Mat Neo directorate meeting WCSS SDR Meeting	TBA	
People and Culture meeting	02/03/2026	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

MATERNITY AND NEONATAL SAFE STAFFING REPORT

JULY-DECEMBER 2025

Author: Kerry Taylor

Head of Midwifery and Neonatal Services

Approved by: Lorraine Tonge

Director of Midwifery and Neonatal Services

Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (2018) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions (2025) Maternity Incentive Scheme (MIS) year 7. Safety action 5 (See appendix 1) a separate paper is now provided for midwifery and neonatal nurse safe staffing. Appendix 1 Mis year 7 guidance.

1.0 Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery and neonatal staffing, including fully funded workforce planning in line with Birthrate Plus, the midwife to birth ratio, vacancies, turnover and sickness rates, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents is analysed and recommendations given. Staff feedback has also been included within this report and recommendations made to ensure safety, improved patient experience and staff satisfaction.

2.0 Birthrate Plus® (BR+) Workforce Planning

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels. The Trust report was published in January 2025 (see Appendix 2 Birthrate Plus® assessment UHD January 2025). Compliance with the report is a requirement of Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS Year 7).

Birthrate Plus® is a framework for workforce planning which calculates the need for clinical midwives in each clinical setting with some recommendations of specialist's midwives and band 3 Maternity Support Workers (MSW) to support care. It is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one to one midwifery care throughout established labour. It also takes local factors into consideration. The case mix data used for the Birthrate Plus® report was taken from January-March 2024.

3.0 The Birth to Midwife Ratio

The Trust birth to midwife ratio is calculated monthly using Birthrate Plus methodology and the actual monthly delivery rate. This calculates Midwife with postnatal MSW ratios.

Month	July	August	Sept	Oct	Nov	Dec
Actual ratio based on births per month	1:18.4	1:19.2	1:19.1	1:20.9	1:18.9	1:19.8

Table 1: Birthrate Plus® births to midwife ratio

UHD Birthrate Plus® assessment 2025 recommended to the Trust a birth to midwife ratio of 1:23.6 midwives per births. The table above shows that this ratio has been exceeded in the last 6 months.

This ratio reflects UHD's position of decreased birthrate since 2021 from 4301 to 3629 in 2024 and 3748 in 2025. As predicted the birthrate has slightly risen since the move to the BEACH building, 180 more babies were born in this 6-month period which is almost one extra birth a day.

There were 594,677 live births in England and Wales in 2024, the first increase since 2021 (ONS, 2024). In October 2025 NHSE supported UHD with an optioneering exercise to enable us to future proof workforce plans for Dorset including the requirement of students and university placements. The full report is available in Appendix 3. The report showed that births across Dorset have fallen consistently since 2021, but they are predicted to rise again from 2032.Student midwifery placements will be reduced to 20 in September 2026 to support future workforce planning.

It should be noted there has been an increase in the complexity and acuity of mothers and babies since 2021. In the recent Birthrate Plus® report it showed that 66% of women had their acuity categorised as IV and V – meaning they were complicated complex cases such as those having an elective / emergency caesarean section, pre-term birth, epidural, diabetes or a retained placenta. An increase in acuity has occurred in all maternity units within the past 4 years.

With professional judgement our birth to midwife ratios provides a good position to meet the additional care needs of women and helps to maintain safe clinical outcomes.

4.0 Turnover:

Table 2: Midwifery Turnover rate -data source Cosmos portal 8th January 2026

In this 6-month period the rolling turnover for midwives has reduced from an average of 7.84% to an average of 6.81% - the previous high turnover was linked to some staff deciding not to move to the BEACH building at the end of March 2025. The national average turnover rate for midwifery in the UK for 2025 was 6.2% and regionally 6.4%. One of the improvement drivers within the Mat Neo department is to aim to reduce turnover to 6.2% in 2026.

There is currently a low uptake in staff completing electronic exit forms, but our data shows that staff recently mainly left due to retirement, relocation or fixed term contracts ending. No midwives have left UHD to work for a neighbouring maternity unit within the same role. Nationally the main reason for midwives leaving their post is for retirement.

5.0 Vacancies

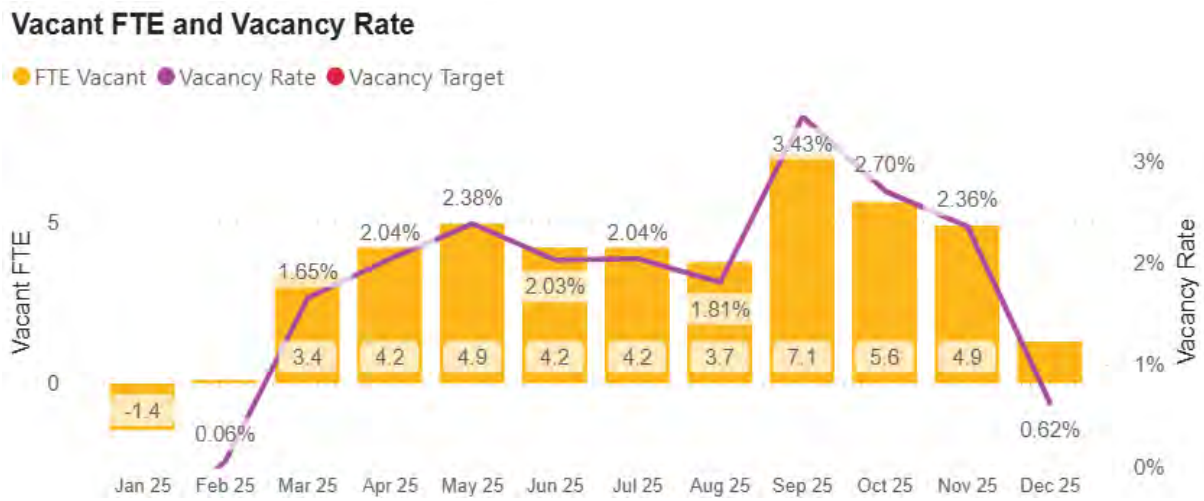


Table 3: Midwifery vacancy rate - data source Cosmos portal 8th January 2026

From our data on cosmos, (and data verified through workforce reviews), there has been a slight increase in vacancy rates within this 6-month period, this was expected as staff expressed, they would give the new building a trial before deciding their future options. The vacancy rate has now settled to pre-move levels.

The national average vacancy rate for midwifery in the UK for 2025 was 4% and regionally 4.1%, UHD have remained below this level even when the peak in September occurred – UHD are still able to fill vacancies in a timely manner and have recently recruited from neighbouring hospitals- indicating people are keen to work at UHD.

Actions taken to manage turnover and vacancy rates in 2026:

- Funding for the recruitment and retention midwife post stopped on the 31st of July 2025 – since the removal of this role there has been an increase in vacancies. Having a recruitment and retention midwife meant that vacancies could promptly be advertised and assessment days co-ordinated. This task is now completed by the senior Mat Neo team, and the process is less stream-lined than when a dedicated staff member managed this process. Monitoring of vacancy rates will continue, and consideration may need to be given for re-introducing the recruitment and retention role in the future.

- Additional wellbeing support is given to midwives by our Professional Midwifery Advocates (PMA). We have recruited a new band 7 PMA who is reviewing the current service provision and is keen to develop the service to ensure staff well-being is supported in a meaningful way. In 2026 away days focussing on staff well-being will commence with the support of the UHD OD team.

- When staff are considering leaving, stay conversation occur to determine if any reasonable plans can be put in place to keep their knowledge and skills in the profession. There is Trust wide a low response rate to electronic exit forms but themes from these are shared with the department where appropriate. In the last 6 months retirement, relocation and the end of a fixed term contract were cited as the reason for leaving.

- The Trust have supported the maternity unit to back-fill maternity leave for midwives – this has enabled the employment of 5 extra newly qualified midwives on fixed term contracts. All of student midwives were given the opportunity to apply and interview for posts at UHD and in total 9 were offered either substantive or fixed term contracts.
- We are pleased to celebrate the success of our international recruitment campaign as we have retained 12 of our 13 midwives who were internationally educated – they are all now band 6 midwives and some of these staff members have secured specialist roles.
- Funding to recruit internationally educated midwives has ceased and is unlikely to be an option moving forwards. Approximately 10.4% of our midwifery and nursing staff are from the global majority community - about 14% of our families are from the global majority we would like to reduce this divide further but do acknowledge that the diversity of our workforce has improved greatly in recent years.
- We have joined the apprentice programme for midwives and are currently training 4 MSW's via Winchester University – we would like to continue to "grow our own" midwives, especially as there is an appetite for this amongst our maternity support workers. However not being able to backfill these posts is challenging. We had intended to offer 2 maternity support workers this opportunity each year, but we have had to halt this development in 2026 due to the financial constraints. The plan is to offer another 2 maternity support workers this opportunity in 2027 as at that point 2 on the current programme will become qualified.
- We have a small pool of bank midwives who provide stability to our workforce, and fill shifts at short notice. Further to listening to staff, we have recently introduced midwifery agency support to enable the filling of shifts to prevent gaps in rotas and to maintain safe staffing We will continue to recruit into these vacancies to provide a long-term solution.

6.0 Sickness

Table 4: Midwifery absence rate - data source Cosmos portal 15th January 2026

Nationally absence rates are 6.5% and regional rates are 6.3% (NHSE Digital, 2025), which is above the national target of 3%. From the data we can see overall rise in the absence rate in the last 6 months which is above the national average. The Mat Neo department have set a target to reduce absence to less than 6% as part of their improvement program.

Human Resources are supporting the Mat Neo team with managing absence with ward managers attending refresher training and a monthly oversite meeting to ensure absence is being managed appropriately. Leaders are encouraged to sign-post staff to appropriate well-being services within the trust to offer overall health improvements.

In 2024 the staff flu vaccine programme resulted in 19% of staff being vaccinated by the end of the season the current vaccination rate for Mat Neo staff is 42%

Top reasons for sickness:

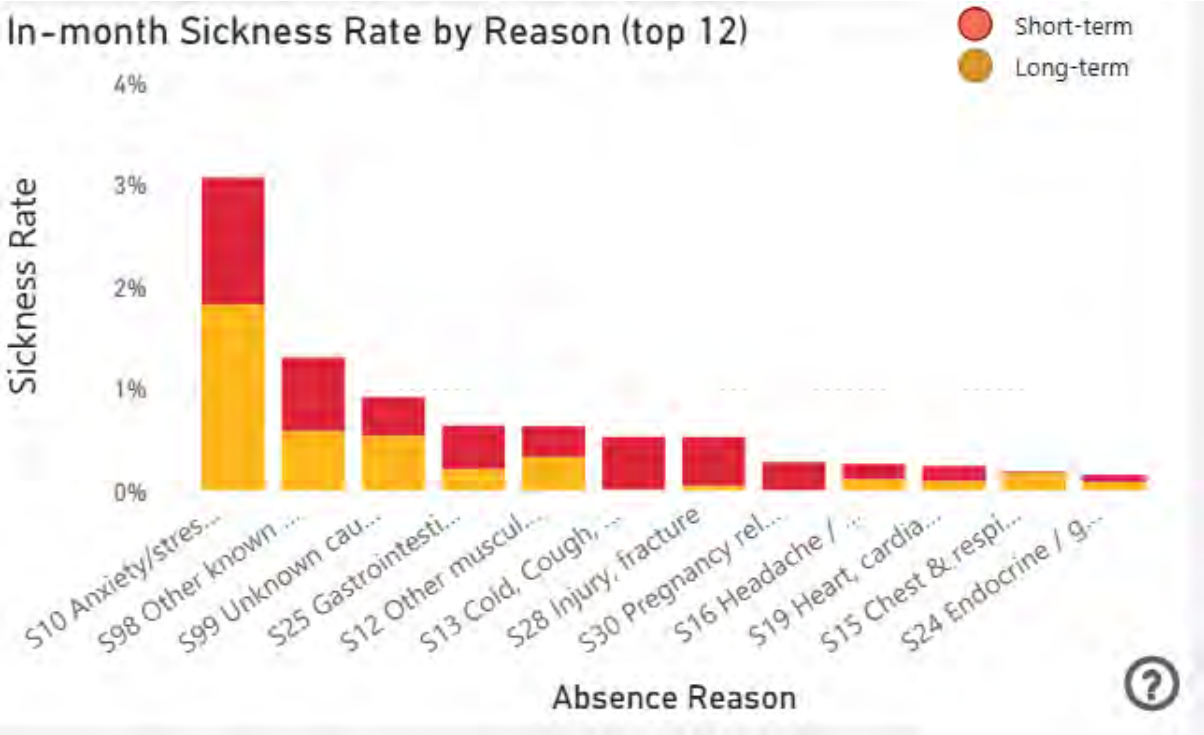


Table 5: Midwifery absence rate top reasons - data source Cosmos portal 9th January 2026

Anxiety stress and depression remain the overall top reported reason for sickness. Listening events are occurring frequently to enable staff to escalate work related issues that are creating stress. We have had some sickness challenges within the PMA team but are hopeful that they will be able to resume supporting the team Mon-Fri shortly.

Reporting of the reason for absence has improved within this 6-month timeframe. Work will continue on managing absence, including improving return to work conversations.

7.0 Systematic reviews of implementing Birthrate Plus® staffing allocations aligned with safety.

7.1 Band 5-7 clinical midwives

Staffing templates are reviewed with the Director of midwifery, Head of Midwifery, ESR allocate and finance team. These will be signed off by the deputy chief nursing officer.

7.2 Funded posts

To calculate the required whole time equivalent (WTE) midwives the Birthrate Plus® report 2025 adds an uplift for midwives of 24% for annual leave, sickness, and training and 22% for support staff. It is important to note that over 90% of our substantive staff are not whole time equivalent and therefore the uplift does not reflect this adjustment.

The review can confirm that **all posts are fully funded to Birthrate Plus® recommendations.**

	Band 5-7 Clinical WTE	Band 3 providing postnatal care 10%	Band 7 to 8 Additional Specialist and management WTE	Total includes all clinical specialists and management roles
Birth- rate plus recommendations WTE (January 2025)	175.79	20.82	27.53	224.14
Current Funded WTE (December 2025)	180.84 + 5WTE Maternity Leave cover *Within this workforce there is a daily board holder overseeing the unit	20.82 (Postnatal ward and community)	20.49 band 7-8 3.49 band 6 (2.8 extra staff externally funded.) Total 26.78	228.44 +5WTE maternity leave cover = 232.44

Table 6: UHD Birthrate Plus® WTE recommendations 2025

7.3 Band 3 maternity support workers

The national vacancy rate for maternity support workers in the UK for 2025 was 10.9% and regionally 8%. In the last 6 months the Maternity Support Worker vacancy rate at UHD is 7%.

In 2023 there have been national changes to re-band all maternity band 2 support workers that provide clinical care to a band 3- there was an option for our staff to remain as a band 2 and to provide only hygiene, nutrition and hydration care. All our staff opted to upskill to a band 3 MSW.

We are currently participating in implementing the NHS England Workforce, Training and Education MSW framework to enhance the skills of our MSW's and provide development opportunities.

The Birthrate Plus® staffing tool is the only staffing tool that reduces the number of trained professionals required due to the number of bands 3 MSW's (within the postnatal setting) – as they are able to support with midwifery tasks such as taking observations, blood tests and offering feeding support. Since the move to the BEACH building the staff have been required to support with nutrition and hydration by serving the food twice a day – staff have formally reported back via their union representative that this task is taking them away from being able to complete their other roles. The team feel that a band 2 housekeeper on level 2 and 3 would help to make this work manageable – The HOM, RCM representative and Human Resources are in discussions about how best to proceed with the issues raised.

We currently have seconded 4 MSW's to complete their midwifery apprenticeship with Winchester University. Over 25% of our current MSW's have expressed an interest in completing a midwifery apprenticeship. The 10-year plan intends to create 2,000 more nursing apprenticeships over the next 3 years, prioritising areas with the greatest need (DHSE, 2025). We currently are unable to backfill these posts and therefore our ability to support staff through this development opportunity is limited.

7.4 Specialist's midwives' roles

Birthrate Plus® have recommended that 14% of the clinical WTE is utilised to provide specialist and managerial support. It is important to note that the Birthrate plus® methodology includes ward manager management time within the clinical allocation of staffing hours.

Additional roles requirements have been recommended by the Ockenden report (DHSE, 2022) such as lead audit midwife, policy, and guidelines midwife, increase quality and risk midwives, increase Professional midwifery advocate (PMA) support for midwives, and lead fetal monitoring midwife are in place. It also accounts for maternity transformation roles such as digital, perinatal mental health (part funded by perinatal mental health service).

It is important to note that the Maternity Care Bundle has launched in January 2026, and this may require additional specialist midwife support that will need to be considered when budget setting in the future.

Birthrate Plus® recommends in their 2025 report that we are funded to 26.53 WTE specialist midwives, we are currently funded for 26.78 WTE, of these 2.8 WTE are currently externally funded and funding for these posts will be reviewed annually. If funding is not provided, then we will need to consider how to resource the following roles:

- Infant Feeding Specialist Midwife
- Learner Environment Lead Midwife
- Perinatal Mental Health Lead Midwife
- Pre-term birth Midwife

If funding is removed, then a business case may need to be presented to for consideration to enable UHD to maintain assurance standards and not impact on clinical care

In the UK a maternity investigation has commenced, and the results will be published in 2026 – if there are recommendations to implement more specialist roles then we will need to consider how these are resourced.

We currently have one Advanced Midwifery Practitioner and another staff member who has completed her training. This role is funded by the medical workforce and there is no further funding for additional posts. If funding were available, we would look to recruit another advanced midwifery practitioner to support the work stream on the postnatal ward – this would help to improve productivity. We would not consider training any further staff members without a substantive post being guaranteed at the end of the training programme.

7.5 Training requirements

The 2025 Birthrate Plus® report has added a 24% uplift for midwives to ensure that there is an adequate allowance to enable completion of the training requirements that have significantly increased over the years following the Ockenden report (DHSE, 2022) the training standards that are required for MIS compliance and the core competency framework 2 (NHSE, 2023) (See appendix 4). Our training needs analysis demonstrates and recognises learning for 2026 which is incorporated into training update days, for example biometrics training has been included in the programme.

Maternity support staff have been allocated a 22% uplift as they have not increased their training requirements.

8.0 Safety

To monitor safety there are several systems and polices in place to provide consistence assessments of the maternity unit. The frequency of the assessment is dependent on our opal status which can be changeable in maternity over the 24-hour period due to the nature of our work which is predominately unpredictable and changeable.

MDT Safety huddles occur each day with a standard meeting each morning at 9:30 and additional meetings within the day according to opal status and change in activity.

To determine the need for additional assessments, we monitor change of activity in a variety of ways as shown below.

8.1 Birthrate Plus® Live Acuity Tool

The Birthrate Plus® Live Acuity Tool is utilised to enable midwives to assess their ‘real time’ workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of ‘acuity’, and the system is based upon an adaption of the same clinical indicators used in the workforce planning system of Birthrate Plus®.

The Birthrate Plus® classification system is a live tool that is completed four- hourly, by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. The tool helps to support the need for redeployment of staff when the number of women requiring care is greater / or less than the number of staff on duty.

8.2 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator at the start of every shift is recommended as best practice to oversee safety on the labour ward and is a MIS safety standard. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. From July 2025 to December 2025 there was 100% compliance for a labour ward co-ordinator being supernumerary at the start of each shift.

The establishment enables two band 7 labour ward co-ordinators to be rostered each shift – priority is given when completing the roster to ensure that 100% of nights, weekends and bank holidays are rostered with 2 labour ward co-ordinators – therefore if short notice sickness occurs there is still a labour ward co-ordinator available during unsociable hours when redeployment is more challenging.

8.3 One to One in Established Labour

Women in active labour are required to have one to one care and support from an assigned midwife as a minimum safety standard. If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the escalation policy – such as redeploying staff or utilising the on-call service. There have been no occasions in the last 6 months where one to one care in labour was not offered. Hospital on-calls were introduced in August 2025 these should help to enable more support out of hours for when activity is high.

	Birth Centre	Labour ward
July	100%	100%
August	100%	100%
September	100%	100%
October	100%	100%
November	100%	100%
December	100%	100%

Table 7: One to One in labour - data source Birthrate Plus® acuity tool

8.4 Red Flags

NICE (2015) recommend the use of red flags as a warning sign that maternity care is being impacted from a safety and patient experience perspective. A red flag should trigger a review to assess if staffing is the reason for delay in care and if so, this should give the staff confidence to escalate to the daily maternity operational co-ordinator who will redeploy staff where appropriate.

During this period July to December 2025 red flags as per NICE recommendations were reported on safe care.

Red flag reason	Number
Delay in commencing induction of labour >2hrs	0
Delay in transfer to labour ward for ongoing induction	241
Delay for epidural	4
Time critical delay for LSCS CAT 1 decision to birth within 30 mins. CAT 2 decision to birth within 75 mins. CAT 3 decision to birth in accordance with clinical condition of woman and baby.	12
Cancelled / postponed Elective LSCS	12
Delay in obtaining 2nd theatre team	4
Delay in perineal suturing 3rd degree tear	2
Delay in manual removal of placenta	0

Table 8: Reasons for red flag - data source safe care

All red flag incidences are reviewed by senior matron for inpatient services, and no care impact was noted. In this 6-month period there has been an increase in red flags for delay in transfer to labour ward for on-going induction – the increased birth rate for this period will have had an impact on the number of red flags. Work continues on improving the flow and function of the maternity unit – Misoprostol inductions will commence in 2026, and this will improve the flow through the maternity unit for women having inductions. Delays in epidurals being provided halved in this time.

The table below demonstrates the number of times that the red flags were closed due to appropriate actions being taken to resolve the issue.

Status	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025
Resolved	55	51	39	27	44	45

Table 9: NICE maternity clinical red flags - data source Safe Care.

There were 15 occasions of Opel 3 in the six-month period and 2 occasion of Opel 4 this was due to acuity and capacity. The number of Opel 4 shifts has halved in this 6-month timeframe, and the last Opel 4 was reported in July 2025. No safety incidences were reported during these periods however staff feedback has been listened to regarding the flow and function of the maternity unit.

With the support of the CNO, OD team and patient first lead – work is in place to focus on how each department can facilitate a more sustainable way of working that ensures patient safety as well as focusses on the well-being of our staff.

8.5 Planned versus actual staffing.

	July				August				September			
	Day		Night		Day		Night		Day		Night	
Maternity	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered
Maternity	89.8%	88.0%	90.7%	92.7%	84.1%	89.8%	87.9%	97.2%	86.4%	85.8%	86.9%	87.9%
Maternity Labour Ward	90.9%	76.6%	95.2%	87.7%	89.5%	71.0%	95.7%	84.2%	95.6%	64.1%	96.2%	79.4%

October				November				December			
Day		Night		Day		Night		Day		Night	
Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered	Registered	Non-Registered
86.2%	85.3%	84.1%	83.7%	84.3%	85.2%	79.4%	90.3%	85.7%	74.4%	85.8%	88.5%
90.1%	79.0%	85.0%	92.5%	96.6%	89.5%	93.8%	88.3%	90.1%	78.0%	94.4%	92.8%

Table 10: Planned versus actual staffing - data source CHPPD January 2026

There was a 87% rota fill rate for midwifery shifts within this 6-month period, with slightly better coverage overnight than during the daytime. When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically.
- Managers at Band 7 level and above work clinically
- Overstaffing of maternity support workers to assist with basic care needs.
- Redeploy staff to ensure one to one care in labour and that the labour ward co-ordinator can remain supernumerary.
- Utilise midwives from the hospital on-call rota and community to support the unit.
- Staff unfilled shifts with agency midwives were appropriate.
- Request additional support from the on-call midwifery manager.
- Request additional support from Trust nursing colleagues this is reported through care group huddles and escalated accordingly.
- Liaise closely with maternity services at regional sites and request. mutual aid.

In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

8.6 Staff feedback.

During a number of listening events staff have fed back the challenges that they have found with working in the new BEACH building, this was further highlighted during the CQC inspection in September / October 2025. Staff are very positive about the modern facilities and the benefits to our service users. Despite this there have been some challenges with settling into the new environment, as detailed below.

- The maternity unit is much larger than the previous site and the original antenatal ward has been split into two departments at opposite sides of the unit. The team are being supported to implement new ways of working such as controlling the flow of inductions in a more manageable way and relocating departments such as the annexe.
- Staff do not feel that they can influence how their department works. Patient first huddles have been introduced in all areas other than Nicu to enable staff to make meaningful changes to the flow and function of their unit.
- Covering breaks is more challenging due to staff being spread across more departments – co-locating some of the teams and promoting the break etiquette will hopefully have a positive impact on this.
- Staff have been concerned at times about skill mix and redeployment, which occurs more frequently in the BEACH building. At the time of writing this report, UHD are awaiting the outcome of the CQC inspections. Workforce improvement plans continue in the meantime.
- Caring for women in single rooms rather than bays is more challenging for staff. There is limited research in this area to demonstrate the impact of this change, but one paper does suggest a need for 7% additional staff (Hurst, 2009).

Our professional judgement is that we would not recommend changing the current establishment despite the findings from the Birthrate Plus® report 2025 – as the challenges within the new unit seem to imply that reducing our staffing would increase further stress for our staff and have an impact on patient safety.

9.0 Neonatal Services

Neonatal Nursing

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

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

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

As per MIS safety action 4, the Neonatal Matron with the Southwest ODN conducted an annual review in Q4 (February 24) using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification in Speciality (QIS). Compliance with BAPM standards for neonatal nursing is a detailed requirement of MIS safety action 4.

A nursing workforce business case was presented to the Board, and funding was agreed in February 2024. The substantive nursing WTE increased in budget in April 2024 to meet the standard BAPM and recruitment has been successful. There is currently just 1.72 WTE vacancies in registered nurses in neonatal services.

The systematic review of nursing review of templates was also repeated in this reporting period as part of the transformation neonatal nursing workforce plans. This review was by the interim Neonatal Matron, HR, ESR allocate, finance team and rostering team and signed off by Chief Nursing Officer. This was part of the workforce review process in moving to the BEACH building in April 2025.

It was identified that the current compliance with (Qualified in Specialty) QIS Registered Nurse workforce is 69.6% (against standard requirement of 70%) this has been due to the recruitment of junior (non-QIS) band 5 nurses. 2 nurses are resubmitting assignments for the course. We currently have 2 band 5 nurses currently undertaking the QIS course, with a further 4 nurses starting in February 2026. With these nurses moving to QIS, the QIS registered Nurse workforce will be 83.9% by 2027.

Recent audit of compliance with BAPM standard for neonatal nursing shows that 93.75% of shifts are staffed to BAPM standards. This illustrates the unit's ability to safely admit unexpected babies following delivery and accept repatriations of ITU step downs from the regional tertiary provider as necessary.

NNAP data plots UHD nurse staffing to above national average, within the middle 50% of units.

Compliance with BAPM standards in Nursing

Shift > 4 over standard	Shift 1-3 over standard	Shift at standard	Shift 1-3 under standard	Shift >4 under standard
3.3%	77.7%	13.6%	5.4%	0%

Table 11: Compliance with BAPM standards in nursing.

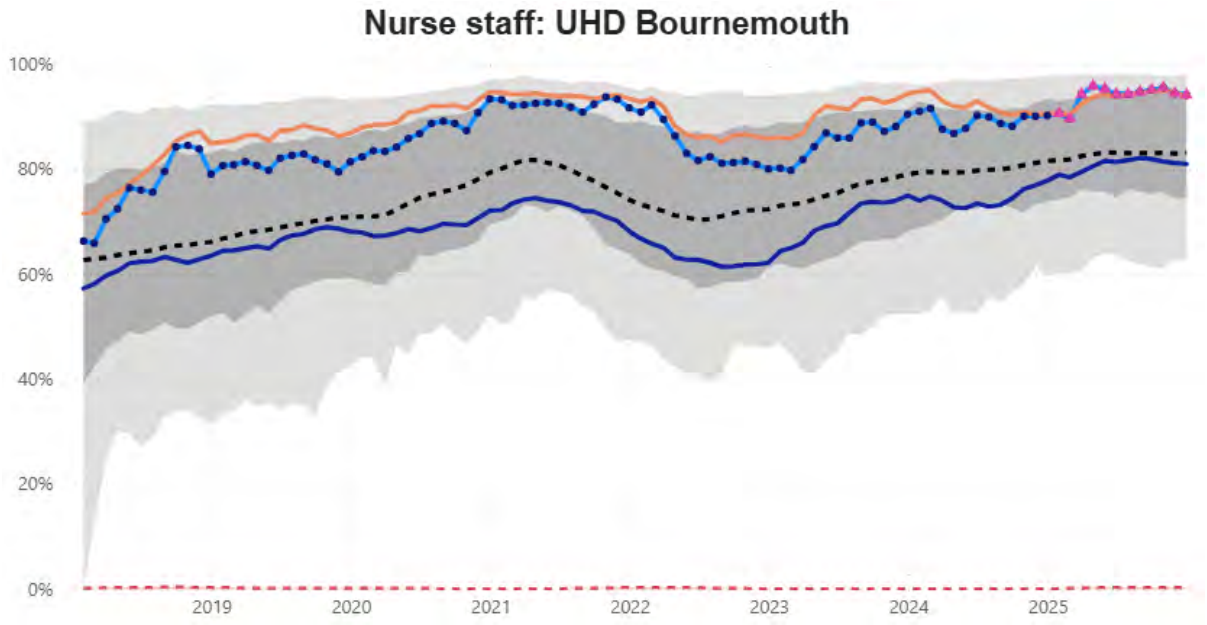


Table 12: Nursing staff at UHD Bournemouth – data Source NNAP December 2025

The line blue axis is our unit. The dark blue line is the Operational Delivery Network (ODN) and the orange line is Integrated Care Board (ICB).

Advanced Neonatal Nurse Practitioners

Over the past two decades advanced neonatal nurse practitioners (ANNPs) have become a highly valued and essential component of the staffing complement of most neonatal units in the UK. Their exact roles vary from unit to unit. At UHD, ANNPs fulfil roles in the Tier 1 and 2 rotas for the neonatal service, in line with BAPM guidance. They are the senior decision makers on the unit when consultants are not present out of hours. They are the first responders to deliveries and resuscitations. They can plan care in postnatal and transitional care wards to prevent neonatal admissions as well as giving advice to community midwives to keep mothers and babies together out of the hospital setting. They perform intensive care procedures and monitor and manage care to admitted babies.

ANNPs provide leadership and management to the neonatal service. They support midwifery and neonatal nurses in planning care and leading reportable improvement projects including ATAIN, postnatal ward respiratory support and deferred cord clamping. The ANNP group teach on the TVWODN (Thames Valley and Wessex Operational Delivery Network) qualified in specialty training course and within the UHD service support these QIS trainees. They deliver the STABLE course across a multi-disciplinary profile. They teach on the national NLS course. There is a dedicated ANNP for research and as a stable component of the neonatal services workforce are key to maintaining the research portfolio.

UHD have a proven track record for training their own ANNPs from their nurse cohort and retain them for long periods. This demonstrates the stability and experience they offer the organisation.

To meet the Tier 2 rota requirements on the neonatal unit and to ensure adequate time is allocated to the four pillars of the ANNP role for continuing professional development, the service requires 11.56 WTE. While the appropriate WTE workforce is currently in post, the corresponding budget provision is not in place, with funding available for only 9.42 WTE.

One ANNP is currently on a career break following maternity leave, and three ANNPs have entered partial retirement. Succession planning is therefore essential to ensure the ongoing needs of the service are met. The most sustainable approach is to develop and train ANNPs internally. Appropriate funding is essential to enable the development of these training posts. Senior management are working collaboratively with the finance team to develop and implement a plan to address this going forward.

10.0 Next steps and actions

- Continue to work through the workforce improvement plans – focussing on staffing, skill mix, absence management, well-being and communication.

- Lead PMA to arrange well-being away days for staff throughout 2026 with agenda for day being set with Operational Development support.

- We will continue identify and create all opportunities to recruit our newly qualified midwives. To work with the national and regional team to ensure workforce planning is robust for the future.

- To ensure that our staff are given the opportunity to have career progression with a focus on enabling our midwives who were internationally educated and our band 3 MSW's to develop further. It is recognised that budgetary support will be required to continue to facilitate the midwifery apprenticeships as per the 10-year plan.

- Determine if band 2 housekeepers / hostesses are required

- We will continue with the action plan to increase the QIS neonatal nursing staffing to the recommended 70%

- Care group to support funding the existing workforce of ANNPs in order that the rota and their four pillars of advanced practice can be fulfilled.

11.0 Conclusion

This report provides assurances of systematic reviews of our workforce and our current position. It is continuous process and will be reported six monthly to the board as per MIS year 7 safety standards. It also provides assurances of safety measures in place to address midwifery and neonatal safe staffing and provision of care.

There are challenges for the team with working in the BEACH building – these have been addressed within the report. The CQC inspection in September / October further highlighted the challenges faced – despite the investment in staffing made by enabling the over-recruitment of staff – on the floor the pressures are still felt. The Mat Neo senior team await the final CQC inspection report and rating and in the meantime will continue to work through the improvement plan.

Our professional judgement is that we would not recommend changing the current establishment despite the findings from the Birthrate Plus® report 2025 and to continue to enable the backfilling of maternity leave for midwifery posts.

Business cases will be presented to Care Group Board of additional requirements.

It is requested for the Board to note the contents of the report and formally record to the Trust Board minutes.

12.0 References

Department Health and Social Care (2022) Ockenden Report – Final. Findings, conclusions and essential actions from the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust.

Department Health and Social Care (2025) Policy Paper: Fit for the Future: 10 Year Health Plan for England – executive summary [Available] https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary#an-nhs-workforce-fit-for-the-future. [Accessed 16th July 2025]

Hurst, K (2009) "Do single rooms require more staff than other wards?" Nursing standard. September 30: vol 24, no 4.

National Institute for Health and Care Excellence (2015) Safe midwifery staffing for maternity settings.

National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for maternity services.

NHSE (2023) Core competency framework v2: Minimum standards and stretch targets. [Available] https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/. [Accessed 16th July 2025]

NHSE Digital (2025) NHS Sickness absence rates, February 2025. [Available] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/february-2025. [Accessed 15th July 2025]

NHS Resolutions (2025) Maternity (Perinatal) Incentive Scheme. Year seven v1.0: Conditions of the scheme. Ten maternity safety actions. Additional guidance.

Office for National Statistics (2025). Births in England and Wales 2024. [Available] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2024. [Accessed 12th July 2025]

13.0 Appendices

Appendix 1: MIS year 7 guidance

20250401 - MIS year 7 Final.pdf

Appendix 2: Birth rate plus® assessment UHD January 2025

University Hospitals Dorset NHS Trust Bir

Appendix 3: NHSE Optioneering Report v1.2 Midwives October 2025

20251031 Dorset Midwifery Optionee

Appendix 4: Core competency framework 2

CCF v2-minimum-standar

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: 11.1

COVER SHEET – ALERT, ADVISE, ASSURE	
TITLE:	Patient Safety Report – January 26
Prepared by:	Jo Sims, Associate Director Quality Governance and Risk Natasha Sage, Head of Patient Safety
Presented by:	Peter Wilson, Chief Medical Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	All
Purpose of paper:	Information
Executive summary:	The purpose of the report is to present the patient safety activity as at end of January 2026.
ALERT:	**Potential Never Event** – An event has been reported involving a potential wrong-site intraocular injection. A term of reference meeting is being arranged to agree the appropriate PSIRF learning response. **Overdue LERN Actions Increasing-** January shows a notable rise in overdue LERN actions in Datix. This is likely to do with target dates being set for year end and also operational pressures. The risk is reduced assurance that learning is being embedded and the potential for repeated incidents due to delays in action completion. Teams have been asked to review their actions and close once completed. **Deteriorating Patient increased Themes** – There have been several recent PSII and learning reviews that have highlighted : • Delays in escalation • Treatment decisions without senior review • Suboptimal monitoring and communication failures Themes will be reviewed via Deteriorating Patient Group.

	PSIR Plan Priorities 2026/28. The recommended PSIRP priorities, based on data collection and stakeholder engagement, for discussion at CGG are: • Recognition and escalation of the deteriorating patient • Cross-site transfers and handovers • Care in non-clinical areas • Medication relating to discharge
ADVISE:	Duty of Candour Toolkit and Training Improvements. New enhanced training co-designed with Patient Safety. Ward Relocation & Datix Integration. Continued transformation and ward moves requires Datix changes to accurately reflect to maintain visibility and reporting integrity.
ASSURE:	LERNs – Sustained Improvement in reducing the number of Open LERNs. Eight consecutive months of reductions, with average days open reduced from 104 → 75. Falls, Pressure Ulcers, VTE, Diagnostics, Deteriorating Patient Trends. All major harm themes remain within statistical process control ranges, providing assurance that variation is expected rather than deteriorating. Term Admissions to NICU. Performance consistently meets or nearly meets the national benchmark, with improvements attributed to bedside CPAP. Enhanced Learning Response Tools Under Review. Assurance that the organisation is actively optimising its PSIRF toolset and oversight processes.
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
Clinical Governance Group	26/02/2026	Discussion held
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 ☐	

Patient Safety Activity – as at end January 2025

Patient Safety Incident Investigations	
PSII commissioned/ reported on STEIS (in month)	0
Total PSII on caseload	6
Of which are Never Event	3
Of which are MNSI investigated	0
Trust closure confirmed (in Month)	0
Thematic review	
Thematic Review commissioned in month	0
Total Thematic review on caseload	2
Trust closure confirmed (in Month)	0

PSII cases for monitoring:

LERN ref & PSII ref	STEIS ref	Care Group	Theme	Update	Target date
L141254 PSII 2411-06	2025/84	Medical	Unexpected death	Awaiting Exec sign off	Feb 26
L148355 PSII 2504-08	2025/2103	Surgical	Never Event- Retained object	Awaiting Exec sign off	Feb 26
L152070 PSII 2507-10	2025/3715	Surgical	Never Event- Wrong site surgery	Awaiting patient feedback	Feb 26
L153399 PSII 2507-11	2025/4038	Surgical	Never Event- Wrong site surgery	Awaiting Exec sign off	Feb 26
L157265 PSII 2509-12	2025/6264	Medical	Mental Health Management	ToR held, information gathering	Mar 26
L159852 PSII 2512-13	2025/6703	WCCSS	Post partum Haemorrhage	ToR held, information gathering	Jun 26

Thematic review for monitoring:

Thematic review reference	Care Group	Theme	Update
TR2501-04	WCCSS	Term admission to NICU	To be reviewed Feb Oversight
TR2512-06	Trustwide	VTE	TOR held Dec 25, Thematic review in progress

Never Events by Date reported on STEIS (Month and year) and Care Group 25/26

UHD	25/26	Apr 25	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 26	Feb	Mar	Total
Surgical CG	**2**	1	0	1	2	0	0	0	0	0	0	0	0	**4**
Medical CG	**2**	0	0	0	0	0	0	0	0	0	0	0	0	**0**
WCCSS CG	**0**	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total	**4**	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	0	0	**4**

The PSII declared in April (L148355 / PSII 2504-08) was confirmed as a Never Event in December 2025 once the final report had been completed and clarified information.

There was one never event reported in June (retained swab in gynae/theatres) and two never events reported in July; one wrong site injection in theatres and the other wrong site injection in ophthalmology (via an insourcing company).

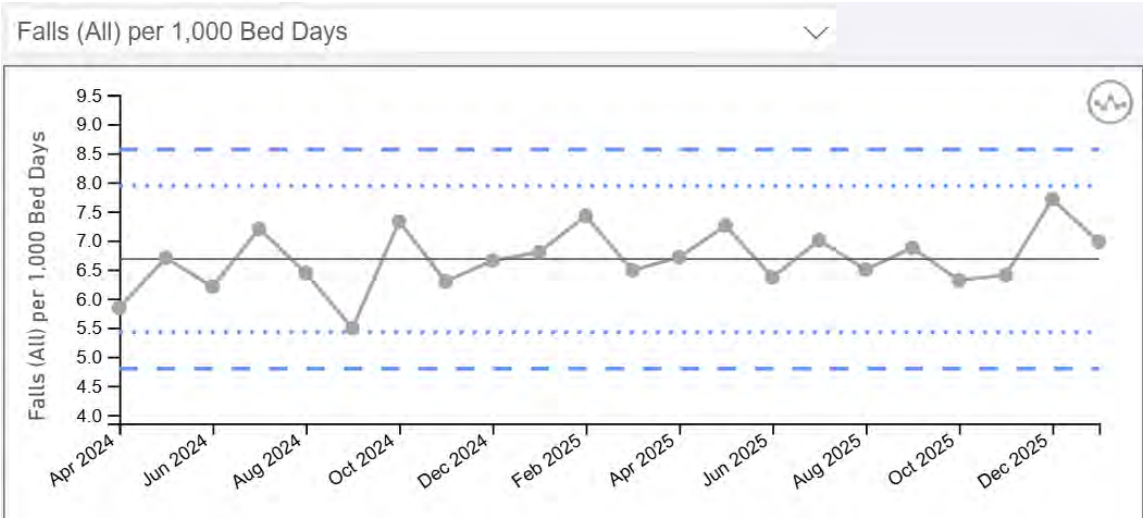
LERN forms:

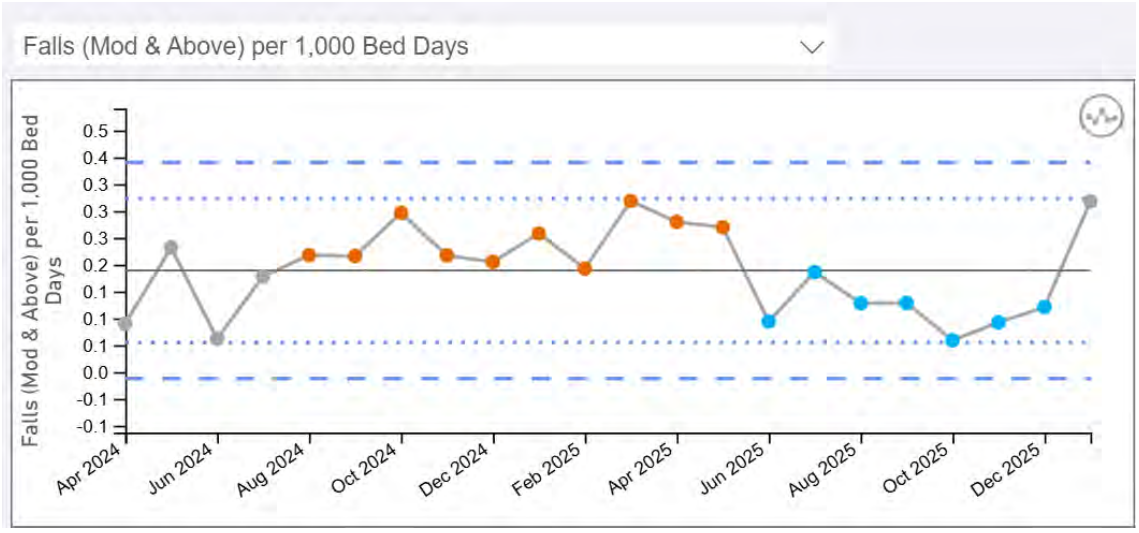
The number of LERN forms- including patient safety events reported remains within standard variation
Data from Cosmos

LERNS by patient safety theme

The patient safety theme is chosen at the time of reporting and can be updated by the 'reviewer' of the LERN.

Falls:
Data from Cosmos pulled through from Datix





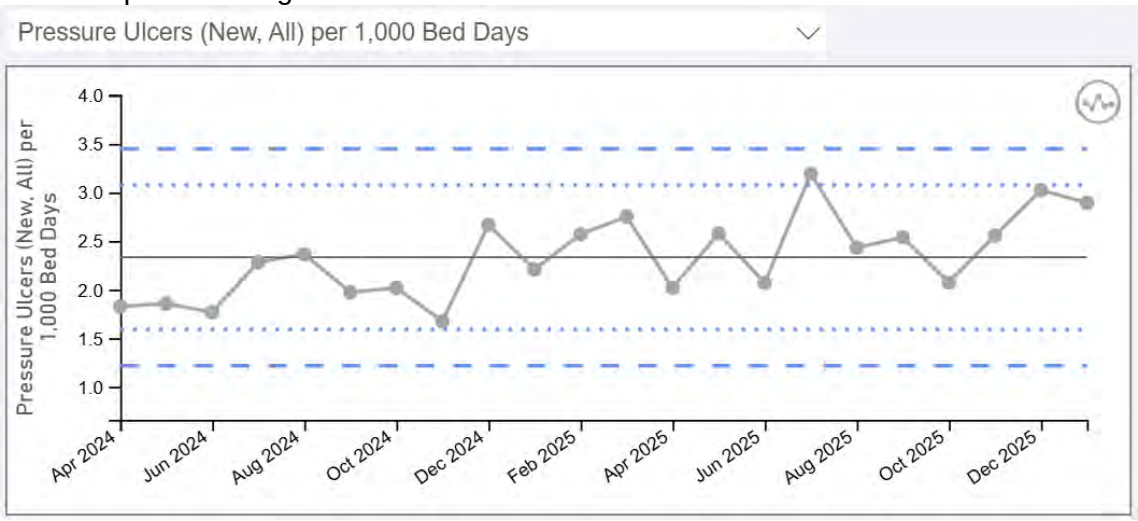
The rate of patient falls per 1,000 bed days remains within the expected range, despite an increase in incidents reported in December, which reflects increased operational pressures. Similarly, falls resulting in moderate or greater harm per 1,000 bed days are also within standard variation. The rise in harmful falls documented in January still requires full validation.

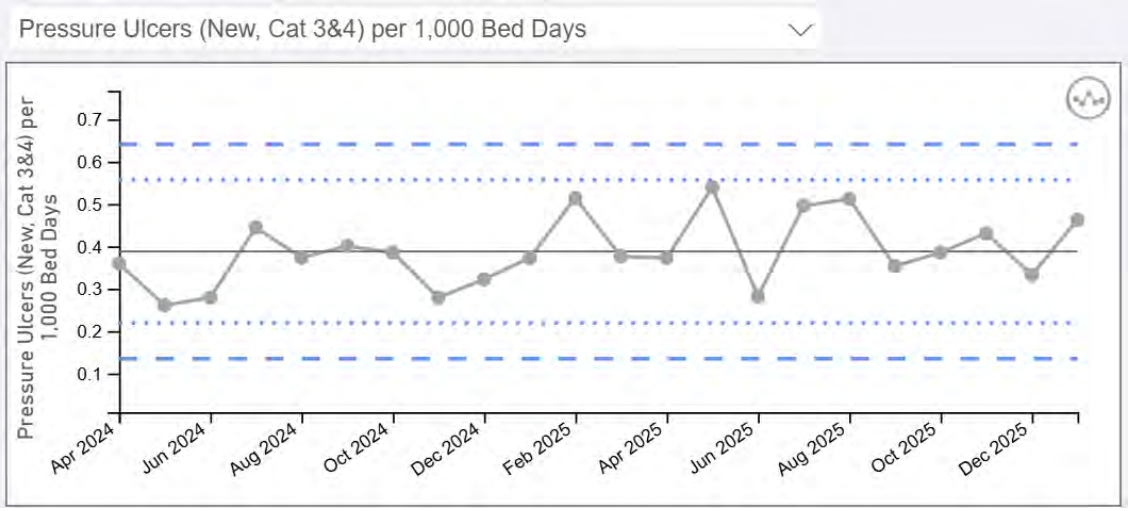
Recent updates to the ‘post-falls grab pack’ include a structured post-fall huddle, a standardised checklist, and improved prompts for escalating cases to a SWARM learning response when appropriate. These enhancements were made in response to findings from the National Audit for Inpatient Falls (NAIF), which showed UHD lags behind the national average for completing post-fall hot debriefs (UHD: 0% vs. National: 30%) and conducting SWARM reviews within five days (UHD: 3.1% vs. National: 31%).

The Falls Steering Group has now started, and increased clinical engagement is encouraged to drive further improvements.

Pressure Ulcers

Data from Cosmos pulled through from Datix



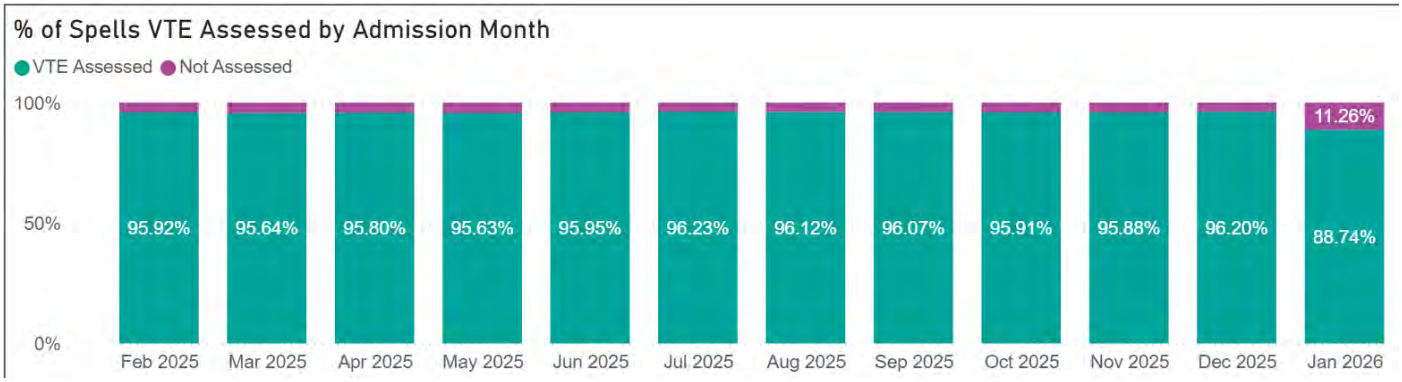


Reported pressure ulcers remain within expected standard variation.

The Tissue Viability Team is moving forward with the Pressure Ulcer Prevention Thematic Review action plan and will soon introduce a PSIRF-aligned process and toolkit to help clinical teams prevent ulcers and improve learning from incidents.

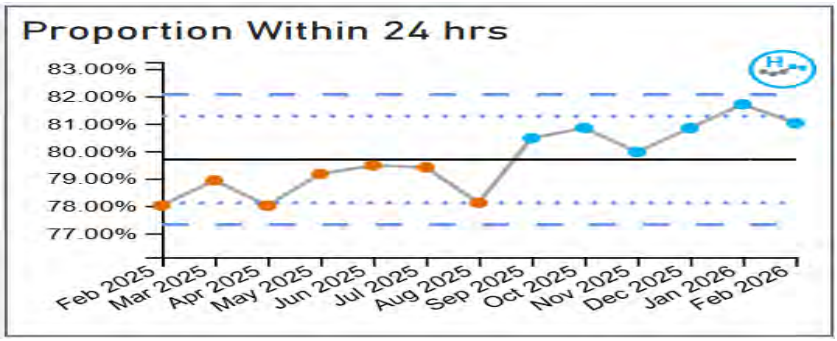
The Total Bed Management Programme has been implemented and targeted communications have raised awareness of available products and services. Updated Pressure ulcer prevention training is scheduled.

VTE:
Data from Cosmos
Risk Assessment:



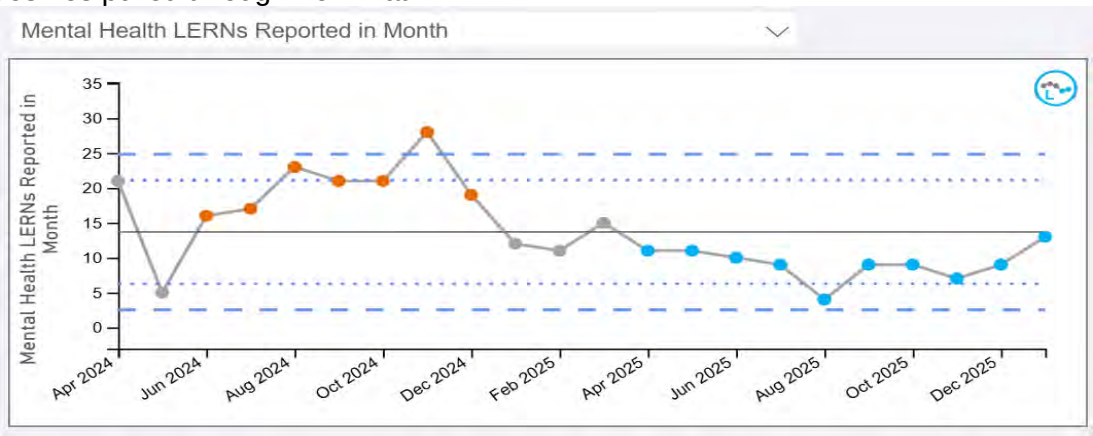
VTE risk assessments continue to remain above 95% completion. The most recent month (Jan 26) has not been validated.

Prescribed:

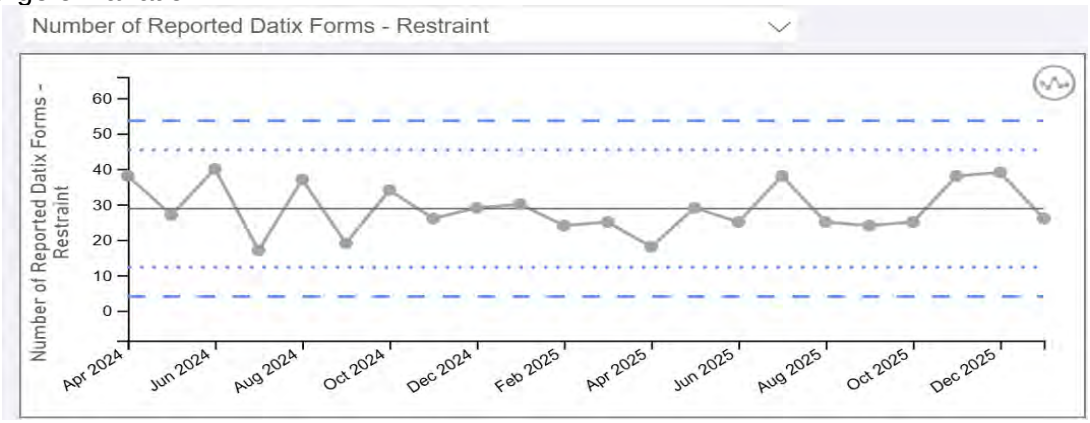


The number of patients receiving VTE prophylaxis within 24 hours is steadily increasing, though February data remains incomplete. A VTE thematic review is currently underway to facilitate learning and promote ongoing improvement.

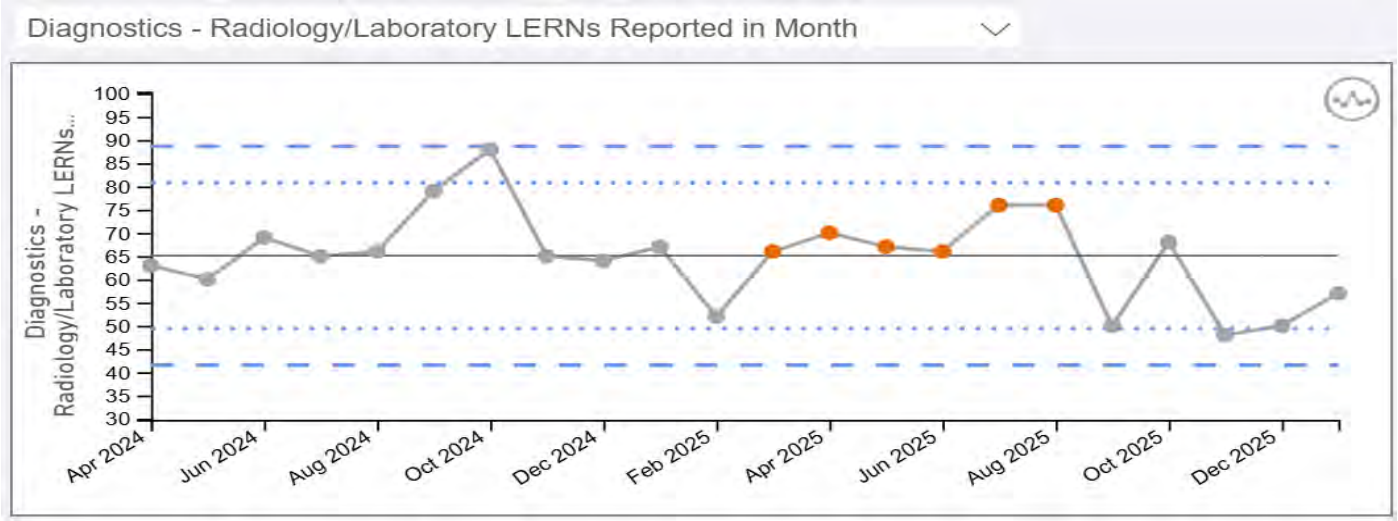
Mental Health
Data from Cosmos pulled through from Datix



The reported number of LERNs related to mental health has declined markedly. It is currently uncertain whether this trend is attributable to the Mental Health workstreams or to staff not associating events with patient mental health management. The incidence of restrictive interventions continues to fall within the expected range of variation.



Diagnostics:
Data from Cosmos pulled through from Datix

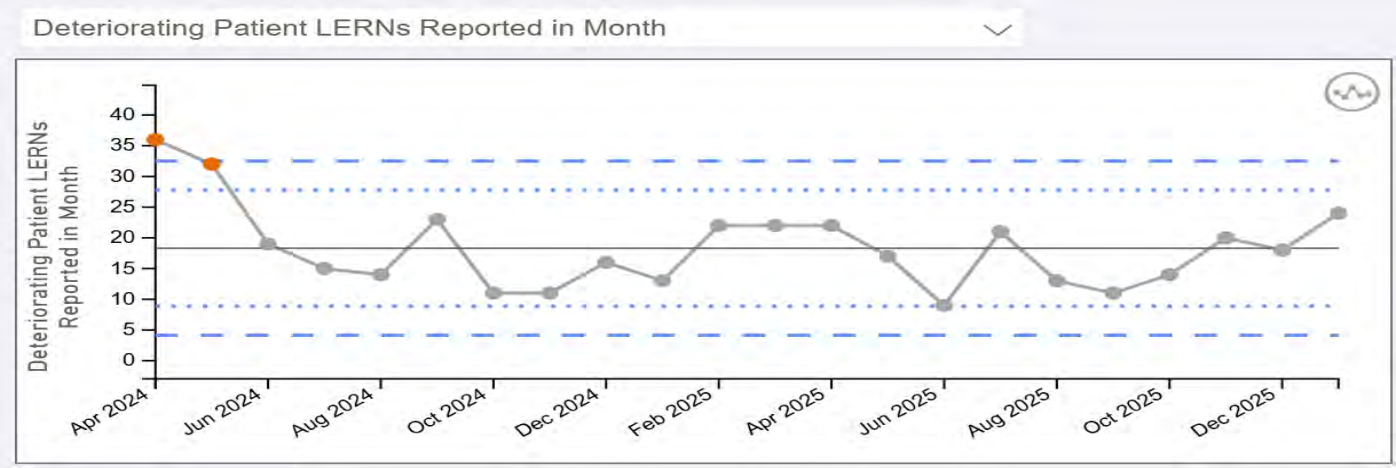


The number of incidents reported under ‘diagnostics’ remains within normal variation, though it has been lower in recent months. Staff use the diagnostics category for a variety of incident types, including both laboratory and radiology cases. ICE filing was introduced to help ensure follow-up on reporting is completed, and this process continues to be integrated.

The Outpatient Improvement Programme consists of six projects designed to reduce patient harm. These projects include advice and guidance, standardizing appointment bookings, optimizing clinic space usage,

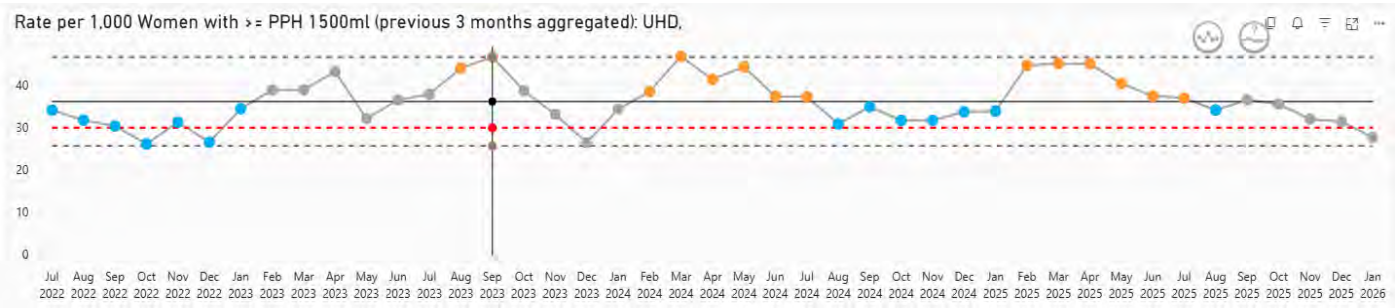
improving patient access, standardizing follow-up procedures, and implementing electronic patient check-in. In addition, a harm review tool is being developed to determine whether patients have experienced harm or are at risk, and to prevent potential harm while they wait for clinical treatment.

Deteriorating Patients:



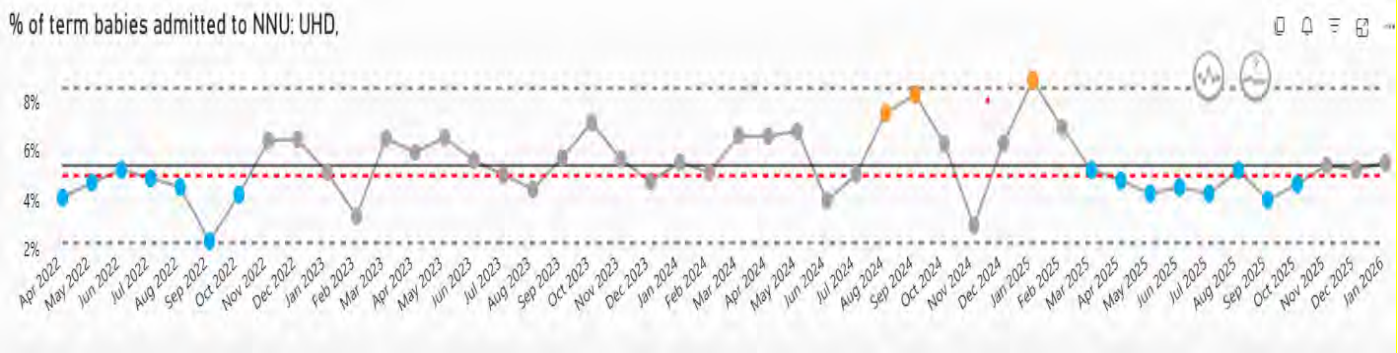
The frequency of incidents reported concerning deteriorating patients has remained within the expected range of variation. The first meeting of the newly established Deteriorating Patient Group is scheduled for March, with subsequent meetings planned to take place every two months. This group will provide enhanced oversight, with the resuscitation group formally reporting into it. In addition, the deteriorating patient policy has now been formally approved. An audit will be carried out to assess the extent to which this policy is being embedded in practice.

Post Partum Haemorrhage



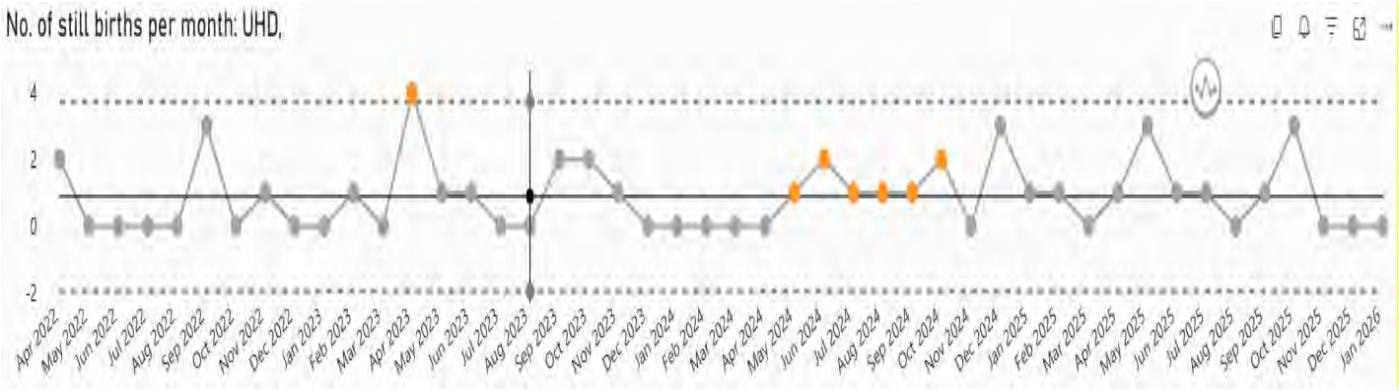
The rate of PPHs remains within standard deviation and is starting to decrease and trend towards the national benchmark. The following themes are currently under review: implementation of the MOH Proforma, timely activation of the emergency bell, availability of the MOH Coordinator, prioritisation of uterotonic administration, and adherence to prophylaxis guidance. A PSII is being undertaken relating to a 6L PPH which will likely identify further opportunities for learning and improvement.

Term admission to NICU



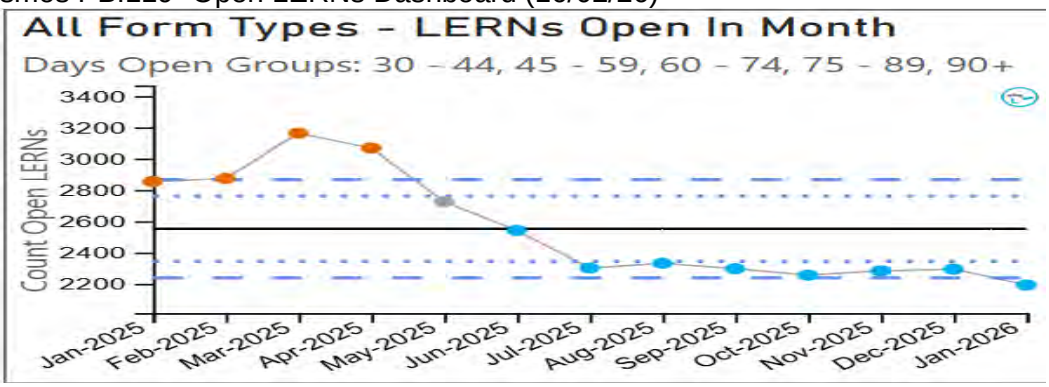
Performance has consistently met or nearly met the national target for 11 months. Bedside CPAP has been instrumental in this improvement. A thematic review was completed, and actions are underway.

Stillbirth



While the stillbirth rate is within the standard deviation, it is higher than the national targets. Currently, there are no major themes or ongoing workstreams; however, cases are consistently reviewed through PMRT processes and peer review with DCH.

Open LERNs:
Data from Cosmos PBI119- Open LERNs Dashboard (16/02/26)



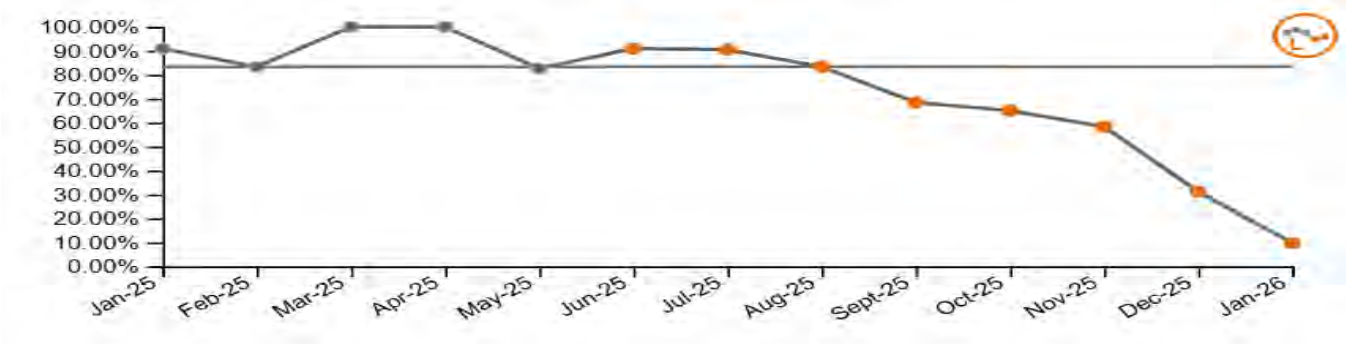
There has been sustained improvement in reducing the number of open LERNs for eight consecutive months, with notable advancements observed in addressing no- and low-harm patient safety events as well as restraint forms.

The Patient Safety Team has facilitated the closure of LERNs not associated with the three clinical care groups, resulting in a reduction from 315 last month to 257 this month. Targeted support is available from the Patient Safety Team to assist with theming and resolving historic LERNs.

Duty of Candour compliance

Data from the Patient first scorecard

Compliance with the statutory duty of candour (DoC) is determined directly from LERN forms. Recent months typically show lower compliance rates because the process involves sharing a formal apology letter with the patient or their family, which requires time to identify responsible leads, draft the letters, and upload them to Datix.



The report notes that the volume of Duty of Candour (DoC) letters documented within Datix does not meet anticipated standards. A range of factors may account for this deviation, such as operational challenges, misclassification of harm events requiring “professional” rather than “statutory” Duty of Candour—which impacts the visibility of obligations—delays in the assessment and documentation of harm levels, and inconsistent completion of mandatory fields evidencing compliance.

The Duty of Candour letter process is currently being reviewed, with updates to be implemented alongside an improved supporting toolkit. This work aims to standardise and strengthen the quality, clarity, and consistency of apology letters issued across the organisation.

The Duty of Candour training session has been revised to incorporate enhanced content on patient and family engagement and involvement. The updated training was co-designed and will be co-delivered in partnership with our Patient Safety Partners to ensure it reflects lived experience and best practice.

Work is ongoing to address patient and family engagement. A working group has been set up under the Quality and Safety Strategy.

Learning Response tools
Data from Datix

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec 25	Jan 26
Personal reflection	55	58	58	60	69	69	76	68	54	87	54	68	60
Team reflection	41	41	30	51	40	32	48	34	43	30	24	22	25
Clinical case review	13	14	13	8	9	10	11	10	12	9	5	9	6
Pressure Ulcer Event Review	11	14	7	5	3	6	7	12	7	2	13	2	11
AAR	10	7	14	8	5	4	7	5	6	7	6	2	8
MDT review	6	3	3	5	8	4	6	8	5	4	8	2	1
FALLS SWARM	13	8	13	5	8	2	3	4	1	2	2	3	7
Timeline	9	3	4	5	9	5	13	4	7	4	5	1	4
SWARM huddle	1	0	0	2	3	1	1	0	3	3	1	2	2
SMART action plan	0	1	1	3	3	2	4	1	1	1	3	11	0
PSII	0	0	1	1	1	1	0	1	0	1	0	0	0
M&M Discussion	2	1	0	1	1	0	3	1	0	2	2	1	0
Total	161	151	150	162	159	136	179	148	139	153	124	124	127

The table above provides an overview of the learning response tool selected to determine learning based on the event's reported date. The available tools are currently under review as part of the Patient Safety Incident Response Plan, with efforts underway to enhance assurance that the most suitable tool is selected.

Patient Safety Incident Response Plan (PSIRP)
The existing PSIRP has been reviewed, and efforts have been made to determine the forthcoming set of priorities while continuing progress on established themes. A presentation regarding the next PSIRP is scheduled for the February Clinical Governance Group meeting (today), in advance of its planned launch in April. The suggested priorities for 2026-2028 are:

- Recognition and escalation of deteriorating patients
- Cross-site transfer and handover
- Care in non-clinical areas
- Medication relating to discharge

PSIRF Templates
As part of the review, existing PSIRF templates are being reviewed and updated to ensure they effectively support learning and contribute to a continuous improvement oversight loop.

Assurance and Oversight
To enhance organisational assurance and visibility of PSIRF priorities, highlight reports will be submitted to the PSIRF Oversight Meeting on a bi-monthly basis. Following approval of the new PSIRP, the terms of reference and agendas for Patient Safety meetings will be updated to reflect revised priorities and processes.

Datix and IT Integration
Efforts are underway to make sure that ward relocations are promptly and accurately reflected in Datix, allowing staff to keep reporting events and view their dashboards without interruption. Please coordinate with the patient safety team to help make this process as smooth as possible for everyone.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 02 March 2026

Agenda item: **11.1**

COVER SHEET – ALERT, ADVISE, ASSURE	
TITLE:	Guardian of Safe Working Hours - Quarterly report
Prepared by:	Rachael Ford, Julie Mantell, Nicola Craig
Presented by:	Rachael Ford, Peter Wilson
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Information
Executive summary:	Good levels of exception reporting, as expected across acute specialties. Although exceptions are stable there is continued pressure on clinical services. In addition, there were a total of 14 Immediate Safety Concerns.
ALERT:	14 safety concerns have been raised – the majority linked to workload pressures, missed breaks, extended hours and insufficient supervision. There is a plan in place to increase medical cover in RBH surgery where the majority of reports were raised.
ADVISE:	Number of exception reports is stable. Seasonal pressures on clinical services within respiratory, medicine, emergency medicine and surgery, are reflected in both exception reporting activity and rising locum demand. Note the end of tenure for Mr Paul Frogatt, the new Guardian of Safe Working is Dr Rachael Ford, a consultant anaesthetist.
ASSURE:	The Exception Reporting process continues to support safe working and enable the appropriate compensation of additional hours worked. Safety concerns are followed up by the GOSW and escalated where appropriate to clinical leads. The trust is compliant with 6th February 2026 exception report reforms.
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 ☐ Operational performance: Continued pressures on clinical services in medicine, ED and Surgery with regards to sufficient cover and service demand. People (staff): RDs reported missing breaks, increased workload, and working extended hours. Quality: The knock-on effect of the above affects the quality of patient care.
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☐ Use of Resources ☐

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

University Hospitals Dorset
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

1st October to 31st December 2025

UNIVERSITY HOSPITALS DORSET

CONTENTS:

GSW Executive Summary

Key points

- The guardian of safe working role is now being undertaken by Dr Rachael Ford
- Total exception report numbers this quarter remain stable
- The majority of reports continue to relate to working beyond contracted hours, i.e. finishing shifts late due to clinical need.
- Areas where number of exception reports have increased correlate with areas that experience seasonal pressures – respiratory, emergency department.
- An increase in reporting from ST3+ shows improved engagement in this resident group who have previously been under represented.
- 14 safety concerns have been raised – the majority from surgery at RBH, where a plan to increase medical cover is being implemented.
- The resident doctors strikes caused significant locum requirements, areas with high locum dependency continue to be medicine and emergency medicine.
- There is a significant number of unfilled locum shifts in medicine, emergency medicine and surgery.

Summary

This report covers the period 1st October to 31st December 2025. At the end of this period Dr Paul Froggatt completed his term as guardian of safe working, many thanks to him for his commitment in the role over the last 4 years. I, Dr Rachael Ford, consultant anaesthetist, have taken over the guardian role.

Across University Hospitals Dorset (UHD), **409 exception reports** were submitted this quarter (Poole: 264; RBH: 145) representing a modest decrease at Poole (-4) and an increase at RBH (+17).

The continued pressures on clinical services particularly within Respiratory, Medicine, Emergency Medicine, and Surgery are reflected in both exception reporting activity and rising locum demand.

There were 14 patient safety concerns raised across both sites (Poole: 2; RBH: 12), the majority linked to workload pressures, missed breaks, extended hours and insufficient supervision.

<u>Key Themes and Risks</u>

- Working beyond contracted hours continues to drive most reports (Poole: 97%; RBH: 90%).
- A significant spike in reporting occurred in:
    - Respiratory at Poole (4 → 88 reports), with 40 reports rejected due to being submitted outside the 14-day limit.
    - Psychiatry at RBH (2 → 15 reports).
- Higher-grade trainees continue to increase their reporting, comprising 36% of reports at Poole, up from 26% last quarter.

<u>Workforce Gaps and Locum Dependence</u>

- Poole recorded 16 trainee vacancies; RBH recorded 8.
- Locum activity continues to rise:
    - Poole: 1% increase in requests

- RBH: 7% increase in requests

Many shifts requested across UHD remain at ST1/2 or CT1/2 grade (75–79%).

- Industrial action and urgent clinical need are major drivers of locum demand at both sites.
- A large proportion of shifts remain unfilled (Poole: 70%; RBH: 32%), with Medicine and O&G having the highest unmet need.

Resident Doctor Forums

There were 2 Resident Doctor Forums during the previous quarter which were held on 3rd November and 1st December 2025.

3rd November: Initial discussions were around the Resident Doctor 10 Point Plan. Variability in how things are implemented across depts. (annual leave etc.) would be good to standardise. Awaiting survey results of problems face by UHD Doctors. Specifically point 9 on the survey FY1s struggle with Community Posts being their first post. RDF Committee to survey resident doctors on their thoughts on the 10 Point Plan.

Increasing RDF Awareness: Poor attendance at RDF meetings noted. A regular meeting day to be set with early communication to allow greater attendance. Setting up of a specific RDF nhs.net email address. Intranet page set up with google form for feedback from RDs. Advertising via Doctors Mess WhatsApp and QR codes.

Removal of Locum Posts: discussion following communication sent in August 2025 removing locum-only doctors who do not have a contract with the Trust. There was no representation from the Trust to discuss further. It was acknowledged that this was a great cause of stress and uncertainty for FY2s/FY3s and those currently locuming.

On-call Rota Burnout and Potential Solutions: discussed need to survey RDs to identify specific issues with the rota so they can be formally presented to rota coordinators. Also need to present an agreed alternative to the current on-call block work plan.

1st December:

Surgical Rota Pressures: Funding has been agreed for an increase in staffing with fixed posts for LEDs from July/August and currently aiming to recruit in next 2 months to cover gap until July. Also lack of senior support – there will be an increase in staffing of an SHO/registrar level cover for night and weekend support. Dr Wilson working with surgical consultants regarding improving support at consultant level.

Insufficient Staffing Levels: discussions around winter pressures and inconsistency in escalated rates.

Not enough teaching time: Missed teaching opportunities i.e. cannot attend theatre times and poor staffing on wards so cannot attend departmental lunchtime teaching. In addition, there is a lack of bedside teaching and loss of teaching environments on the wards. IMT teaching for IMT1 seems to be the same for IMT2. F2s receive no clinical teaching which

was raised by the previous Foundation Representative meeting with no satisfactory outcome.

10 Point Plan: Majority of RDs are unaware of the plan, general feedback is that it feels political, high level and disconnected from operational reality. BMA reps to feedback the feeling of RDs at our Trust. Trust has completed 90-95% of the survey, the remainder is out of our hands. Was agreed that the RDF should focus on issues that are presented by RDs and to ask BMA reps to attend the RDF.

Annual Leave: Policy being created to standardise the process of requesting leave ahead of the rota being created. This is only for LEDs as Deanery cannot guarantee leave requests when moving between organisations i.e. IMTs moving hospitals etc.

Policy Search: Policies are difficult to access which represents a patient safety concern. Suggestion from FY1 to make a page on the intranet. Dr Wilson agreed to speak with Head of Digital, Beverly Bryant, to arrange a meeting. RDF will liaise with the FY1 to request a meeting.

e-Forms: RDF to make a list of all e-forms commonly used for requesting and to request that all RDs have full access to these on starting.

RDF Visibility: To set up an email address for uhd.residentdoctors@nhs.net and set up an intranet page including a who's who (DMEs/Committee) and form to submit points for discussion, meeting minutes etc.

University Hospitals Dorset: Poole Hospital

High level data

Number of doctors / dentists in training (total): 443.00 (Across UHD)

Number of doctors / dentists in training on 2016 TCS (total): 443.00 (Across UHD)

Time available in job plan for guardian to do the role across both sites: 1 PA/4hrs per wk

Admin support provided to the guardian (if any): 0.13 WTE

Exception reports

Speciality	Exceptions raised 1st October to 31st December 2025	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Child Health	6	1	0	6	0
Colorectal/Upper GI	10	0	6	3	1
Emergency Medicine	12	2	0	11	1
Endocrine	8	0	0	8	0
ENT	7	0	0	6	1
General Medicine	8	1	0	8	0
General Surgery	30	0	1	27	2
Haematology/Onc	10	0	0	9	1
Neuro	1	0	0	1	0
OPS	79	0	0	76	3
Respiratory	88	44	0	88	0
Trauma and Ortho	1	0	0	0	1
Vascular	2	0	0	2	0
Women's Health	2	0	0	2	0
Total	**264**	**48**	**7**	**247**	**10**

(Source: HealthRota)

All exceptions which were either entered in error or rejected have been included within exceptions closed figures. One exception was entered in error from OPS.

In total, forty-three exceptions were rejected and these were submitted by six different doctors. One within OPS with the reason stating this is due to being unable to pay for

missed breaks. Two exceptions (one Colorectal Surgery and one Endocrine) were rejected due to an error with the exception reporting system.

Of note, forty exceptions were rejected with the reason listed being that these should be submitted within a maximum of fourteen days from the date of the exception. All of these are from the Respiratory department by three different doctors.

The outstanding excpetion reports have subsequently been closed.

Brief Overview of Exception Reports Raised

There was total of 264 exception reports raised for the quarter 1st October to 31st December, this is a decrease of four compared to the last quarter.

Two patient safety concerns were raised during this quarter, one from General Surgery and the other from Respiratory. These is a decrease of six from the previous quarter.

Rota/Dept	Number of ISCs Raised	Grade	Reasons
Respiratory	1	Junior Clinical Fellow	Difference in hours worked.
General Surgery	1	Foundation Year 1	Inadequate clinical exposure/experience/supervision

Exception Reports – Previous Quarter Comparisons

Speciality	Exceptions raised 1st July to 30th September 2025	Exceptions raised 1st October to 31st December 2025
Child Health	0	6
Colorectal/Upper GI	16	10
Emergency Medicine	19	12
Endocrine	0	8
ENT	1	7
General Medicine	90	8
General Surgery	27	30
Haematology/Oncology	29	10
Neurology	0	1
OPS	78	79
Respiratory	4	88
Trauma and Ortho	0	1
Vascular	2	2
Women's Health	2	2
Total	268	264

As seen in the above table, Respiratory has seen the greatest increase in exceptions raised from 4 to 88. Those which were rejected, were not re-submitted by the doctors so no duplication has occurred. However, the significant increase can also be attributed to the decrease in those under the General Medicine heading on the exception reporting system.

Reasons for Exceptions Raised

Over 97% of reports raised were in relation to staff working over their contracted hours, this remains as the key reporting reason. These reports were raised by 67 doctors during this period.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
257	2	1	1	3

(Source: Healthrota)

Reporting Grades for this Period

There is a continuing rise in the number of higher grades who are exception reporting, accounting for 36% of the total compared to 26% last quarter.

FY1	FY2	GP/ST1/2	Trust SHO	IMT1/CT1/ST1	IMT2/CT2/ST2	IMT3/CT3/ST3	ST4+
87	28	6	96	8	3	15	21

(Source: Healthrota)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Work Schedule Review/Pattern	Outcome Still Awaited
132	78	43	1	6	0	4

(Source: Healthrota)

Fines

There were no fines this quarter.

Vacancies – Doctors in Training

Department	Number of vacancies
Anaesthetics	2
Emergency Medicine	1
Ear, Nose and Throat	1
General Medicine	5
GP	1
OMF	5
Radiology	1

(Source: Medical Staffing)

Locum Bookings via Bank

The below table indicates the number of shifts and hours worked through the bank during this period, identifying whether increase / decrease from the previous quarter.

Locum bookings (Bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Emergency Medicine	681 ↓	490 ↓	6,312 ↓	4,537 ↓
Endoscopy	2 ↑	2 ↑	8 ↑	8 ↑
ENT	120 ↑	89 ↑	1,105 ↑	832 ↑
General Surgery	50 ↑	36 ↑	502 ↑	372 ↑
Maxillo-facial Surgery	45 ↓	34 ↓	381 ↑	262 ↑
Medicine	432 ↑	247 ↑	4,136 ↑	2,387 ↑
Obstetrics and Gynaecology	2 ↓	1 ↓	13 ↓	4 ↓
Oncology	66 ↓	56 ↓	658 ↓	560 ↓
Orthopedic Surgery	337 ↓	262 ↓	3,201 ↓	2,507 ↓
Paediatrics	94 ↑	62 ↑	1,000 ↑	650 ↑
TOTAL	**1,829 ↑**	**1,279 ↓**	**17,314 ↑**	**12,116 ↓**

(Source Temp Staffing Office)

During this quarter there was an increase of 1% in the number of locum shifts requested from 1818 to 1829.

The majority of shifts requested are again from within Medicine and Orthopaedic specialties, making up 24% and 18% of the total respectively.

The most significant increases have been within General Surgery from 33 to 50 shifts (52%) increase and Paediatrics from 61 to 94 shifts (55% increase).

There was an increase in the number of unfilled shifts between last quarter and this quarter from 77% to 70%. With the most unfilled shifts being within Medicine (43%).

The table below shows a different aggregation in which the grades for locum shifts were requested.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	3 ↑	1 -	24 ↓	5 ↓
F2	30 ↑	14 ↑	297 ↑	141 ↑
ST/CMT1/2	1,520 ↑	1,090 ↓	14,513 ↑	10,424 ↑
ST3+	276 ↓	174 ↓	2,481 ↓	1,546 ↓
TOTAL	**1,829 ↑**	**1,279 ↓**	**17,314 ↑**	**12,116 ↓**

(Source Temp Staffing Office)

Continuing the previous quarters trend, the majority of shifts (79%) have been requested at ST/CMT 1/2 grades. The greatest increase has been within the F2 Grades, rising from 4 to 30 shifts requested during this quarter.

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
Annual Leave	151 ↓	116 ↑	1,290 ↓	993 ↑
Covering Absent Colleagues	75 ↑	52 ↑	648 ↓	414 ↓
Deanery Vacancy	15 ↓	12 ↓	177 ↓	140 ↓
Escalations	13 ↓	6 ↓	123 ↓	54 ↓
Industrial Action	667 ↑	397 ↑	6,778 ↑	4,175 ↑
LTFT Cover	1 ↓	1 ↓	13 ↓	13 ↓
Maternity/Paternity Leave	15 ↓	9 ↓	75 ↓	28 ↓
Service Demand (e.g winter pressures)	128 ↓	103 ↓	1,239 ↓	1,005 ↓
Sickness	183 ↑	117 ↑	1,596 ↑	1,024 ↑
Study Leave	31 ↓	19 ↓	246 ↓	146 ↓
Trust vacancy	336 ↓	265 ↓	3,187 ↓	2,477 ↓
Urgent Clinical Need	211 ↑	179 ↑	1,932 ↑	1,637 ↑
WLI (Waiting List Initiative)	3 ↓	3 ↓	12 ↓	12 ↓
TOTAL	**1,829 ↑**	**1,279 ↓**	**17,314 ↑**	**12,116 ↓**

(Source Temp Staffing Office)

This quarter, the notable increases have been for Industrial Action increasing by 107% from 322 to 667 shifts and Urgent Clinical Need from 34 to 211 shifts.

Whilst there have been notable decreases within Deanery Vacancy of 67% and also Trust Vacancy of 55%.

The highest percentage of shifts unfilled were for Escalations, Industrial Action and Maternity/Paternity Leave.

Locum Bookings via Agency

Grade	**Number of shifts requested**	**Number of shifts worked**
FY1	0 -	0 -
FY2	0 -	0 -
ST1/2 - CT1/2	15 ↑	15 ↑
ST3 +	0 ↓	0 ↓
TOTALS	**15** ↓	**15** ↓

(Source Temp Staffing Office)

The agency shifts were for covering general surgery and ENT.

University Hospitals Dorset: Royal Bournemouth Hospital

High level data

Number of doctors / dentists in training (total): 443.00 (Across UHD)
Number of doctors / dentists in training on 2016 TCS (total): 443.00 (Across UHD)
Time available in job plan for guardian to do the role across both sites: 1 PA/4hrs per wk
Admin support provided to the guardian (if any): 0.13 WTE

Exception reports

Speciality	Exceptions raised 1st October to 31st December	Exceptions raised outside of 14 days from event	Outcome agreed (not closed)	Number of exceptions closed	Number of exceptions outstanding
Acute	6	0	0	6	0
Cardiology	7	0	0	7	0
Colorectal	14	0	0	13	1
Emergency Medicine	13	0	0	13	0
Endocrine	5	3	0	5	0
Gastroenterology	5	0	0	5	0
General Medicine	7	0	0	7	0
OPS	22	0	0	21	1
Psychiatry	15	6	0	15	0
Respiratory	18	0	0	14	4
Stroke	1	0	0	0	1
Upper GI	21	0	0	18	3
Urology	3	0	0	3	0
Vascular	3	0	0	2	1
Women's Health	5	2	0	5	0
Total	**145**	**11**	**0**	**134**	**11**

(Source: HealthRota)

Brief Overview of Exception Reports Raised

There was a total of 145 exception reports raised during the quarter 1st October to 31st December, an increase of 17 compared to the previous quarter.

All exceptions which were either entered in error or rejected have been included within exceptions closed figures. One exception was entered in error from Psychiatry.

Six exceptions were rejected – five within Psychiatry and one within Urology.

Patient Safety Concerns Raised

There were twelve patient safety concerns raised during this quarter, increasing from eight in the previous quarter. Once again, the majority of these reported were reported from within the surgical directorate – 9 from Upper GI and one from Colorectal.

Rota/Dept	Number of ISCs Raised	Grade	Reasons
Respiratory	2	Trust SHO	Difference in hours worked
Upper GI	5	FY1	Unable to take breaks
Upper GI	4	FY1	Difference in hours worked
Colorectal	1	FY2	Difference in hours worked

Exception Reports – Previous Quarter Comparisons

Speciality	Exceptions raised 1st July to 30th September 2025	Exceptions raised 1st October to 31st December 2025
Acute	**4**	**6**
Cardiology	**6**	**7**
Colorectal	**12**	**14**
Emergency Medicine	**11**	**13**
Endocrine	**0**	**5**
Gastroenterology	**0**	**5**
General Medicine	**11**	**7**
General Surgery	**1**	**0**
Haematology/Onc	**5**	**0**
OPS	**23**	**22**
Psychiatry	**2**	**15**
Respiratory	**16**	**18**
Stroke	**0**	**1**
Upper GI	**7**	**21**
Urology	**11**	**3**
Vascular	**15**	**3**
Women's Health	**1**	**5**
Total	**128**	**145**

There have been notable changes within Psychiatry exceptions, raising from 2 to 15 reports and a decrease of 80% within the Vascular exceptions made.

Reasons for Exceptions Raised

The main reason for exceptions being raised during this quarter was for doctors working over their contracted hours totalling 90% of the reports; a theme which follows the pattern of the previous quarter.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
130	4	0	0	11

(Source: HealthRota)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1-2	ST1/ST2/CT1/CT2	IMT3/ST3/CT3+
79	30	5	13	13	1	4

(Source: HealthRota)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Work Schedule Review/Pattern	Outcome Still Awaited
64	59	10	1	10	0	1

(Source: HealthRota)

Vacancies

Department	Number of vacancies
Anaesthetics	1
Cancer Care	1
Emergency Medicine	1
General Medicine	2
Ophthalmology	2
Orthodontics	1

(Source: Medical Staffing)

Fines

There were no fines this quarter.

Locum Bookings Via Bank

Locum bookings (Bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hrs requested**	**Number of hrs worked**
Anaesthetics	5 ↓	5 ↓	46 ↓	46 ↓
Emergency Medicine	773 ↑	557 ↑	7,227 ↑	5,171 ↑
General Surgery	191 ↑	128 ↓	1,864 ↑	1,236 ↓
Medicine	654 ↑	431 ↑	6,604 ↑	4,537 ↑
Obstetrics and Gynaecology	185 ↑	100 ↓	1,642 ↓	904 ↓
Ophthalmology	5 ↑	3 ↑	92 ↑	63 ↑
Orthopedic Surgery	169 ↓	128 ↓	1,313 ↓	966 ↓
Urology	6 ↓	4 ↓	57 ↓	42 ↓
Vascular surgery	2 ↑	0 -	20 ↑	0 -
TOTAL	**1,990 ↑**	**1,356 ↓**	**18,864 ↑**	**12,965 ↓**

(Source Temp Staffing Office)

The above table highlights the number of shifts and hours worked, compared to the previous quarter figures.

There was an increase of 7% in the number of shifts requested from 1849 to 1990 with 68% of these worked during the quarter. The majority of the number of increased shifts requested have been in Emergency and Medicine. This was alongside a notable increase of 78% within the Urology shifts from 27 to 6.

The notable increases in number of shifts requested have been in Medicine from 585 to 654 shifts (12% increase) and Emergency from 686 to 773 (13% increase)

The most unfilled shifts were within Medicine (34% unfilled) and Obstetrics and Gynaecology (46% unfilled).

The table below shows a different aggregation in which the grades for locum shifts were requested. Continuing the previous quarters trend, the majority of shifts (75%) have been requested at ST/CMT 1/2 grades.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	4 ↓	0 -	45 ↓	0 -
F2	31 ↑	5 ↓	256 ↑	34 ↓
ST/CMT1/2	1,483 ↑	1,049 ↓	13,680 ↑	9,659↓
ST3+	472 ↑	302 ↑	4,884 ↑	3,273 ↑
TOTAL	**1,990 ↑**	**1,356 ↓**	**18,864 ↑**	**12,965 ↓**

(Source Temp Staffing Office)

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
Annual Leave	98 ↓	74 ↓	827 ↓	619 ↓
Covering Absent Colleagues	32 ↓	22 ↓	284 ↓	210 ↓
Deanery Vacancy	76 ↓	58 ↓	775 ↓	618 ↓
Escalations	8 ↓	4 ↓	62 ↓	30 ↓
Industrial Action	741 ↑	440 ↑	7,510 ↑	4,654 ↑
LTFT Cover	9 ↓	8 ↓	76 ↓	73 ↓
Maternity/Paternity Leave	15 ↓	14 ↓	142 ↓	130 ↓
Service Demand (e.g winter pressures)	181 ↑	123 ↑	1,490 ↑	1,000 ↑
Sickness	223 ↑	129 ↑	2,043 ↑	1,160 ↑
Study Leave	30 ↑	25 ↑	260 ↑	220 ↑
Trust vacancy	184 ↓	125 ↓	1,755 ↓	1,173 ↓
Urgent Clinical Need	390 ↑	331 ↑	3,610 ↑	3,049 ↑
WLI (Waiting List Initiative)	3 ↓	3 ↓	30 ↓	30 ↓
TOTAL	**1,990 ↑**	**1,356 ↓**	**18,864 ↑**	**12,965 ↓**

(Source Temp Staffing Office)

This quarter, the biggest bank locum bookings increase has been for Industrial Action (from 353 to 741 shifts) and Study Leave (3 to 30 shifts).

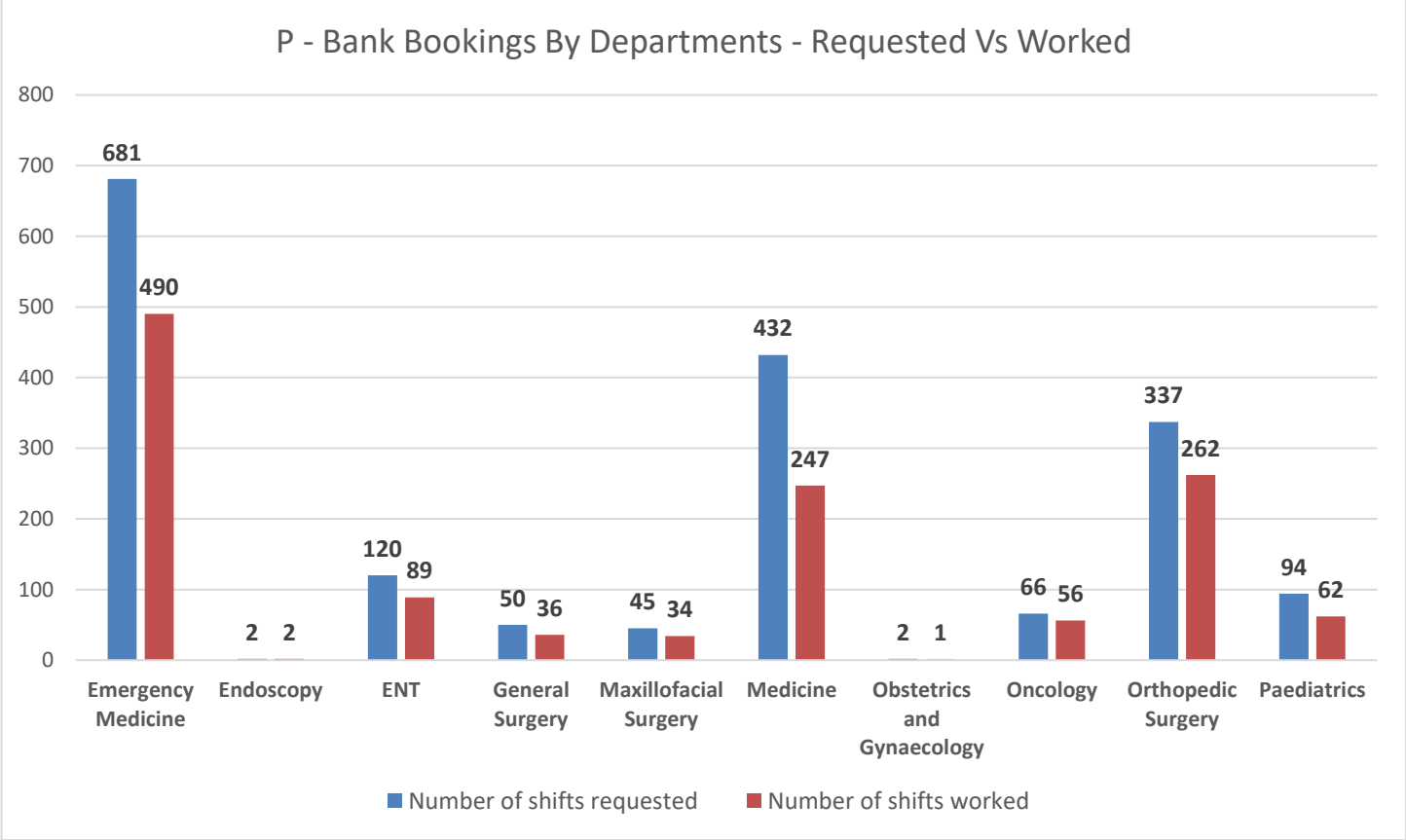
The notable decreases have been for Deanery Vacancy decreasing by 60% from 193 to 76 shifts and Trust Vacancy by 54% from 397 to 184 shifts.

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
FY1	0 -	0 -
FY2	0 -	0 -
ST1/2 - CT1/2	0 -	0 -
ST3+	0 -	0 -
TOTAL	**0 -**	**0 -**

(Source Temp Staffing Office)

Visual Data Representations: Poole



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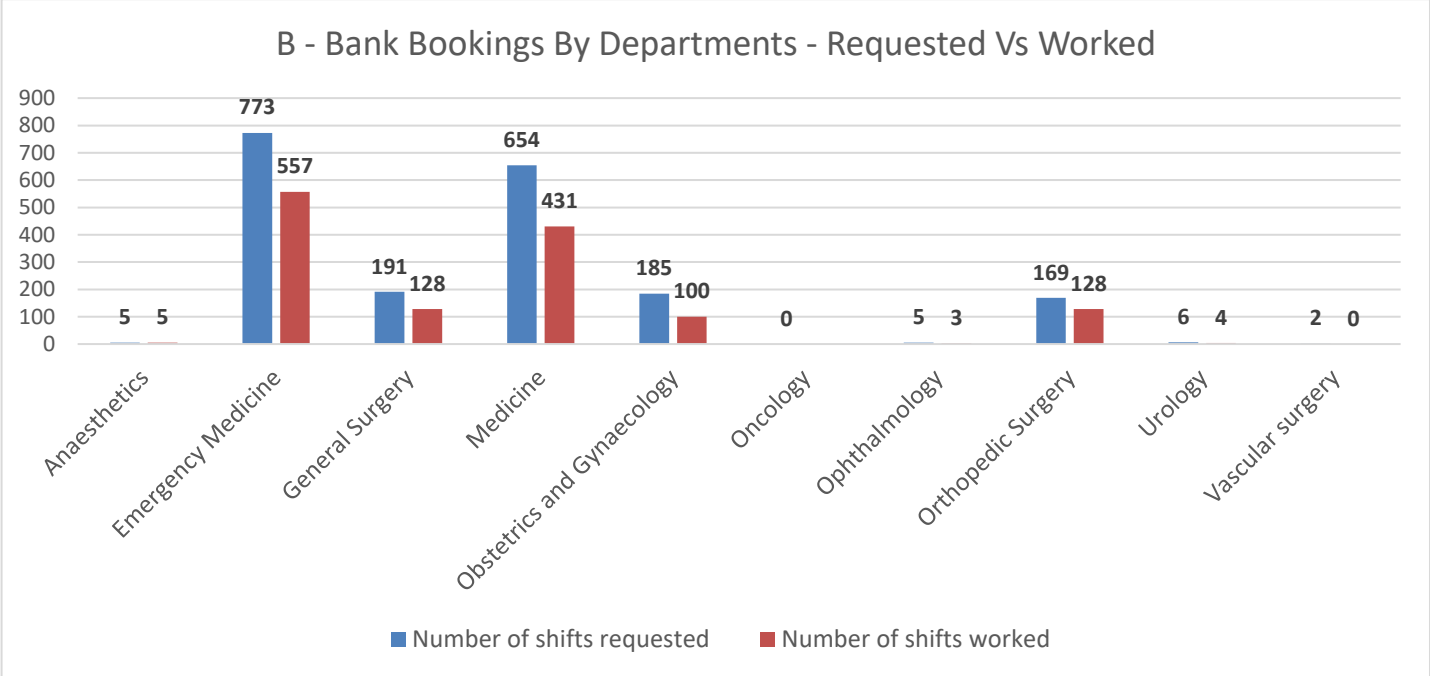

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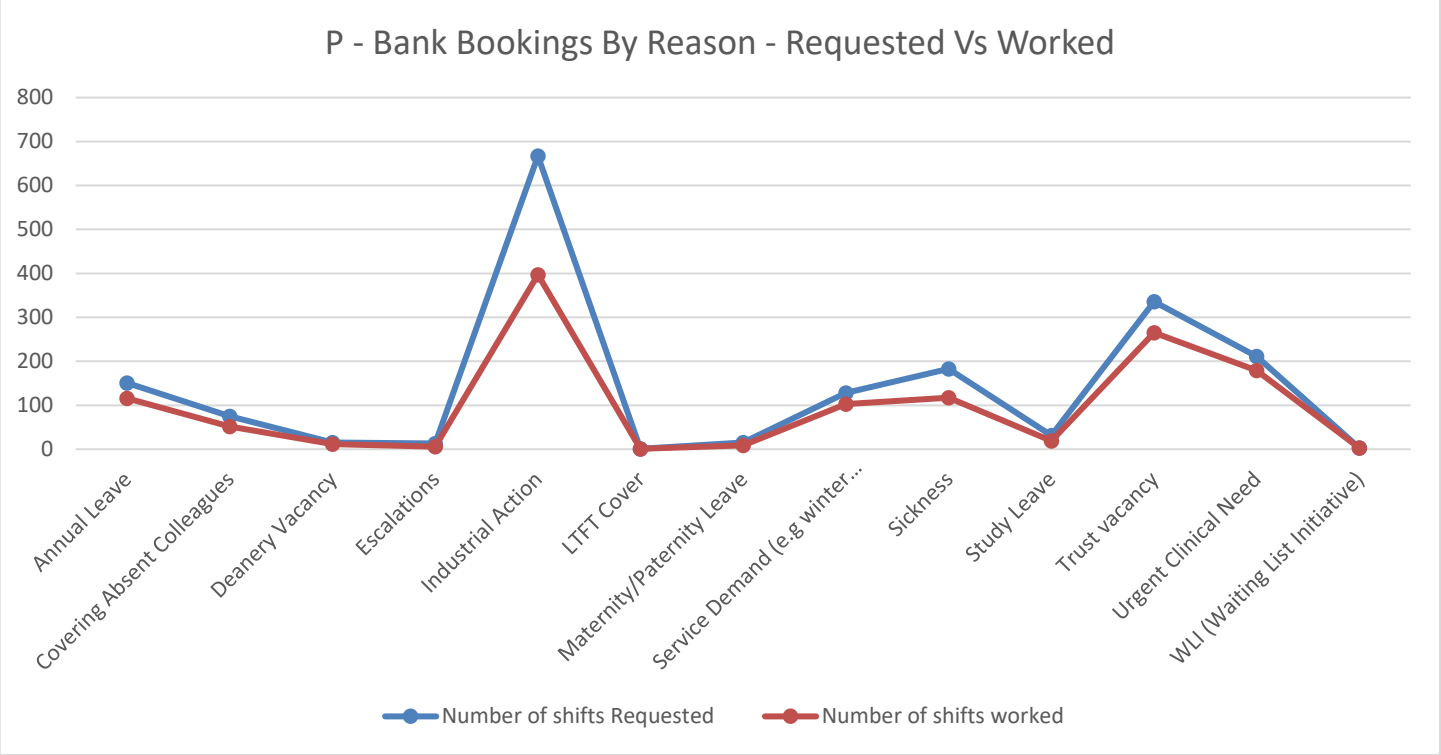

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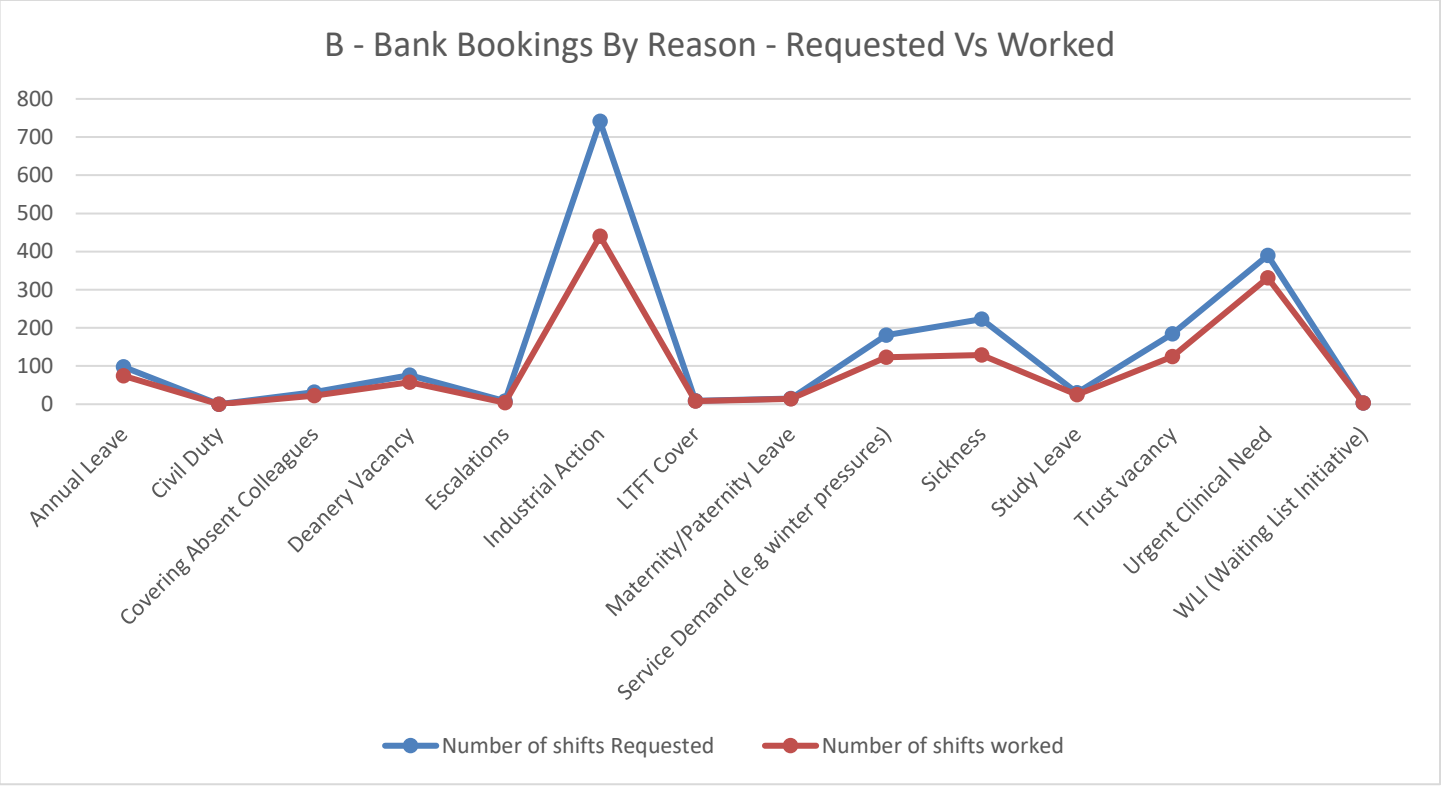
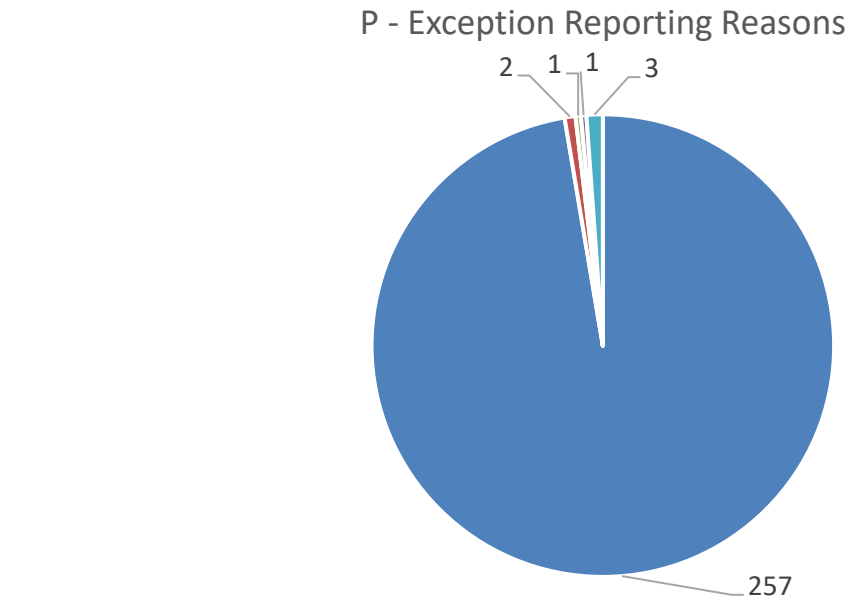


Poole

Guardian of Safe Working Report
Authors: Dr Rachael Ford, Julie Mantell, Nicola Craig



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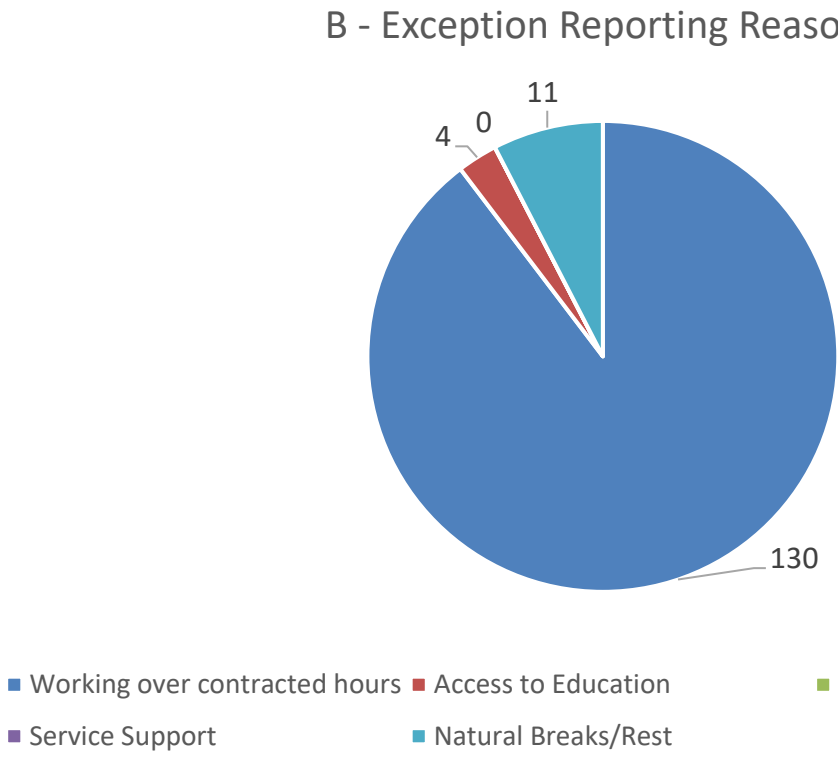


University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: **11.1**

COVER SHEET – ALERT, ADVISE, ASSURE	
TITLE:	Gender, Disability and Ethnicity Pay Gap Report - March 2025
Prepared by:	Bridie Moore – Head of Organisational Development Deepa Pappu – OD Practitioner - EDI lead Jane Dudley – Interim People Project Lead
Presented by:	Melanie Whitfield – Chief People Office
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 first drafts of these reports were taken to People and Culture Committee in January 2026 for discussion and some additional data and analysis was requested. The detailed reports have now been consolidated into one report with an overarching pay gap action plan. Reporting the gender pay gap is an annual statutory requirement. Since 2025 we have also produced Disability and Ethnicity pay gap reports. The data is taken from ESR with effect from 31st March 2025. The Gender Pay Gap for 2026 has increased to 4.83%. This is the first increase since we have been reporting as UHD. The factors driving such a change are complex. • The mean gender pay for UHD overall in 2025 was 19.30%, an increase from 18.37% in 2024. • UHD's mean hourly pay for female staff was £20.99 and £26.02 for male staff which is a difference of £5.02. • UHD's median hourly pay for female staff was £18.82 and £19.78 for male staff which is a difference of £0.95.

	• In 2025 UHD saw a reduction in the lowest banded roles (Band 1 and 2) and an increase in male staff in Band 3. Lower paid male colleagues were paid more than in the previous year. • UHD had a higher proportion of males in **trainee roles**, than the proportion of females in trainee roles. • The impact of proportionality; there are fewer males employed at UHD, but males disproportionately occupy the more senior bands. So even though the pay rates will be equal, the overall median pay for males will be higher (Medical Consultants and in Bands 8-9). • We are investigating whether a higher proportion of males reached an increment in 2025. • For the staff who joined or left in the last two years, they also follow a similar pattern male tending to be in higher bands. The Ethnicity Pay Gap for 2026 is -0.75%. Using the median pay rate this means there is a small gap in favour of our BME staff. White staff receive higher mean ordinary pay for non-medical and medical staff groups. Our headcount sample has increased by 198 to 9,774 since last year with 270 more BME staff and a reduction of -72 white staff across UHD (31st March 2024 vs. 31st March 2025). 274 staff who did not declare their ethnicity have been excluded. The Disability Pay Gap for 2026 is 8.56%. This has reduced from 12.29% in 2025. Our headcount sample is 8,714 with 741 staff declaring a disability or long-term condition. 1,334 staff or 13.28% have been excluded due to no declaration. This could mean the data is not a true picture. The report will be published on the UHD website by 31st March 2026 following Board approval on 11th March 2026. One overarching pay gap action plan has been created for 25/26.
ALERT:	The Gender Pay Gap for March 2025 has increased. We will continue to work on our understanding of this. We will also link in with regional and national colleagues to understand whether the reasons outline above have the same impact for other trusts.
ADVISE:	For Disability, we will look to increase the disability declaration rates on ESR to improve the validity of the Disability Pay Gap report and help us to understand a fuller picture of the experience of our staff with a disability. The national Staff Survey results by protected characteristics will also help us to monitor this.

ASSURE:	We have identified a small number of actions under the 6 NHS High Impact Actions and which align with the WRES and WDES actions that have already been published for 25/26. These are: 1. Leadership and accountability 2. Inclusive Recruitment 3. Career Development and Progression 4. Workplace adjustments and support 5. Data transparency and Monitoring 6. Culture & Engagement
Celebrating Outstanding:	6% of Dorset's population are from a BME background. At UHD 26.8% of our staff are BME and this increased by 270 last year. We have also seen a thriving DEN network and a number of trust wide engagement and listening events to improve the experience of our BME colleagues.
RECOMMENDATION:	To approve the pay gap report for publication on the UHD website before 31st March 2026.
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	05/01/2026	Provide more detailed analysis and reduce the number of actions.
People and Culture Committee	02/03/2026	The Committee received further update and recommended the report to the 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 ☐	

Gender Pay Gap – Annual Report 2025

Published March 2026

University Hospitals Dorset
NHS Foundation Trust

Introduction and background to the UHD Gender Pay Gap Annual Report - 2025

At University Hospitals Dorset NHS Foundation Trust (UHD) we are dedicated to **advancing genuine equality** across our workforce and welcome the requirement to report annually on the UHD Gender Pay Gap (GPG).

UHD has published annual reports each year since 2021 (UHD was formed through the merger of two predecessor organisations).

This GPG Annual Report 2025, published in March 2026, includes data from a snapshot date of 31 March 2025.

We publish our results on the government website, and on the UHD website, and the results are available for three years.

We recognise that equality challenges extend beyond gender, so we publish pay gap data relating to ethnicity and disability.

Gender Pay Gap reporting presents data on the difference in average pay between **those who identify as male and those who identify as female.** There is an important distinction between this and ‘equal pay reporting’, which is instead concerned with males and females earning equal pay for the same (or equivalent) work.

How publishing the Gender Pay Gap supports change and improvement

Disparity in pay can have a lasting socioeconomic impact.

Publishing the Annual Gender Pay Gap Report sheds light on the differences in pay between male and female employees and helps us to raise awareness and act to reduce disparities.

This approach helps promote fairness and accountability and helps us to push for a shift towards equality in the workplace, in turn, this enhances our ability to retain skilled employees.

Executive Summary

The headcount at UHD increased by 199 people to 10,048 in the year to March 2025 with 121 more females and 78 more males.

UHD experienced an increasing Gender Pay Gap of in 2025, the first year since 2020 that the Gender Pay Gap had increased.

Significant analysis has been undertaken to understand why the gap increased during the year to March 2025.

Our action plan to address this adverse trend is informed by the Equality Six High Impact Actions are includes:

- ✓ Board level focus.
- ✓ Supporting our Executive-led Women's Network to play an increasingly prominent role at UHD and to lead on the equality 'High Impact Actions.'
- ✓ Positive action to make senior jobs more accessible to female colleagues including reviewing our recruitment and selection processes.
- ✓ Improving opportunities to address work-life balance.
- ✓ Aiming to increase staff satisfaction that UHD values their work.

Equality Six High Impact Actions

1. Leadership & Accountability
2. Inclusive Recruitment
3. Career Development & Progression
4. Workplace Adjustments and Support
5. Data Transparency & Monitoring
6. Culture & Engagement

Summary of the Gender Pay Gap and the changes between 2024 and 2025

Gender Pay Gap Reporting University Hospitals Dorset NHS Foundation Trust		2024-25	Previous Year (2023-24)	Change 24.25 v 23.24
Substantive Headcount	Female	7420	7299	⇧ 121
	Male	2628	2550	⇧ 78
	Total	**10048**	**9849**	
	Female	73.85%	74.11%	⇩ -0.26%
	Male	26.15%	25.89%	⇧ 0.26%
Difference in hourly rate	Mean Average	19.30%	18.37%	⇧ 0.93%
	Median	4.83%	2.30%	⇧ 2.53%
Proportion of females in each pay quartile	Lower	74.93%	75.80%	⇩ -0.87%
	Lower middle	76.89%	75.75%	⇧ 1.14%
	Upper middle	80.32%	81.16%	⇩ -0.84%
	Top	64.06%	65.01%	⇩ -0.95%
Who received bonus pay	Female	2.48%	2.40%	⇧ 0.08%
	Male	10.31%	10.67%	⇩ -0.35%
Difference in bonus pay	Mean Average	31.57%	32.79%	⇩ -1.22%
	Median	0.00%	0.00%	⇨ 0.00%
Our Gender Pay Gap is -		**4.83%**	**2.30%**	

Headline data – we saw a worsening of the gap from 2.30% in 2024 to 4.83% in 2025, based on the median

How we calculate the Gender Pay Gap

- We use a 'snapshot date of 31 March 2025', using the national Electronic Staff Record (ESR) Business Intelligence Standard Report on Gender Pay Gap.
- In line with NHS Employers guidance, Local Clinical Excellence Awards (LCEAs), a scheme for Medical Consultants, have been categorised as bonuses.
- **Pay includes** basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay.
- Bonus pay is included, but only as a separate metric, as one of the six key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay; bonus pay is not hourly.
- **Pay does not include** overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. childcare vouchers), redundancy pay and tax credits.

The UHD workforce - gender demographics

The gender split within the overall workforce is 73.8% identifying as female and 26.2% identifying as male. The breakdown of the proportion of females and males in each Agenda for Change banding is as set out in the table.

	Latest Year 2024-25				
	Female		Male		Total
Pay Band	Headcount	%	Headcount	%	
Band 1	4	25.0%	12	75.0%	16
Band 2	548	61.7%	340	38.3%	888
Band 3	1671	78.6%	455	21.4%	2126
Band 4	572	84.4%	106	15.6%	678
Band 5	1502	79.7%	383	20.3%	1885
Band 6	1276	83.6%	251	16.4%	1527
Band 7	867	80.8%	206	19.2%	1073
Band 8a	192	69.1%	86	30.9%	278
Band 8b	91	67.9%	43	32.1%	134
Band 8c	27	57.4%	20	42.6%	47
Band 8d	13	59.1%	9	40.9%	22
Band 9	9	56.3%	7	43.8%	16
VSM	5	41.7%	7	58.3%	12
Non-Executive Director	4	44.4%	5	55.6%	9
Chair	0	0.0%	1	100.0%	1
Other	0	0.0%	1	100.0%	1
Consultant	214	41.7%	299	58.3%	513
Non-Consultant Career Grade	68	42.0%	94	58.0%	162
Trainee Grade	357	54.1%	303	45.9%	660
Total	**7420**	**73.8%**	**2628**	**26.2%**	**10048**

The Gender Pay Gap data

What we analyse and publish in our Gender Pay Gap Annual Report is mandated through the Equality Act (Gender Pay Gap Information) Regulations, and there are **six specific pay-related metrics:**

1. The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
2. The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
3. The difference between the mean bonus pay to male relevant employees and that paid to female relevant employees.
4. The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees.
5. The proportions of male and female relevant employees who were paid bonus pay.
6. The proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

Understanding the data

One of the key purposes of the Gender Pay Gap Annual Report is to analyse the data and highlight trends that can be addressed.

Because the GPG data for 2025 showed an adverse trend between the 2024 and 2025 Annual Report data we have done more detailed analysis to seek to find out what caused this adverse trend.

The factors driving such a change are complex.

- The mean gender pay gap for UHD overall in 2025 was 19.30% an increase from 18.37% in 2024.
- UHD's mean hourly pay for female staff was £20.99 and £26.02 for male staff, a difference of £5.02.
- UHD's median hourly pay for female staff was £18.82 and £19.78 for male staff, a difference of £0.95.

HOW TO CALCULATE MEAN AND MEDIAN

- The ***Mean and Median*** are two ways to represent a set of numbers, also called a data set.
- The ***Mean*** represents the *average* of the numbers.
- The ***Median*** represents the *middle* number.

Mean	Median
When to apply	
• Data is continuous, discrete, or numeric. • Data is normally distributed • Data is symmetrically distributed.	• Data has outliers. • Data is skewed. • For the order or ranking reporting. • For clusters, buckets, or groups reporting.
When Not to use	
• Categorical data • Data has extreme values or outliers. • Skewed distribution	• Categorical nominal data
Examples	
• Transactions, activities per user per day • Frequency of user activity • Student grades or performance report • Growth rate • The rate of change for churn or retention	• Salaries, age groups, etc., if skewed • Total miles, activities, or meals logged, if skewed • Time spent to complete a log, onboarding, activation • Ticket resolution time • Outage reporting

How pay changes at UHD

- The Agenda for Change (AfC) pay scales are reviewed each year, by national Pay Review Bodies (PRB), and a percentage uplift may be agreed, usually from 1 April each year.
- This annual change to pay scales is usually applied consistently across all AfC pay bands but may be a different percentage for Medical colleagues.
- The pay scales have 'increments' and people may move up within the pay scale as they spend more time at UHD.
- Pay may be affected by doing additional work that attracts a 'premium' rate of pay including working at weekends, on bank holidays and doing 'overtime'.
- Pay may also increase because people are promoted or decrease if they take a role at a lower AfC Banding.
- Most people do not receive bonuses, but Consultant Medical colleagues may receive Clinical Excellence Awards.

Understanding how changes in pay have influenced the gender pay gap

Hourly Rate Change (2025 v 2024)	Female	Male
Decrease	15.6%	14.6%
£1 - £5 increase	78.8%	70.2%
£6 - £10 increase	4.8%	13.6%
£11 - £15 increase	0.6%	1.3%
£16 - £20 increase	0.1%	0.1%
>£20 increase	0.1%	0.1%
Total	**100.0%**	**100.0%**

Proportion of Males and Females in each Quartile Pay Band

The proportion of all staff group females reduced between 2024 and 2025 - except Quartile 2.

Ordinary Pay - Headcount x Quartile & Staff Group

All Staff Groups

	2024-25				Previous Year (2023-24)			
	Female		Male		Female		Male	
Quartile	Count	Proportion	Count	Proportion	Count	Proportion	Count	Proportion
1 (Lower)	1946	74.93%	651	25.07%	1948	75.80%	622	24.20%
2 (Lower middle)	1996	76.89%	600	23.11%	1946	75.75%	623	24.25%
3 (Upper middle)	2085	80.32%	511	19.68%	2085	81.16%	484	18.84%
4 (Top)	1663	64.06%	933	35.94%	1670	65.01%	899	34.99%
Grand Total	**7690**	**74.05%**	**2695**	**25.95%**	**7649**	**74.43%**	**2628**	**25.57%**

Non-Medical Staff Groups

	2024-25				Previous Year (2023-24)			
	Female		Male		Female		Male	
Quartile	Count	Proportion	Count	Proportion	Count	Proportion	Count	Proportion
1 (Lower)	1945	74.95%	650	25.05%	1948	75.83%	621	24.17%
2 (Lower middle)	1976	76.89%	594	23.11%	1905	76.41%	588	23.59%
3 (Upper middle)	1999	81.79%	445	18.21%	1978	82.73%	413	17.27%
4 (Top)	1137	78.47%	312	21.53%	1220	78.86%	327	21.14%
Grand Total	**7057**	**77.91%**	**2001**	**22.09%**	**7051**	**78.34%**	**1949**	**21.66%**

Bonus Pay*

**Bonus Pay includes both local and national awards, and includes Discretionary Points.*

	2024-25		
	Female	Male	Female change 24.25 v 23.24
Number of Staff Receiving Bonus Pay	184	271	⇧ 9
Proportion of All Staff Receiving Bonus Pay	2.5%	10.3%	⇧ 0.1%
Proportion of Medical Staff Receiving Bonus Pay	28.8%	38.9%	⇩ -0.2%
Average (mean) Bonus Pay Received	£5,499.84	£8,037.23	⇩ -£8.82
Difference in Bonus Pay - Mean Average	£2,537.39		⇩ -£149.60
Average Bonus Pay Gap	31.57%		⇩ -1.2%
Median Bonus Pay Received	£3,643.47	£3,643.47	⇧ £139.81
Difference in Bonus Pay - Median	£0.00		⇨ £0.00
Median Bonus Pay Gap	0%		⇨ 0.0%
Minimum Bonus Pay Received	£452.40	£3,015.97	⇩ -£60.37
Maximum Bonus Pay Received	£33,803.43	£47,582.04	⇧ £139.81

Clinical Excellence Awards Payments

UHD does not have a local approach to 'bonus payments' other than following the national schemes for Consultant Medical colleagues

The Local Clinical Excellence Awards LCEA) ceased in 2024. When the LCEA was in place payments were distributed equally to all eligible Medical Consultants.

Some pre-2018 awards continue.

A new scheme is being introduced the National Clinical Impact Award (NCIA) scheme. At UHD we do have current NCIA award holders and Medical Consultants can apply for a new award at any time after they have completed a full year in an eligible role, with a permanent NHS contract (fixed-term and locum contracts are not usually eligible). If they already hold an LCEA granted under the old scheme, transitional arrangements apply in England between the old and the new schemes.

Explanations of the adverse trend

- In 2025 UHD saw a reduction in the lowest banded roles (Band 1 and 2) and an increase in male staff in Band 3. Lower paid male colleagues were paid more than in the previous year.
- UHD had a higher proportion of males in **trainee roles**, than the proportion of females in trainee roles.
- The impact of proportionality; there are fewer males employed at UHD, but males disproportionately occupy the more senior bands. So even though the pay rates will be equal, the overall median pay for males will be higher (Medical Consultants and in Bands 8-9):

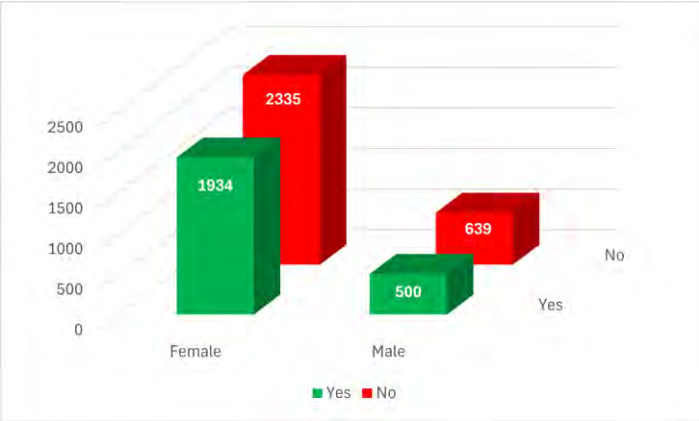
	Female		Male	
	Headcount	% of females at UHD	Headcount	% of males at UHD
Bands 8 - 9	332	4.5%	165	6.3%
VSM / Exec	5	0.1%	7	0.3%
Medical - Consultant	214	2.9%	299	11.4%
Medical - Career Grade	68	0.9%	94	3.6%

- We are investigating whether a higher proportion of males reached an increment in 2025.
- For the staff who joined or left in the last two years, they also follow a similar pattern with males tending to be in higher bands.

How people perceive their pay, how they are valued, and flexibility at UHD: Staff Survey 2024

5689 staff responded to the 2024 survey – Female (4269) and Male (1139)*

Q. 4b The extent to which my organisation values my work (Satisfied/Very satisfied):

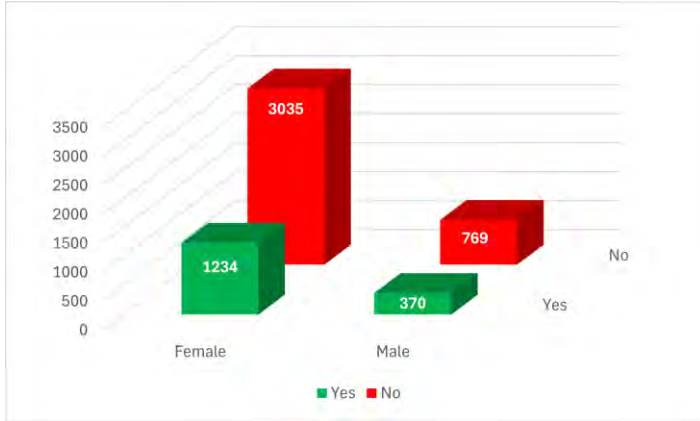


45.3% of female employees said that they were satisfied that the organisation values their work. This was an **increase** of **0.4%** on our 2023 result.

43.9% of male employees said that they were satisfied that the organisation values their work, a **1.2% decrease** from the previous years' result.

The gap between male and female satisfaction has widened in the 2024 staff survey, with a difference of 1.4% in satisfaction, compared to 0.2% difference in 2023.

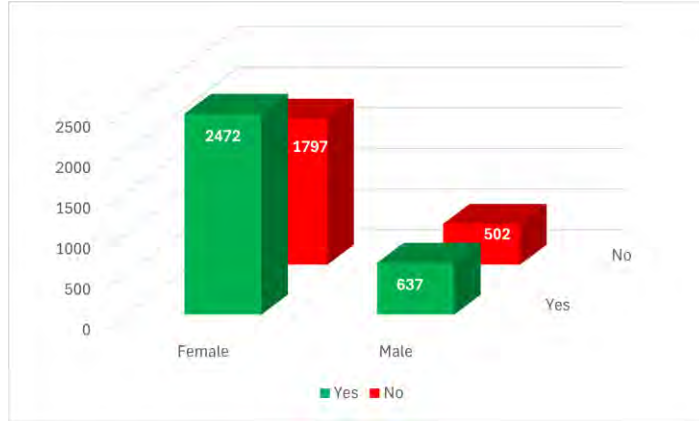
Q. 4c My level of pay (Satisfied/Very satisfied):



28.9% of female staff said they were satisfied with levels of pay. This was a **1.5% increase** from 2023. 32.5% of male employees said they were satisfied, a **significant increase** of **6.9%** from the previous years' result.

These responses highlight a reduction in dissatisfaction on pay levels by both males and females. However, the gap between male and female satisfaction has doubled since 2023, from 1.8% to **3.6%**.

Q. 4d The opportunities for flexible working patterns (Satisfied/Very satisfied):



57.9% of female employees said they were satisfied with the opportunities for flexible working patterns, a **slight decrease** of **0.3%** from the previous year. Meanwhile, 55.9% of male staff which had **improved** by **2.8%** from 2023.

This demonstrates a disparity in satisfaction among male and female staff in relation to opportunities for flexible working.

How we are responding

To promote fairness and accountability and our drive for equality in the workplace, we are refreshing our annual **Gender Pay Gap Action Plan**

Up-date from the UHD 2024 Gender Pay Gap Action Plan – agreed eight actions

Action Plan	Progress Update
Communicate Gender Pay Gap information	Published on intranet and internet and shared across UHD.
Continue UHD's commitment to an equitable workforce	Demonstrated in our objectives, values and the wider EDI action plan.
Continue equitable access to leadership training and development	We are continuing to deliver UHD Leadership Programmes and expand opportunities through Bournemouth University and with partners across the Integrated Care System.
Support all staff in protected groups through living our values and implementing our People and Culture Strategy	Work is underway to assess delivery against the UHD People and Culture Strategy, linked to the national NHS People Promise, and to refresh the strategy. The UHD Equality Delivery System (EDS) Assessment has identified areas where protected characteristics should be recorded, including Occupational Health, Employee Relations Cases, Education, and Continuous Professional Development.
Flexible working – Raising the profile of the benefits of Flexible Working across UHD	With UHD's Flexible Working Policy, positive progress is being achieved through greater staff engagement, improved work–life balance, and a stronger culture of inclusion, supported by enhanced communication. 38% of the total UHD workforce were part-time in 2025 (46% of the female workforce and 18% of the male workforce)
Career Progression - Accessible bite-sized and online training to ensure development can be accessed by those working part-time and flexible work patterns.	UHD currently provides increased access to online leadership training modules, rotating across different days and times to improve accessibility. The managers' induction highlights the UHD approach to compassionate and inclusive leadership. The Conscious Inclusion Workshops have replaced the traditional 'bias-focused' training.
Introduce a Women's Network.	The network is now established, with three hundred members, and is working in collaboration with other UHD staff networks, the ICS, and with Dorset Police to expand its reach and influence. The Women's Network meets monthly: it has had nine meetings to-date and has organised two events focused on Menopause Awareness and International Women's Day (8 March).
CEA awards – will be more inclusive, transparent, and fair and will reward excellence and improvement, underpinning the delivery of local priorities.	New Local Clinical Excellence Awards ceased to exist as part of the Medical Consultant pay negotiations in 2024 and the payments were distributed equally to all eligible Medical Consultants, regardless of gender. In 2025 UHD had 214 female Medical Consultants and 299 male.

Offer	Total (2024/25	Male	Female
Manager's Induction	163	26 (16%)	137 (84%)
Coaching Conversations	119	11 (9%)	108 (91%)
Feedback Skills Workshop	130	11 (8%)	119 (92%)
Courageous Conversations	27	3 (11%)	24 (89%)
Leading Through Change	88	13 (15%)	75 (85%)
Conscious Inclusion	75	3 (4%)	72 (96%)
Leadership Fundamentals	21	1 (5%)	20 (95%)
Leadership in Action	14	2 (14%)	12 (86%)
Bournemouth University Level 7 Senior Leaders Apprenticeship	6	3 (50%)	3 (50%)

Refresh of the *Pay Gap Action Plan for 2025 – linked to the Equality, Diversity, and Inclusion

High Impact Actions

*Our Pay Gap Action Plan is blended to include actions on the gender, ethnicity and disability pay gaps

EDI High Impact Action	Pay Gap Interventions
1. Leadership & Accountability	• Include EDI objectives in Board and senior leader appraisals. • Publish progress updates and Board representation metrics.
2. Inclusive Recruitment	• Implement inclusive recruitment training for hiring managers. • Ensure that HR Business Partners track all vacancies at Band 8A and above and support positive action in recruitment and selection (Band 7 and above from 2027/28). • Introduce clear guidance and requirements for a diverse selection panel.
3. Career Development & Progression	• Work with the Women's / Pro-ability and Diverse Ethnicity Network to identify key areas of interest that support career opportunities. • Record promotion rates by gender / race / disability status – to inform positive action in subsequent years. • Establish status reports on appraisals and personal development plans for staff with protected characteristics of race/ living with a long-term condition and gender. • Focus for colleagues in Band 1 to assess opportunities for progression. • Assess demographic data for Band 8-9 and Consultant Medical colleagues to assess impact on pay gaps in future years.
4. Workplace Adjustments and Support	• Gather feedback on the impact/ benefit of phased returns, flexible hours and keeping in touch programmes so women can reintegrate smoothly without career setbacks and improvements proposed for subsequent years • Promote well-being/ health check-ins and connect staff with support platforms like Thrive Live.
5. Transparency	• Continue to publish and communicate Pay Gap data (gender / disability / ethnicity) including in-year tracking of data trends. • Link pay gap data to Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Data. • Encourage declaration of disability.
6. Culture & Engagement	• Increase bespoke listening events and open space discussions. • Continue campaigns such as International Women's Day, women's health, disability and ethnicity-based campaigns and Thrive Live. • Implement the next phase of the Behavioural Charter to promote civility, respect, and professionalism at UHD, supporting improved retention and progression of all staff. • Promote zero-tolerance stance on bullying, harassment, and discrimination.

In conclusion

UHD is committed to advancing genuine equality across our workforce

In the year to 31 March 2025 UHD experienced an increasing Gender Pay Gap

The 2025 results have brought about a helpful focus on understanding the trends highlighted by the data.

There is confidence in the refreshed Gender Pay Gap Action Plan.

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Gender Pay Gap Annual Report

Compiled by the Organisational Development Team

March 2025

University Hospitals Dorset
NHS Foundation Trust

The strategic aim for UHD is for there to be no ethnicity-based pay gap.
The positive trend is that, in the second year of reporting, the Ethnicity Pay Gap at UHD, based on the median, decreased from –1.13% in 2024 to -0.75% in 2025.

Appendix One: Part A – Ethnicity Pay Gap

Ethnicity Pay Gap Reporting
University Hospitals Dorset NHS Foundation Trust

		2024-25	*Previous Year (2023-24)*	*Change 24.25 v 23.24*
Substantive Headcount	BME	2619	*2349*	⇧ *270*
	White	7155	*7227*	⇩ *-72*
	Total	**9774**	***9576***	
	BME	26.80%	*24.53%*	⇧ *2.27%*
	White	73.20%	*75.47%*	⇩ *-2.27%*
Excluded due to no declaration on ESR	Headcount	274	*273*	⇧ *1*
	Proportion	2.73%	*2.77%*	⇩ *-0.04%*
Difference in hourly rate	Mean Average	0.23%	*-1.02%*	⇧ *1.25%*
	Median	-0.75%	*-1.13%*	⇧ *0.38%*
Proportion of BME staff in each pay quartile	Lower	20.82%	*17.80%*	⇧ *3.02%*
	Lower middle	32.32%	*29.63%*	⇧ *2.69%*
	Upper middle	29.74%	*29.04%*	⇧ *0.70%*
	Top	24.27%	*21.15%*	⇧ *3.11%*
Who received bonus pay	BME	3.89%	*4.30%*	⇩ *-0.41%*
	White	4.60%	*4.43%*	⇧ *0.17%*
Difference in bonus pay	Mean Average	19.52%	*18.77%*	⇧ *0.76%*
	Median	0.00%	*0.00%*	⇨ *0.00%*
Our Ethnicity Pay Gap is -		**-0.75%**	***-1.13%***	

Our Pay Gap Action Plan includes actions to pursue pay equality for all ethnicities.

Appendix One: Part B – Ethnicity Pay Gap

2025 key data on ethnicity at UHD

2025: median BME pay was £19.07 compared to £18.92 for white colleagues:

Median Ethnicity Pay Gap - Ordinary Pay

	2024-25			Previous Year (2023-24)		
	BME	White	% difference	BME	White	% difference
All Staff	£19.07	£18.92	-0.75%	£17.88	£17.69	-1.13%
Non-Medical Staff Groups	£17.73	£17.98	1.42%	£16.75	£16.68	-0.44%
Medical Staff Group	£33.55	£51.38	34.71%	£30.28	£44.91	32.58%

2025: 'bonus' pay (for Medical Consultants only):
the gap increased slightly, 18.8% to 19.5%. A high proportion of Medical Consultant colleagues did not record their ethnicity:

Between 2024 and 2025 the UHD headcount increased by 198, with 270 more BME colleagues, and 72 fewer white colleagues.

Bonus Pay*

**Bonus Pay includes both local and national awards, and includes Discretionary Points.*

	2024-25			Previous Year (2023-24)	
	BME	White	BME change 24.25 v 23.24	BME	White
Number of Staff Receiving Bonus Pay	102	329	⇧ 1	101	320
Proportion of All Staff Receiving Bonus Pay	3.9%	4.6%	⇩ -0.4%	4.3%	4.4%
Proportion of Medical Staff Receiving Bonus Pa	18.8%	45.9%	⇩ -1.8%	20.6%	44.6%
Average (mean) Bonus Pay Received	£6,040.59	£7,506.00	⇩ -£185.39	£6,225.98	£7,664.44
Difference in Bonus Pay - Mean Average	£1,465.41		⇧ £26.96	£1,438.45	
Average Bonus Pay Gap	19.52%		⇧ 0.8%	18.8%	
Median Bonus Pay Received	£3,643.47	£3,643.47	⇧ £139.81	£3,503.66	£3,503.66
Difference in Bonus Pay - Median	£0.00		⇨ £0.00	£0.00	
Median Bonus Pay Gap	0%		⇨ 0.0%	0.0%	
Minimum Bonus Pay Received	£3,643.47	£452.40	⇧ £139.81	£3,503.66	£33.51
Maximum Bonus Pay Received	£39,835.47	£47,582.04	⇧ £139.81	£39,695.66	£47,582.04
Number of Staff Receiving Bonus Pay Excluded Due to No Ethnicity Recorded on ESR	24			26	

The strategic aim for UHD is for there to be no disability-based pay gap.
There appears to be a positive trend, based on the median, a gap of –12.29% in 2024 to -8.56% in 2025.

Appendix Two: Part A – Disability Pay Gap

Disability Pay Gap Reporting
University Hospitals Dorset NHS Foundation Trust

		2024-25	Previous Year (2023-24)	Change 24.25 v 23.24
Substantive Headcount	Disabled	741	663	⇧ 78
	Non-Disabled	7973	7784	⇧ 189
	Total	**8714**	***8447***	
	Disabled	8.50%	*7.85%*	⇧ *0.65%*
	Non-Disabled	91.50%	*92.15%*	⇩ *-0.65%*
Excluded due to no declaration on ESR	Headcount	1334	*1402*	⇩ *-68*
	Proportion	13.28%	*14.23%*	⇩ *-0.96%*
Difference in hourly rate	Mean Average	11.72%	*11.73%*	⇩ *-0.02%*
	Median	8.56%	*12.29%*	⇩ *-3.73%*
Proportion of disabled staff in each pay quartile	Lower	10.93%	*10.90%*	⇧ *0.03%*
	Lower middle	8.53%	*7.71%*	⇧ *0.82%*
	Upper middle	8.11%	*6.36%*	⇧ *1.75%*
	Top	5.67%	*5.68%*	⇩ *-0.01%*
Who received bonus pay	Disabled	0.81%	*0.75%*	⇧ *0.06%*
	Non-Disabled	3.96%	*3.88%*	⇧ *0.08%*
Difference in bonus pay	Mean Average	-12.93%	*-3.42%*	⇩ *-9.50%*
	Median	-41.39%	*0.00%*	⇩ *-41.39%*
Our Disability Pay Gap is -		**8.56%**	***12.29%***	

Our Pay Gap Action Plan includes actions to pursue pay equality for those with disabilities

Appendix Two: part B – Disability Pay Gap

2025 key data on disability at UHD

2025: median pay for colleagues who had declared a disability was £17.46 compared to £19.09

In 2025 the number of colleagues who declared a disability was 741 (as recorded on the Electronic Staff Record.1200 declared a disability through the 2025 Staff Survey). 1,334 colleagues were excluded from the disability pay gap data because they made no declaration: 13.3% of the UHD workforce.

Ordinary Pay - Pay Gap x Staff Group

Average (Mean) Disability Pay Gap - Ordinary Pay

	2024-25			Previous Year (2023-24)		
	Disabled	Non-Disabled	% difference	Disabled	Non-Disabled	% difference
All Staff	£19.50	£22.08	*11.72%*	£17.94	£20.33	*11.73%*
Non-Medical Staff Groups	£18.13	£19.23	*5.73%*	£16.82	£18.00	*6.55%*
Medical Staff Group	£33.45	£41.73	*19.84%*	£29.47	£37.00	*20.34%*

Median Disability Pay Gap - Ordinary Pay

	2024-25			Previous Year (2023-24)		
	Disabled	Non-Disabled	% difference	Disabled	Non-Disabled	% difference
All Staff	£17.46	£19.09	*8.56%*	£15.65	£17.85	*12.29%*
Non-Medical Staff Groups	£16.53	£18.04	*8.36%*	£14.73	£16.89	*12.80%*
Medical Staff Group	£29.05	£35.37	*17.85%*	£25.71	£31.35	*17.99%*

2025: 'bonus' pay (for Medical Consultants only); a high proportion of colleagues did not record their status regarding disability:

Bonus Pay*

**Bonus Pay includes both local and national awards, and includes Discretionary Points.*

	2024-25			Previous Year (2023-24)	
	Disabled	Non-Disabled	Disabled change 24.25 v 23.24	Disabled	Non-Disabled
Number of Staff Receiving Bonus Pay	6	316	↑ 1	5	302
Proportion of All Staff Receiving Bonus Pay	0.8%	4.0%	↑ 0.1%	0.8%	3.9%
Proportion of Medical Staff Receiving Bonus Pay	8.6%	30.0%	↑ 0.5%	8.1%	30.2%
Average (mean) Bonus Pay Received	£6,408.13	£5,674.62	↑ £506.43	£5,901.70	£5,706.39
Difference in Bonus Pay - Mean Average	-£733.52		↓ -£538.20	-£195.31	
Average Bonus Pay Gap	-12.93%		↓ -9.5%	-3.4%	
Median Bonus Pay Received	£5,151.45	£3,643.47	↑ £1,647.79	£3,503.66	£3,503.66
Difference in Bonus Pay - Median	-£1,507.98		↓ -£1,507.98	£0.00	
Median Bonus Pay Gap	-41%		↓ -41.4%	0.0%	
Minimum Bonus Pay Received	£3,643.47	£3,643.47	↑ £139.81	£3,503.66	£33.51
Maximum Bonus Pay Received	£12,691.47	£39,835.47	↑ £213.58	£12,477.89	£39,695.66
Number of Staff Receiving Bonus Pay Excluded Due to No Disability Declaration on ESR	133			140	

Disability Pride month is July

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 March 2026

Agenda item: **11.1**

COVER SHEET – ALERT, ADVISE, ASSURE	
TITLE:	The National Cancer Plan 2026 briefing
Prepared by:	Katie Lake, Head of Cancer Services
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)	All BAF
Purpose of paper:	Information
Executive summary:	UHD is now one of the largest providers of Cancer Care in the UK. We have an opportunity to become a Centre of Excellence in the future for our local population as well as supporting our staff recruitment and retention rates. The National Cancer Plan was published on World Cancer Day on March 4th, 2026. The plan sets out the ambitions of the government to deliver world class cancer outcomes by 2035. The plan has 3 core ambitions: • To meet all of the National Cancer Waiting Times standards by the end of this parliament. • By 2035, 3 out of 4 people with cancer will be cancer free or living well after 5 years. • Improve quality of life for those diagnosed and those going through treatment. The plan outlines 3 key shifts: • Analogue to Digital • Sickness to Prevention • Hospital to Community

	The key themes include: • Improved cancer performance • Becoming a global leader in cancer outcomes • Delivering care by design • Becoming leaders in research • Improving access for Children and Young Adults • Investing in rare cancers and genomics
ALERT:	n/a
ADVISE:	1. **Governance** – UHD need to establish a Cancer Board, as mandated in the plan to oversee the delivery of the cancer priorities. 2. **Strategy** – UHD does not currently have a Cancer Strategy. This is an opportunity to develop a strategy for the organisation that supports meeting the ambitions in this plan. 3. **Patient First** – UHD need to decide how a Cancer Strategy fits within the existing Patient First Programme.
ASSURE:	UHD have seen a sustainable improvement across the 28 Day Faster Diagnosis Standard and the 31 Day Decision to Treat Standard throughout 2025/2026. This plan provides further national clarity and support to work collaboratively with the Wessex Cancer Alliance to meet all of the constitutional standards, with a specific focus on the nationally challenged 62 Day Referral to Treatment target.
Celebrating Outstanding:	UHD have consistently achieved 90% in the annual National Cancer Patient Experience Survey.
RECOMMENDATION:	To note the contents of the briefing
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
UHD Cancer MDT Clinical Leads	25/02/2026	Briefing noted.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

The National Cancer Plan 2026

Briefing

Katie Lake
Head of Cancer Services

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

The National Cancer Plan 2026

VISION

To become a global leader in cancer survival by 2035

To meet all of the National Cancer Waiting Times Standards by the end of this parliament

By 2035, 3 out of 4 people diagnosed with cancer will be cancer free or living well after 5 years

Improve Quality of Life for those diagnosed and those going through treatment

Executive Summary

- Expect increased **performance** expectations and scrutiny to meet **waiting-time standards by 2029.**
- Prepare for expanded use of **digital and AI tools** to streamline diagnostics and clinical decision making
- Align local cancer service improvement with national investment in **technology, capacity and patient-centred pathways**.
- **Strategic workforce planning** will be critical to deliver on ambitious early diagnosis and personalised care targets.
- Focuses on **earlier diagnosis, geographical inequity, survival rates, 'left-shift', cancer vaccines and genomics**.
- Not a major policy change as such, it's about disciplined delivery and working differently across the system.
- Clear that there will be more intensive support and scrutiny and an expectation for **enhanced Executive level scrutiny.**

3 Shifts

Analogue → Digital
Sickness → Prevention
Hospital → Community

Links with the 10 Year Health Plan

"We must do better"

6 Key Themes

- ✓ Improved cancer performance
- ✓ Be a global leader in cancer outcomes
- ✓ Care by design
- ✓ Leaders in research
- ✓ Improving access for Children and Young Adults
- ✓ Investment in rare cancers and genomics

Reducing Health Inequalities is integral to the delivery of the National Cancer Plan

Considerations for UHD

- **Governance** – we need a Cancer Board with either Exec or non-Exec chair – mandated in plan.
- **Strategy** – we need a Cancer Strategy that is realistic but builds on this plan.
- We need to **support clinicians** to have the headspace to redesign for the future, not just working harder and doing more.
- A reformed **National Cancer Board** will be accountable for delivery of the National Cancer Plan – we need to ensure our internal governance can align with this and respond accordingly.
- There will be funding ring-fenced for cancer, totalling **£200 million in 2026 to 2027**. The funding, distributed through Cancer Alliances, will only be used for sustainable improvements to cancer delivery, that contribute to better performance and outcomes.
- **Cancer Alliances are being strengthened** – they will be able to fund secondments for senior managers from more successful trusts to poorer performing trusts, to help lead performance improvement programmes.

The National Cancer Plan 2026

VISION *To become a global leader in cancer survival by 2035*

We are now one of the largest providers of Cancer Care in the UK. We have an opportunity to become a Centre of Excellence in the future for our local population and staff recruitment and retention rates.

Initial thoughts & Challenges

There are 125 commitments – this is a lot to focus on to deliver a meaningful impact

- A good opportunity to improve our **governance** and have a clear plan for our **cancer ambitions**.
- No clear **workforce plan** that supports the plan, particularly with regards to psychological support for patients.
- Need to have **confirmed metrics** to quantify any improvement in outcomes, experience and research
- There is a significant focus on **AI and digital development**. We need to ensure we have the correct governance to manage this and collaborate with the Dorset & Somerset wide digital transformation programme.
- Performance will remain the focus with intensive scrutiny from regional teams and the expectation that **Cancer performance is prioritised** in the same way as Elective and UEC performance.
- An increased expectation for further system working including **single PTL management** and **single services** across larger footprints.
- **Targeted public health campaigns** to come with regards to tobacco, alcohol, vaping, GPL-1s, and sunbeds.
- What does the **estate for the future** need to be for cancer services to meet the increasing activity and ambitions in this plan?
- Need to hold this plan centrally through a programme board to ensure there is documented, transparent and co-ordinated central management.
- There will be more focus on **diagnostic productivity,** and we need to ensure cancer development collaborates with cross care group work and the CDC programme.
- **The focus on earlier diagnosis is the right thing to do** but UHD need to work with commissioners to ensure the referral impact is commissioned as we will see more activity and a lower conversion rate to diagnosed cancers.

How does this fit with our existing Patient First Programme?

Further information on Key Themes

Driving up NHS Cancer Performance

- **Harness innovations** to offer patients the right services, enable at-home tests, and prioritise care for those with the highest need.
- Scale up the use of **single –queue diagnostics** across local providers, supported by the Federated Data Platform
- **Transform outpatients** through straight to test pathways and expansion of patient initiated follow up.
- Prioritise cancer for **NHS Online**
- **Expand diagnostic capacity** by ensuring that, where possible, all Community Diagnostic Centres are fully operational 12 hours a day 7 days a week.
- **Ensure 98% if histology results** are back within **10 days** of the sample being taken
- Expects systems to use capital funding flexibly to support a return to constitutional standards, including further investment in **state-of-the-art radiotherapy machines** where needed.
- **Streamline MDT meetings**, increasing efficiency.

Improving Cancer Outcomes

- Roll out **lung cancer screening** nationally by 2030 and lower the sensitivity of bowel cancer screening.
- Enable patients to manage screening invitations, appointments and treatment plans using the **NHS App** by 2028.
- Develop and deliver more proactive approaches to identifying people at risk of cancer through **symptomatic case finding**, additional support for GPs and **genomic testing**.
- Provide greater access to **specialist cancer treatment centres** and improve approaches to quality monitoring.
- Establish clear **quality standards** for cancer delivery through **cancer manuals**, published by tumour type.
- Proactively prepare for **Multi-Cancer Early Detection tests** and similar breakthroughs

Designing care around people's lives

- Provide a **named neighbourhood care lead** for each patient, to co-ordinate post treatment care by 2035.
- Support patients to **stay in and return to work**
- Enable patients to provide real time feedback to clinicians, through **digital Patient Reported Outcome Measures**
- Roll out a **national digital first prehabilitation offer** to support patients before they start treatment – setting out new standards for prehabilitation and rehabilitation.
- Provide every cancer patient with a **holistic needs assessment and personalised care plan**, to support their physical, mental and social needs and employment support.
- Where safe, value for money, and better for patient care, deliver cancer care at home.

World class research

- **Expand access** to trials by improving digital trail finding tools and using genomic testing to open up personalised care treatment options.
- Ensure **faster and fairer access** to trials, reducing set-up times from 250 to 150 days and launching a Cancer Trials Accelerator Programme.
- Speed up adoption of proven innovations through a **clear cancer innovation pathway and the National HealthTech Access Programme** – including four new diagnostic technologies by 2027.
- Set clear national cancer research priorities, applying **data, AI, genomics, wearables and robotics** to accelerate progress
- By 2030, up to **10,000 cancer immunotherapies** will be delivered via the Cancer Vaccine Launch and Vaccine Innovation Pathway.

Children and Young Adult's Cancer

- Improve experiences of care by providing up to **£10m per year for travel costs** and ensuring child-friendly hospital food and play/youth support.
- **Improve early detection and diagnosis**, ensuring primary and emergency care clinicians can access paediatric advice for suspected cancer areas.
- Advance neighbourhood care by providing a **lead paediatrician in every Neighbourhood MDT**.
- Speed up diagnosis by ensuring imaging for suspected cancer in reported, or reviewed, by a **paediatric radiologist.**
- **Strengthen psychosocial and long-term support** by standardising access to psychological care, improving surveillance for late effects, and providing neurorehabilitation keyworker for children with CNS tumours.
- **Ensure equitable access to genomics and research** by making CYP genomics a core NHS Genomic Medicine Service deliverable and tackling age related barriers to clinical trials for 16-24 yr olds.

Prioritising rarer and less common cancers

- **Diagnose rarer cancers earlier** by reducing emergency diagnoses and expanding proactive care finding in primary care.
- **Improve access to specialist treatments** by developing specialist multi-provider MDTs and prioritising genomic testing.
- Expand access to clinical trials by **implementing the Rare Cancers bill from 2026** and using AI tools to match patients to studies.
- Give rarer cancer parity by appointing a **National Specialty Lead for Rare Cancers by 2026**.
- **Improve data transparency** by expanding NDRS Get Data Out publications and defining recurrent cancers by 2027.
- **Accelerate research and innovation through novel procurement routes**, increased research funding and mission-led models.

Reducing Health Inequalities is integral to the delivery of the National Cancer Plan

- ✓ Continue to roll out cancer screening and surveillance programmes which can specifically benefit those in underserved communities, including **lung cancer screening** and **community liver health checks**.
- ✓ Develop locally targeted campaigns to improve the awareness of cancer **risk factors**, reduce the gap in screening uptake and address barriers to **early diagnosis** in underserved communities.
- ✓ Roll out adjustments to existing screening programmes to improve take up in underserved communities such as **self-testing for cervical screening and mammography machines** that are accessible to people with physical disabilities.
- ✓ Create an **equal playing field on health literacy** utilising AI tools on the NHS App to make care less dependent on personal knowledge of health.
- ✓ Publish regular data and assess our performance to ensure we are **reducing the gap** in between the most and least deprived areas.

Consideration required for how the '3 Shifts' support the reduction of Health Inequalities in Cancer Care

→

Analogue → Digital
Sickness → Prevention
Hospital → Community

Part 1		07 May 2025	18 June 2025	02 July 2025	08 September 2025	5 November 2025	14 January 2026
Members Present	Beverley Bryant						
	Judy Gillow						
	Siobhan Harrington						
	Sarah Herbert						
	Tracie Langley						A
	John Lelliott	A					
	Femi Macaulay			A			
	Alastair Matthews						
	Michael Marsh						
	Helena McKeown				A		A
	Mark Mould						
	Pete Papworth						
	Sharath Ranjan						
	Richard Renaut						
	Cliff Shearman						
	Claire Whitaker						
	Melanie Whitfield						
	Peter Wilson					A	
In Attendance (excl Governors, members of public and non-Standing Invitees)	David Broadley						
	Terri Clark						
	Andrew Doe		A				
	Jamie Donald						
	Yasmin Dossabhoy						
	Paul Froggatt						
	Alison Honour						
	Eiri Jones						
	Phillipa Knight						
	Deborah Lane						
	Irene Mardon						
	Helen Martin						
	Deborah Matthews						
	Richard Moreman						
	Truda Scriven						
	Joanne Sims						
	Lorraine Tonge						
	Tara Vachell						
	Klaudia Zwolinska						A
Was the meeting quorate?		Y	Y	Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent