University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: May 2025

Contents

Key Achievements

In 2025/26 achievements to date have been :

- The overall number of people on a referral to Treatment (RTT) 18 week pathway continues to reduce significantly following commencement of a validation sprint and is now within the planned trajectory for May 2025.
- The percentage of RTT pathways at 18 weeks or less and the volune od pathwwyas over 52 weeks have met the planned trajectory for May .
- DM01 99% standard has been achieved by CT, Dexa, MRI and Ultrasound this month.
- The Trust delivered 113.9% (value weighted activity year to date) in 2025/26 compared to the 2019/20 baseline period, exceeding the operational plan and resulting in more patients being seen and treated.
- Improvements in agency usage and spend is now evident and below plan . Agency usage is flagging as special cause variation improvement.

Performance at a Glance Indicators (1)

			standard	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
SAFE																
Quality	Presure Ulcers (Hospital Acquired Cat 3 & 4)			11	9	15	11	13	14	9	10	10	16	13	12	17
	Inpatient Falls (Moderate +)			8	2	6	8	7	10	7	7	11	6	11	9	8
	Medication Incidents (All)			193	177	168	156	179	164	130	155	162	165	175	149	146
	Patient Safety Incidents (All)			1254	1092	1211	1173	1178	1334	1107	1219	1193	1216	1226	1115	1238
	Hospital Acquired Infections	MRSA		2	0	2	2	0	0	0	3	1	0	2	1	0
		MSSA		1	4	8	8	5	5	3	5	3	7	8	4	4
		C Diff		10	8	7	11	11	11	10	14	18	6	8	10	11
		E. coli		14	9	14	13	7	9	12	14	18	14	19	18	13
		Kleb		3	1	3	12	8	8	3	7	8	5	8	3	6
		Pseudo		1	1	3	1	0	5	2	3	4	2	0	3	2
	Hand Hygiene Compliance			96.2%	95.9%	96.0%	94.7%	95.6%	96.6%	96.2%	96.2%	96.2%	94.3%	95.7%	95.1%	94.3%
	Infection Control Mandatory Training Compliance			89.2%	89.0%	89.4%	90.1%	90.0%	89.9%	89.6%	89.6%	89.5%	89.2%	89.2%	88.9%	89.1%
EFFECTIVE																
Mortality	HSMR In Month (UHD)	Latest Feb 25		103.2	113.5	98.9	92.3	109.1	93.4	97.4	94.7	96.9	92.4			
	Deaths within 36hrs of Admission			24	39	32	18	28	22	33	44	41	33	34	25	26
	Deaths within 5 day readmission spell			19	20	15	16	23	21	18	22	22	22	17	11	18
CARING																
	Complaints Received			90	68	64	58	76	75	63	54	65	54	54	79	58
	Complaint Response Rate (Grade based target)			58.6%	54.9%	59.3%	48.6%	56.6%	64.7%	42.2%	33.9%	41.3%	31.5%	43.8%	51.7%	67.2%
	Friends & Family Test			94.6%	95.0%	94.5%	94.9%	99.5%	94.3%	94.2%	96.2%	96.0%	94.3%	93.5%	93.0%	94.3%
WELL LED																
Safety	Risks 12 and above on Register			33	46	45	44	59	67	68	65	65	70	73	63	64
	Risks 15 and above on Register			17	21	22	20	19	20	19	21	22	23	23	19	19
	Red Flags Raised			11	9	20	13	26	31	15	21	51	19	24	5	5
People	Turnover			10.7%	10.6%	10.5%	10.6%	10.7%	10.6%	10.6%	10.5%	10.6%	10.7%	10.7%	10.8%	11.0%
	Vacancy Rate	Reported 1 month in arrears		9.0%	8.3%	8.8%	8.6%	8.2%	6.6%	5.0%	5.1%	5.1%	4.8%	4.4%	7.4%	
	Sickness Rate (rolling 12 month)			4.4%	4.5%	4.6%	4.6%	4.6%	4.6%	4.6%	4.7%	4.7%	4.7%	4.8%	4.8%	4.8%
	Statutory and Mandatory Training			90.1%	90.2%	90.5%	90.9%	89.8%	90.1%	89.9%	90.2%	90.2%	90.4%	90.3%	89.9%	89.7%
	Appraisal Compliance - Values Based			59.4%	55.1%	55.8%	63.2%	71.5%	78.2%	81.2%	82.6%	83.4%	83.8%	84.2%	81.3%	75.9%
	Appraisal Compliance - Medical & Dental			78.6%	78.1%	79.7%	80.8%	77.9%	81.0%	82.8%	82.7%	84.8%	83.4%	85.0%	86.2%	87.0%
	Temporary Hours Filled by Bank			57.7%	61.3%	61.4%	62.1%	62.4%	60.7%	61.8%	57.5%	62.3%	63.9%	65.6%	65.8%	66.4%
	Temporary Hours Filled by Agency			22.0%	19.2%	18.5%	19.0%	19.4%	18.7%	18.2%	18.1%	15.6%	14.2%	13.0%	13.8%	14.3%
	Agency Pay as Proportion of Total Pay			3.5%	3.0%	3.0%	2.6%	2.7%	1.9%	2.0%	1.9%	1.7%	1.4%	0.8%	1.3%	1.4%

Performance at a Glance Indicators (2)

			standard	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	
RESPONSIVE																		
RTT	18 week performance % (92% standard)	61.2% (May 2025)		62.4%	61.1%	61.2%	61.1%	61.4%	60.8%	61.1%	60.5%	60.6%	59.9%	60.9%	60.8%	62.3%	RAG rated based on trajectory
	Waiting list size	67,842 (May 2025)		68,343	67,977	68,825	68,760	68,039	67,993	67,413	68,079	67,553	67,733	67,109	64,489	62,270	RAG rated based on trajectory
	No. patients waiting 52+ weeks	2,152 (May 2025)		2,960	2,999	2,841	2,532	2,226	2,177	2,172	2,044	2,167	2,216	2,184	2,261	2,065	RAG rated based on trajectory
	No. patients waiting 65+ weeks			393	472	459	351	65	48	16	16	29	32	10	5	15	
	No. patients waiting 78+ weeks		0	11	0	0	0	0	0	0	0	0	0	0	0	0	RAG rated based on trajectory
Theatre	Theatre utilisation (capped)		85%	81.7%	81.4%	81.2%	82.9%	80.3%	80.6%	81.9%	78.7%	78.3%	80.5%	80.9%	81.5%	81.3%	
	NOFs (Within 36hrs of admission rom ED - NHFD)		85%	51%	50%	47%	32%	80%	73%	72%	62%	74%	68%	47%	54%	49%	
Outpatients	**Outpatient metrics**																	
	Overdue Follow up Appts			26,046	25,642	25,492	25,407	25,706	25,658	25,982	27,881	28,813	27,688	26,571	26,821	27,349	
	% DNA Rate		5%	5.3%	5.1%	5.1%	5.7%	5.5%	5.3%	5.6%	5.7%	5.1%	4.9%	4.8%	5.2%	5.1%	
	Patient cancellation rate			11.4%	11.6%	11.3%	11.2%	11.5%	11.2%	9.9%	11.4%	10.5%	10.4%	10.3%	10.2%	10.5%	
	% non face to face (telemedicine) attendances		25%	17.3%	17.1%	17.2%	16.6%	17.7%	17.3%	17.4%	18.0%	17.8%	17.3%	17.8%	17.2%	17.5%	
DM 01	**Diagnostic Performance (DM01)**																	
	% of >6 week performance		1%	12.9%	11.6%	12.5%	14.7%	13.2%	9.8%	10.6%	12.6%	14.5%	11.2%	7.5%	9.6%	9.7%	
Cancer	28 day faster diagnosis standard		75%	73.5%	73.1%	73.4%	65.5%	69.0%	75.6%	75.3%	78.1%	75.1%	81.2%	79.8%	72.1%	*72.1%*	*May cancer position provisional*
	62 day standard		85%	66.8%	69.0%	67.7%	69.4%	68.7%	67.0%	68.2%	70.6%	64.7%	65.0%	72.0%	68.2%	*67.6%*	
Emergency Dept	4 hour care standard	70.0% (May 2025)		72.5%	72.2%	73.5%	74.6%	72.5%	70.3%	70.0%	64.1%	70.6%	69.8%	72.1%	70.6%	70.8%	RAG rated based on trajectory
	Arrival time to initial assessment		15	19.0	20.0	19.0	17.0	18.0	17.0	18.0	18.0	15.0	18.0	19.0	20.0	20.0	
	Clinician seen <60 mins %			29.9%	28.8%	28.7%	33.7%	30.6%	29.9%	31.6%	27.8%	43.4%	33.4%	29.7%	29.9%	28.6%	
	Patients >12hrs from DTA to admission		0	214	171	140	39	139	227	136	428	510	294	305	207	142	
	Patients >12hrs in dept			801	785	702	400	705	924	652	1312	1163	946	1043	873	684	
SWAST SCAST	Ambulance handovers			4336	4082	4052	4165	4087	4250	4151	4318	4048	3744	4197	4192	4223	
	Ambulance handovers - average hours lost UHD			30	31	28	24	30	32	27	40	36	34	38	36	36	
	Ambulance handovers - average hours lost RBH			33	36	33	26	31	36	28	45	39	38	38	40	40	
	Ambulance handovers - average hours lost Poole			26	27	24	23	28	27	25	35	32	33	37	32	32	
	Ambulance handover >60mins breaches			312	357	269	156	287	368	188	1072	476	421	541	494	523	
Patient Flow	Bed Occupancy (capacity incl escalation)		85%	93.7%	92.7%	93.6%	89.1%	91.6%	92.3%	92.0%	93.6%	94.5%	95.1%	93.0%	91.5%	92.6%	
	Stranded patients:																	
		Length of stay 7 days		512	510	545	507	529	518	505	532	571	559	555	541	529	
		Length of stay 14 days		324	327	343	329	337	324	320	322	369	354	346	339	328	
		Length of stay 21 days	108	230	229	237	234	236	222	225	218	252	245	232	233	216	
	Non-elective admissions			7030	6365	6668	6458	6161	6737	6823	6648	6573	5971	6724	6697	6798	
	> 1 day non-elective admissions			4193	3957	4086	4011	3926	4179	4238	4202	4079	3701	4118	4078	4105	
	Same Day Emergency Care (SDEC)			2629	2384	2581	2446	2234	2558	2584	2444	2492	2270	2603	2617	2689	
	Conversion rate (admitted from ED)		30%	30.30%	29.90%	31.20%	31.80%	30.00%	30.70%	32.50%	31.10%	32.00%	31.30%	30.50%	31.50%	29.70%	

Statistical Process Control (SPC) – Explanation of Rankings

Variation/Performance \ Assurance	P	?	F	
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
○	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
○				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Quality Outcomes & Safety Patient Experience

University Hospitals Dorset
NHS Foundation Trust

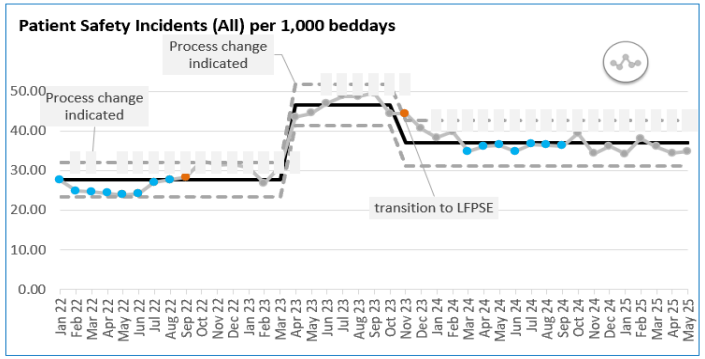
Sarah Herbert
Chief Nursing Officer
Dr Peter Wilson
Chief Medical Officer

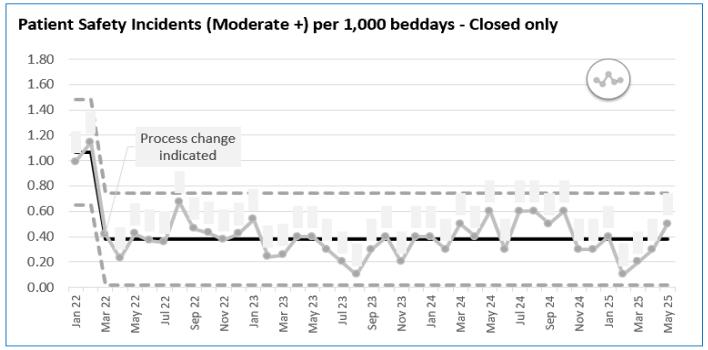
Operational Leads:
Vivian Alividza – Deputy Chief Nursing Officer (Workforce, Safeguarding)
Madeleine Seeley – Interim Deputy Chief Nursing Officer (Patient Experience, Clinical Practice)

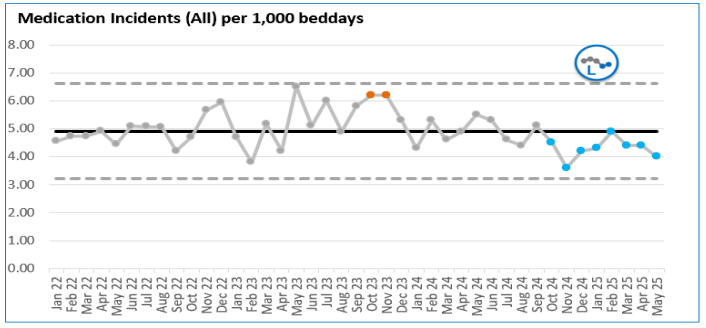
Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Quality (1) – Safe







Background/target description

To improve patient safety.
Number of patient safety incidents per 1,000 bed days
Number of patient safety incidents (moderate or above) per 1,000 bed days – closed only
Number of medication incidents (moderate or above) per 1,000 bed days

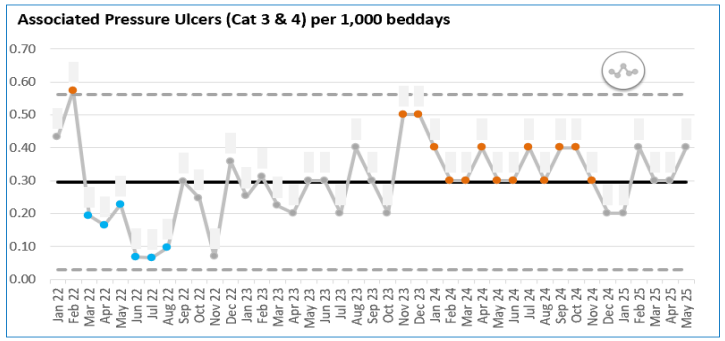
Performance

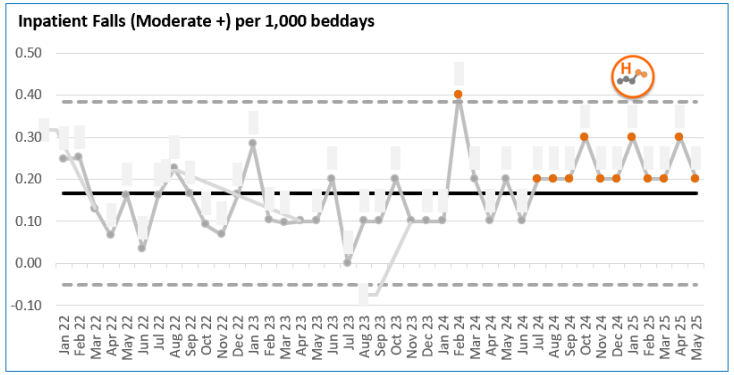
- The Trust transitioned to LFPSE in November 2023 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. The definition change significantly reduced the number of incidents reportable to LFPSE as a Patient Safety Incident.
- From 1 April 2024 the Trust has adopted the Patient Safety Incident Response Framework (PSIRF) and in October 2024 the new PSIRF/LERN Policy was approved. PSIRF investigation response tools are available on the Quality and Risk pages of the intranet.
- Increase in LERNs over last 3 months – audit and validation in progress.

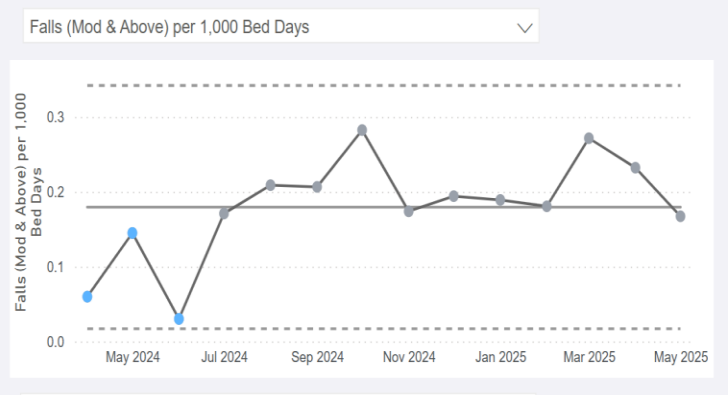
Key Areas of Focus

Full report on learning from completed patient safety incident investigations is included in CMO report to Quality Committee and Board. Learning is also shared via Safety Alerts, SBAR reports, LERN synopsis and the Clinical Governance Group (CCG) Top 10.

Quality (2) – Safe







Background/target description

To improve patient safety and care; supporting reduced length of stay. Data is reported 1 month arrears.

Performance

Clinical practice:

- 12 patients acquired 13 pressure ulcers of Category 3 during April 2025 and one pressure ulcer which evolved into a Category 4 damage was noted post discharge. Pressure damage was located on the sacrum/ buttocks (n=9), heel (n=3), hip (n=1) and ankle (n=1). Data remains within usual statistical variance
- One incident related to pressure damge due to a medical device (air cast boot)
- In 6 incidents all care was delivered as planned. 7 patient were nearing end of life and have since passed
- Learning points remain as gaps in timing of documented care delivery, gaps in efficacy of repositioning e.g. left to right side and consistent off-loading of the heels.
- Falls per 1,000 bed days May 2025: 6.1. Moderate and above harm falls per 1,000 bed days: 0.2.
- Overall figures remain within the expected range. Medical Care Group: Continued reduction in moderate and above harm falls over the last three reporting periods. Surgical Care Group: Increase in moderate and above harm falls over the same period.

•Falls resulting in fractures or head injuries remain consistently above the expected median of 5 per month, indicating a sustained area of concern.

•Audit & Compliance: NAIF rolling audit (Q1 2025): Demonstrates improvement in post-fall management. Falls assessment quality score: 20%, below the national average of 28%.

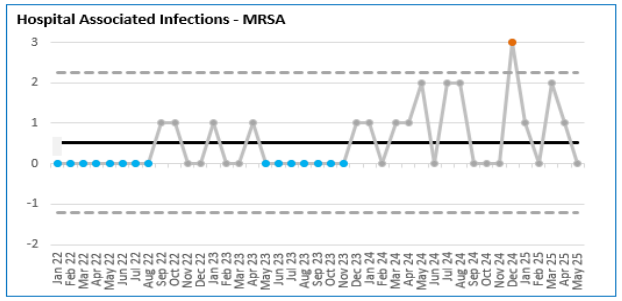
•NICE Guideline NG249 (April 2025): UHD is not fully compliant, particularly regarding updated falls assessment standard

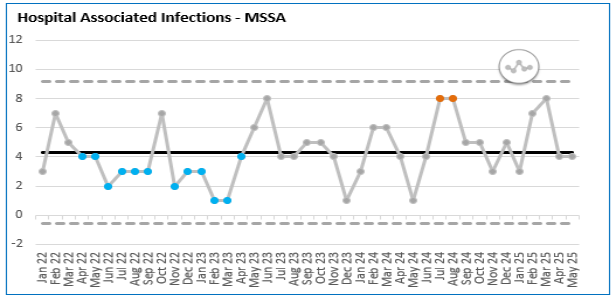
Key Areas of Focus

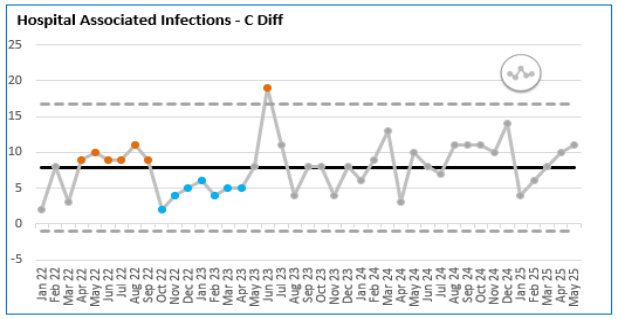
•The Falls Team has implemented a new working process to support timelier PSIRF (Patient Safety Incident Response Framework) responses, aiming to strengthen learning and reduce harm.

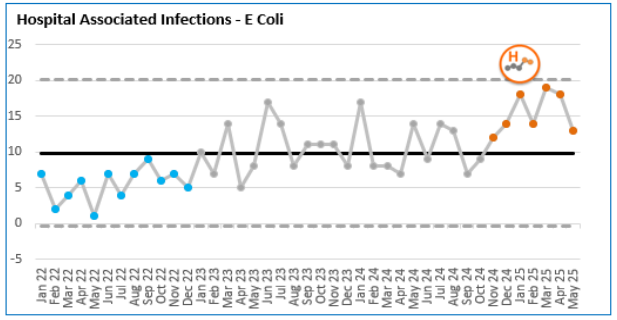
- Themes regarding learning from pressure ulcer incidents remain unchanged. Education sessions continue
- A pressure ulcer validation report for the year April 2024-March 2025, is currently being undertaken

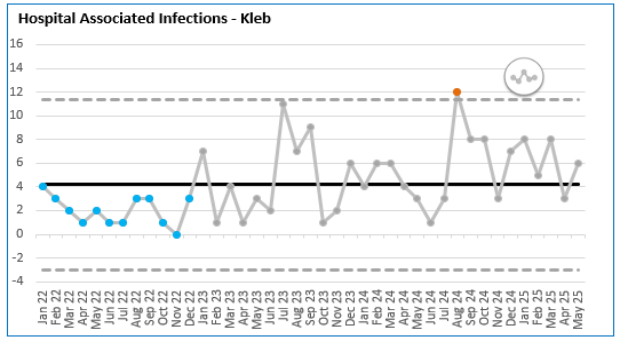
Quality (3) – Safe

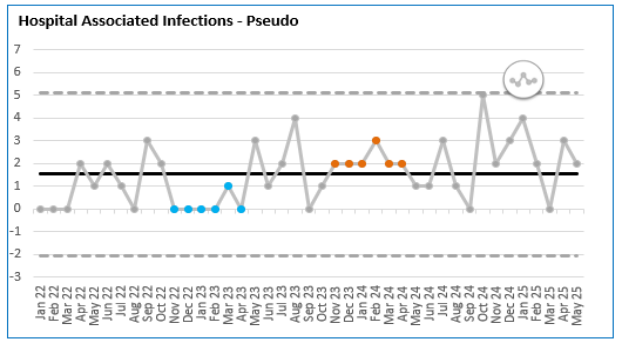












Background/target description

To improve patient safety and care; supporting reduced length of stay.

Performance

Infection Prevention and Control (IPC):

- There were no cases of MRSA bacteraemia identified in May 2025.
- There were 4 cases of MSSA bacteraemia in May 2025, static compared to April 2025. Case numbers remain at mean level.
- *Clostridioides difficile* cases increased in May 2025, above the mean level and taking the Trust over projected trajectory for Quarter 1.
- Cases of *Escherichia coli* bacteraemia decreased slightly in May 2025 showing a downward trajectory in Quarter 1 away from the upper control limit.
- Total number of cases of *Klebsiella* increased in May 2025 compared to April 2025, exceeding the mean level.
- Cases of *Pseudomonas* decreased in May 2025 compared to April 2025, moving towards the mean level.

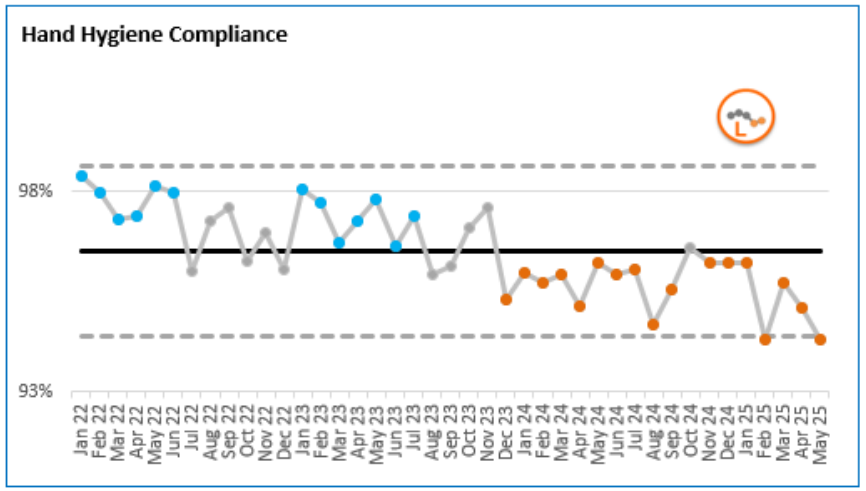
Key Areas of Focus

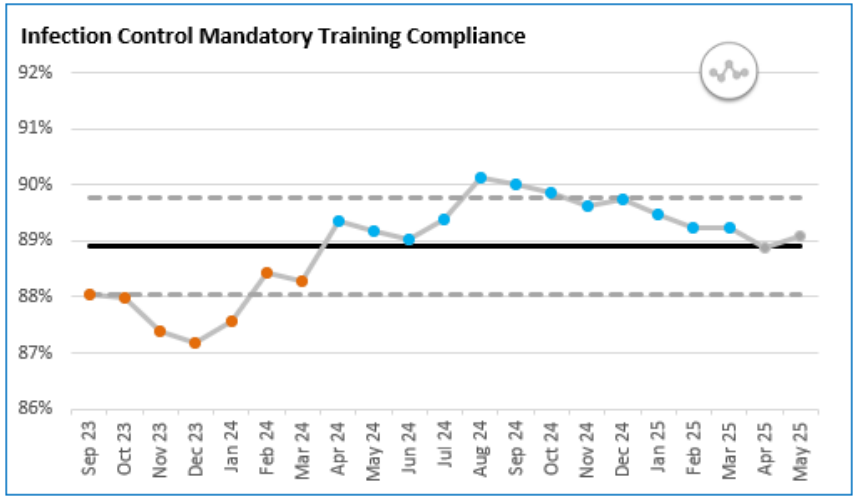
- Infection Prevention and Control (IPC) Summit focusing on fundamentals of IPC practice and empowerment of good practice at local level

Hospital Associated Infections Summary for IPR

Organism	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
MRSA	0	2	2	0	0	0	3	1	0	2	1	0
MSSA	4	8	8	5	5	3	5	3	7	8	4	4
C Diff	8	7	11	11	11	10	14	4	6	8	10	11
E Coli	9	14	13	7	9	12	14	18	14	19	18	13
Kleb	1	3	12	8	8	3	7	8	5	8	3	6
Pseudo	1	3	1	0	5	2	3	4	2	0	3	2
Outbreaks	4	1	2	1	0	0	4	5	5	0	0	0

Quality (4) – Safe





Background/target description

To improve patient safety and care; supporting reduced length of stay.

Performance

Infection Prevention and Control (IPC) :

Hand hygiene audit

- Overall, Trust compliance at 94.3%, IPC discuss monthly at each care group IPC resource meeting to drive accurate reporting and oversight of hand hygiene compliance, noting that Hand Hygiene is a low special cause common variation. Greater variation has been seen in hand hygiene compliance results over the last few months as data quality has been an area of focus alongside implementation of peer review, ensuring greater confidence in reported results.

May 2025

- Medical care group: 92.7% compliance
- Surgical care group: 95.1% compliance
- WCCSS care group: 94.5% compliance

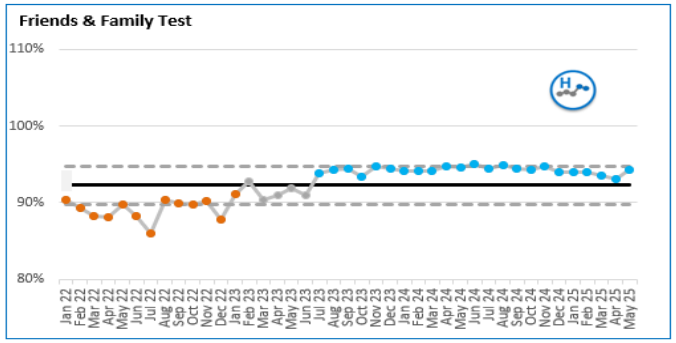
Infection Control Mandatory Training Compliance summary

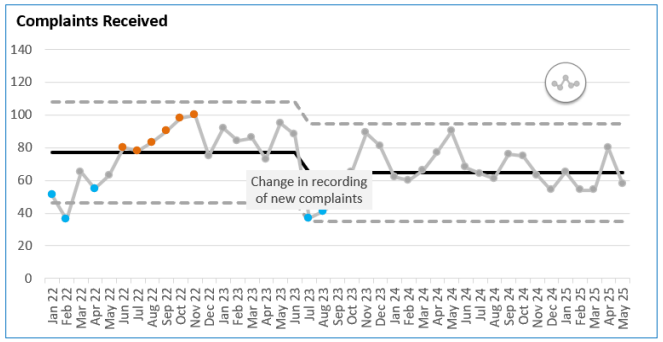
- Overall Trust compliance with Level 1 IPC training (all staff): 94.98%
- Overall Trust compliance with Level 2 IPC training (staff with patient contact): 86.20%

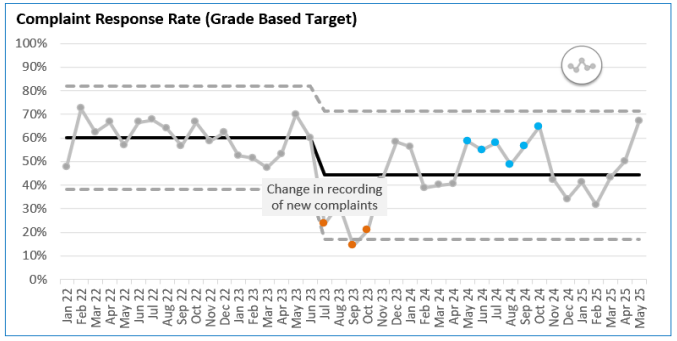
Key Areas of Focus

- The focus remains Bare Below the Elbow and the fundamentals of IPC including hand hygiene and the correct use of PPE with focus on local ownership of action plans to drive improve.

Quality (5) – Caring







Performance and Areas of Focus

PALS and Complaints Data for May 2025:

Overview:

- 583 PALS concerns raised
- 36 new formal complaints
- 22 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed was 66

Complaints and PALS themes include communication and not meeting fundamentals of care. These concerns are being addressed at several meetings, including the Ward leaders and Patient Experience Group.

The number of open complaints over 55 days continued to be prioritised within the complaints team and care groups with 4 complaints breaching this. The average complaint turnaround time was 31.03 days in May 2025. (The average complaint turnaround time was 47.68 days in May 2024). More frequent meetings with GDoNs and HoN have commenced to focus even further on earlier resolution, starting the process from PALS contacts.

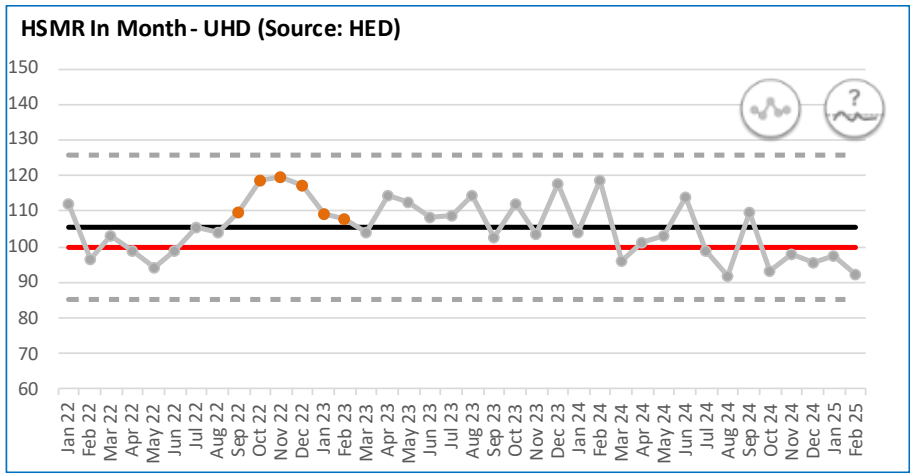
Friends and Family Test (FFT)

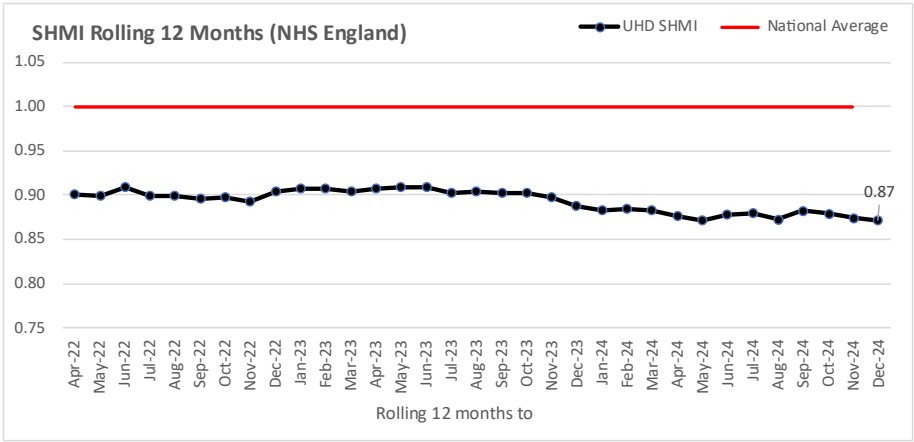
FFT results: There was an increase in the number of FFT responses being received with a stable overall positive score Seen in the SPC chart as special cause improved variation. Note mapping of FFT to areas is being examined in detail to improve data accuracy for location and in preparation for departmental location moves.

Mixed Sex Accommodation Breaches

There was 1 reported breach of mixed sex accommodation in May 2025.

Quality (6) – Effective & Mortality





Background, Performance and Areas of Focus

The headline figure for mortality reporting is UHD trust-wide Hospital Standardised Mortality Ratio (HSMR). This is the key metric for the Patient First Quality Outcomes and Safety strategic theme.

The other main mortality metric is the Summary Hospital-level Mortality Indicator (SHMI)*. This does not alter by change in data supplier (now HED) and is set by NHS Digital over the previous year.

Our in month HSMR for February 2025 is 92.4, below the national average of 100 for the last 5 data points. Our rolling 12 month position is 99.22. This has been continuously decreasing month on month and the first time we have seen this below 100 since March 2022.

We continue to remain well below the national average in our SHMI (0.87) and is deemed 'expected'. UHD is in the top 13 trusts of the 119 included in the SHMI publications.

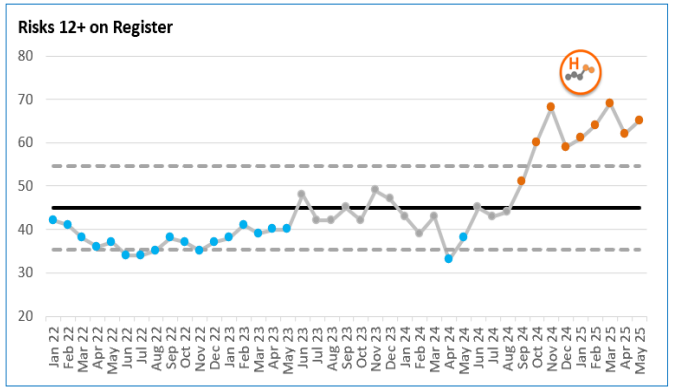
*The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust (within 30 days) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

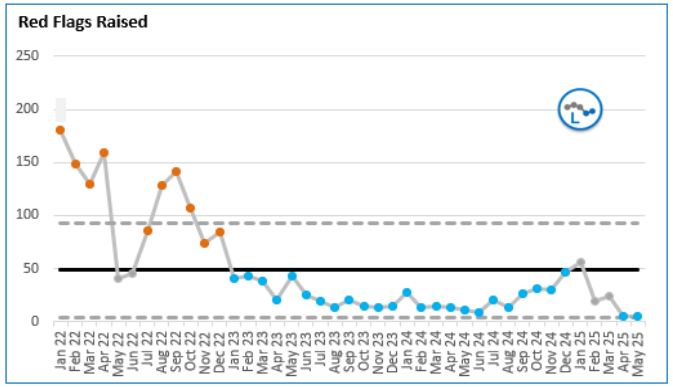
Areas of Focus

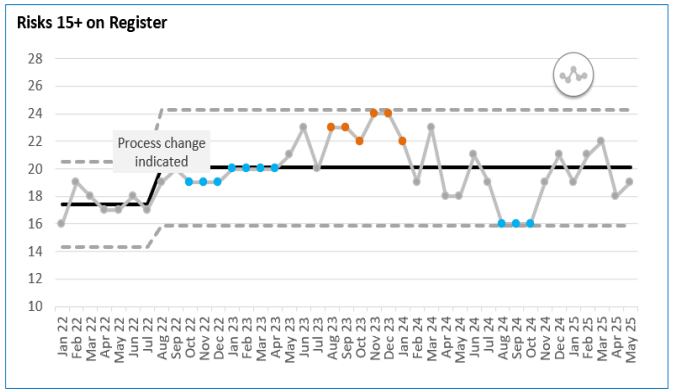
The Learning from Death process changed on the 11 November 2024. Deaths will now be selected against a clear set of criteria set out in the updated Learning from Deaths Policy – the aim is to ensure a sample size of circa 30% of total deaths. This will be monitored and reported down to consultant level data.

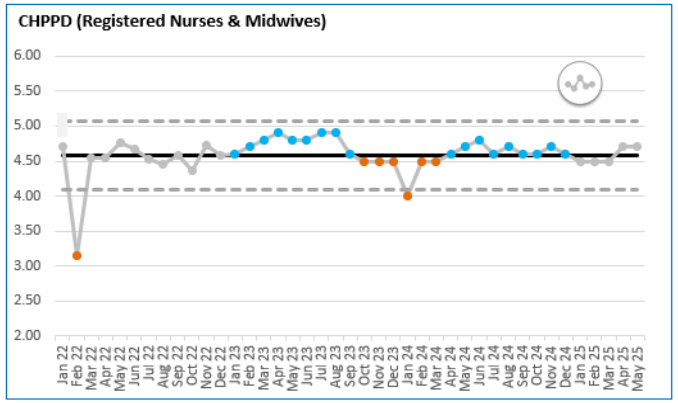
The Learning from Deaths Policy allows a 3 month time period for completion of required mortality reviews. Care Group compliance forms part of SDR process.

Quality (7) – Well Led









Performance

- May 2025 care hours per patient day (CHPPD) for registered nurses and midwives combined is 4.7. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for May was 5 raised in month; 40% (2) reported challenges in the provision of enhanced care for patients, 40% (2) RN Shortfall of greater than 8hrs or 25% versus shift demand and 20% (1) was attributed to only Agency RNs on shift. There were no critical staffing incidents reported indicating that mitigations were enacted to maintain safe staffing overall.
- Overall percentage rota fill rate against planned staffing (day & night) was 93.4% for May 2025.

Key Areas of Focus

- Separate risk report provided to Trust Management Group (TMG) Quality Committee and Trust Board
- New UHD Trust Risk management strategy approved with greater focus on risk appetite, risk tolerance and risk escalation. Risks rated up to 12 can now be approved at Care Group level and do not require Exec sponsorship and approval at Board.
- This process change was introduced in October 24 and has resulted in a significant increase in risks rated 12.
- Risks rated 15-25 are now approved at TMG.

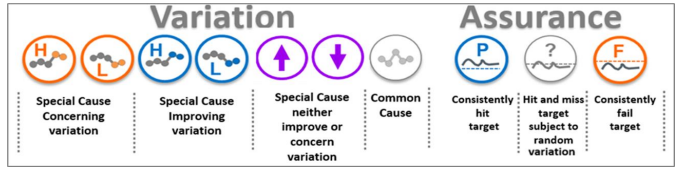
Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) May 2024/25

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	16009	77611.3	72724.1	93.7%	4.5
Bournemouth & Christchurch	17198	89464.4	83373.5	93.2%	4.8
UHD Total	33207	167075.7	156097.6	93.4%	4.7

Performance at a glance
Quality - Key Performance Indicator Matrix

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Patient Safety Incidents (All) per 1,000 beddays	May 25	34.90	-			36.98	31.29	42.67
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	May 25	0.50	-			0.38	0.02	0.74
Medication Incidents (All) per 1,000 beddays	May 25	4.00	-			4.91	3.21	6.61
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	May 25	0.40	-			0.29	0.03	0.56
Inpatient Falls (Moderate +) per 1,000 beddays	May 25	0.20	-			0.17	-0.05	0.38
Hospital Associated Infections - MRSA	May 25	0	-			1	-1	2
Hospital Associated Infections - MSSA	May 25	4	-			4	-1	9
Hospital Associated Infections - C Diff	May 25	11	-			8	-1	17
Hospital Associated Infections - E Coli	May 25	13	-			10	0	20
Hospital Associated Infections - Kleb	May 25	6	-			4	-3	11
Hospital Associated Infections - Pseudo	May 25	2	-			2	-2	5
Hand Hygiene Compliance	May 25	94.3%	-			96.5%	94.4%	98.6%
Infection Control Mandatory Training Compliance	May 25	89.1%	-			88.9%	88.0%	89.8%
Friends & Family Test	May 25	100.0%	-			92.4%	89.5%	95.3%
Complaints Received	May 25	58	-			65	35	95
Complaint Response Rate (Grade Based Target)	May 25	67%	-			44%	17%	71%
Mixed Sex Accommodation Breaches	May 25	0	-			8	-12	28
HSMR In Month - UHD (Source: HED)	Feb 25	92.40	100.00			105.48	85.30	125.65
Deaths Within 36hrs of Admission	May 25	26	-			34	13	55
Deaths Within Readmission Spell (5 day readmission)	May 25	18	-			21	8	33
Risks 12+ on Register	May 25	65	-			45	35	55
Risks 15+ on Register	May 25	19	-			20	16	24
Red Flags Raised	May 25	5	-			49	4	93
CHPPD (Registered Nurses & Midwives)	May 25	0.00	-			4.47	3.66	5.28



Maternity (1)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: Lisa Clarke GDO / Lorraine Tonge Director of Midwifery and Neonatal Services / Abi Langrish Lead Obstetric Consultant / Kerry Taylor Head of Midwifery and Neonatal Services

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 a 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 Year 5 Maternity incentive scheme
MBRRACE reportable cases: There were 3 new PMRT (MBRRACE reportable) cases in May 2025: Antenatal Stillbirth delivered @ 32+2 weeks. RFM reported at routine Community AN check Antenatal Stillbirth delivered @ 36+6 weeks. Cat 1 EMCS for CTG concerns. No FH or heartbeat despite resuscitation attempts. Antenatal Stillbirth delivered @ 38+4 weeks. Inpatient awaiting ELCS for unstable lie. **MNSI** There were no new MNSI cases in May 2025 and no ongoing or outstanding MNSI cases.	**Patient Safety Incident Response Framework (PSIRF)** has been implemented in maternity. In May there were no incidents requiring escalation through PSIRF. Of the 3 incidents featured in April's report that were escalated through WCCSS Insight in May: #1 - Transfer to theatre for Manual removal of placenta (MROP), metal instrument identified in the vagina attached to the umbilical cord prior to siting spinal anesthesia. This is not being reported as a Never Event AAR #2– FSE attached to baby's back in utero. Case review agreed. Timeline reviewed further with fetal monitoring lead and individual learning identified. Plan: For professional discussion of case and reflection. #3 - LFPSE incidents due to 'delays to maternity theatre' (also discussed at MatNeo Quality Safety meeting). Plan: delays to theatre to continue to be captured and information collated by Obstetric and Risk Team **Top incidences LFPSE:** Term admissions to NICU –ATTAIN at 3.9% Failure / insufficient / incomplete monitoring = 11 PPH >1500mls 32.7 per 1000 **Safety champions reviews this month:** •Patient survey and action plans •ATAIN quarter 4 report. •Caesarean Section	CQC action plan - Assure: Action Plan now closed as completed – monitoring standards continuously. Maternity incentive scheme year 7- Release of year 7 in April. Standards increased – assurance processes continue Insight and 3-year delivery plan - Assure End of year 1 report presented and actions for year 2 in place. 2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022. Staff survey shown overall staff satisfaction -action plan in place for each area to individualize the improvements in 2025.

Maternity (2)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: Lisa Clarke GDO / Lorraine Tonge Director of Midwifery and Neonatal Services / Abi Langrish Lead Obstetric Consultant / Kerry Taylor Head of Midwifery and Neonatal Services

Perinatal Quality Surveillance - Dashboard

Summary of maternity & neonatal metrics

Provider	UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance
Total number of bookings	May 25	315			
% of bookings booked <10 Weeks	May 25	46.3%			
% of women smoking at booking	May 25	7.94%			
% of women with a CO measurement at time of booking	May 25	95.9%	95%		
% of women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation	May 25	6.71%			
% of Black and Asian women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation	May 25	49.1%			
% of women (IMD-1) placed on a continuity of carer pathway	May 25	16.7%			
% of women with a CO measurement at time of 36 weeks gestation	May 25	81.0%	95%		
% of women smoking at delivery (previous month)	May 25	5.51%	6%		
Rate per 1,000 women with PPH 1500ml or more (previous 3 months aggregated)	May 25	44.0			
Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated)	May 25	17.9	28		
Number of women delivered (all births)	May 25	310			
Number of women delivered (unregistrable)	May 25	4			
Number of women delivered (multiple births where at least one unregistrable and one registrable)	May 25	0			
Number of babies born	May 25	314			

Data and Target

The national PQS Diis Scorecard is rated based on SPC methods and comparison to national targets.

Performance

Areas to note improvement :

Term admissions to NICU: QI improvements in place less than 5% regional target for March, April and May.

Oasi: Levels remain low locally and nationally.

Key Areas of Focus

Term admissions to NICU: QI improvements continue.

PPH >1500 mls : all cases reviewed -QI continues-no significant changes seen to rate.

% of bookings <10 weeks: Compliance has dropped this month – More training for admin staff required.

Number of readmitted babies within first 30 days: This remains high at UHD and work in progress to improve reporting and support feeding issues at home

Warch metrics:
Increase in still birth rate – possible fluctuation but will be monitored

Maternity (3)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: : Lisa Clarke GDO / Lorraine Tonge Director of Midwifery / Mr Alex Taylor Clinical Director

Summary of maternity & neonatal metrics

Provider	UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance
No. of registrable babies born	May 25	310			
% of babies <3rd birthweight centile, born >37+6 weeks	May 25	0%			
Number of still births	May 25	3			
Annual rate of stillbirths per 1,000 births - rolling 12mths	May 25	4.35	2.5		
Number of singleton babies born less than 27 weeks gestation or multiples born at less than 28 weeks or the weight of the baby is less than 800 grams.	May 25	5			
Rate per 1,000 births which are preterm (< 37 week's gestation)	May 25	100	60		
% of term babies admitted to NNU	May 25	4.27%			
Number of registrable livebirth babies who died < 28 days from birth	May 25	0			
Rate per 1,000 registerable live birth babies who died <28 days from birth	May 25	0			
% of babies receiving breast milk at first feed	May 25	76.5%			
% of babies receiving breast milk at discharge from midwifery 10-28 days	May 25	73.3%			
All deaths of pregnant women and women up to one year following the end of the pregnancy (regardless of the place and circumstances of death)	May 25	0			
Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth)	May 25	0			
Apgar score < 7 at 5 mins - term singletons (current three months)	May 25	10			
Number of incidents of Hypoxic-Ischemic Encephalopathy (HIE) in babies	May 25	0			
Percentage of FTE days absent for midwives	May 25	4.65%	3%		
Percentage head count of midwives leaving the trust in the last 12 rolling months	May 25	7.70%			
% of midwifery posts which are vacant (A negative value indicates an employed FTE is higher than a funded FTE, and that there's an overstaffing compared to funded FTE.	May 25	3.19%			

Our People

Irene Mardon
Interim Chief People Officer

Operational Leads:
Jane Dudley - Interim Deputy Chief People Officer

Committees:
People and Culture Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Workforce (1)

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										
	Plan	9086.0	9099.0	9072.3	9064.3	9055.3	8999.2	8979.2	9015.2	8965.6	8903.6	8855.6	8770.9
Bank	Actual	643.3	647.5										
	Plan	609.0	591.0	564.0	565.0	560.0	557.0	495.0	495.0	492.3	543.6	541.6	520.6
Agency	Actual	135.8	148.1										
	Plan	158.0	135.0	135.0	136.0	137.0	139.0	141.0	146.0	151.0	144.0	128.0	116.7

Staff Type	Plan/Actual	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Staff	Actual	9877.2	9866.1										
	Plan	9853.0	9825.0	9771.3	9765.3	9752.3	9695.2	9615.2	9656.2	9609.0	9591.2	9525.2	9408.3

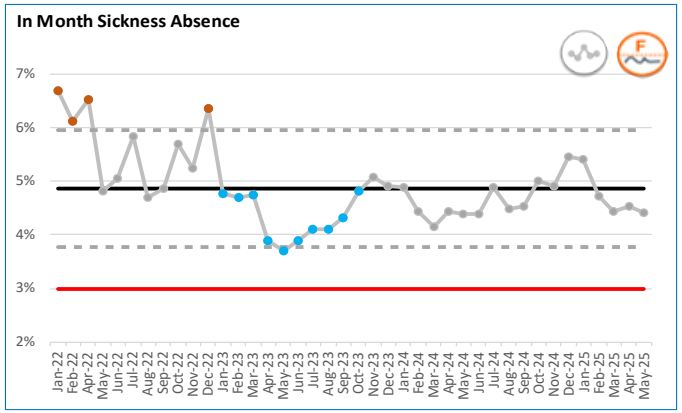
Operational Plan Monitoring

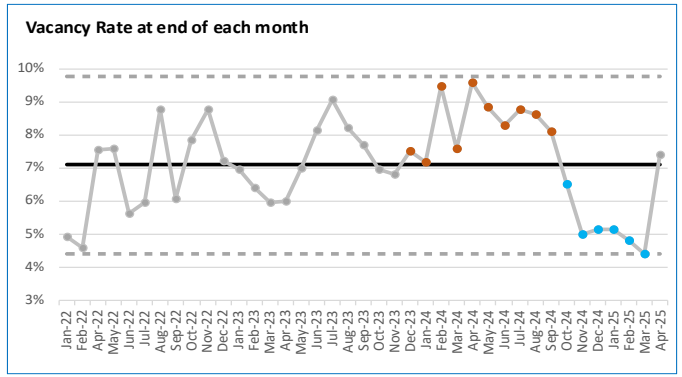
The workforce trajectories for FY 2025/26 have been planned to achieve reduced demand for workforce from the start point in April 2025 through to March 2026

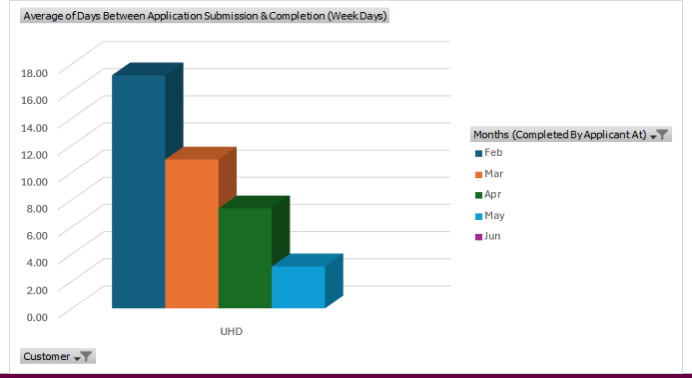
This table shows that performance against the workforce plan as at month 2 gives some cause for concern as we are at 9866.1whole time equivalents (wte) , (against a plan of 9825.0 wte), so 41.13 wte away from the May 2025 plan.

It is anticipated that the over plan figure for bank and agency staff are attributed to the opening of the BEACH and service moves particularly aligned to ED (the Emergency Department)

Well Led - Workforce (2)







Performance

Sickness Absence and Wellbeing

- In month sickness absence for May 2025 was 4.4%, lower than the winter sickness rate common with seasonal variation, but higher than last year. The latest rolling 12-month rate is 4.77% which the same as last month.

Vacancy Rate

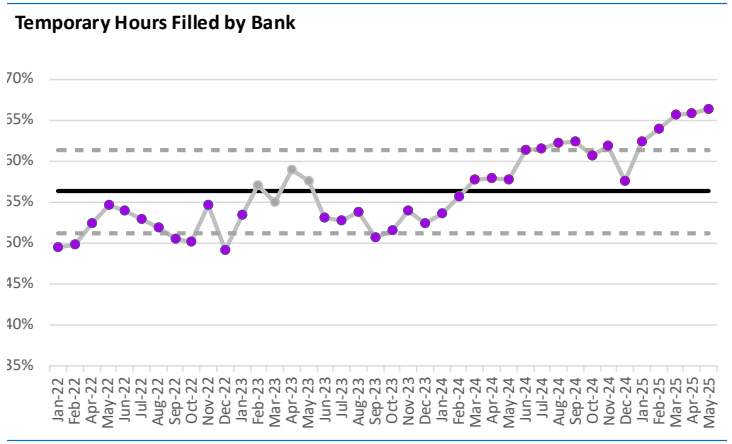
- The vacancy rate is reported a month in arrears to allow for reconciliation with the ledger (we no longer exclude students from our establishment when calculating the vacancy rate).
- **Vacancy Rate**: The vacancy rate at the end of April 2025 (latest data) stands at **7.4%**, a significant increase from **4.4%** in March.
- In May 2025, the Trust received **5,847 applications** and posted **351 new vacancies**, with **4865 applications** for general recruitment roles. This equates to an **average of 17 applications per vacancy**, indicating a further drop from **32** in March 2025.
- **New Starters and Offers**: There were **128 new starters** in May 2025, including **79 internal appointments**. A total of **229 offers** were made. Notably, **advertised posts increased** again for the second time since October 2024, continuing to reverse the trend of month-on-month declines. Total number of new joiners to the Trust was **49** for May, this number is the lowest recorded since May 2021.

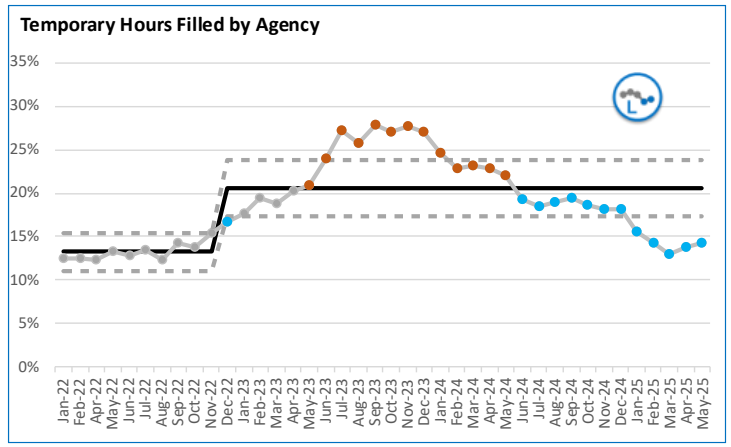
Time to Hire (TTH): The average time to hire has continued to improve, reducing from **52 days in January 2025 to 49.4 days in May 25**. The NHS England target remains **42 days,**

Occupational Health (OH), Psychological Support and Counselling Service (PSC)

- OH received 155 management referrals in May 2025, 55% of staff where in work and 45% where off sick at the time of the referral. 71.5% of the management referrals were seen in 7 days of the referral being made
- The staff physiotherapy service referral numbers continue to grow - March 2025-May 2025 showing a 25% increase in referrals
- Pre placements completion has fallen in line with the set KPI of 3 days following the installation of the new computer system G2 in February 2025 and the efficiencies it has enabled.
- Self-referrals to the Psychological Support and Counselling Service (PSC) remained the same at 11 per week in May. The primary reasons reported for referral remain high stress (↑90%) and depression (↓44%) with ↓19% reported as signed-off work by their GP. Waiting times for an initial assessment remain within the target of less than 2 weeks. 54 staff are receiving ongoing support within PSC. This remains slightly lower than usual due to the vacancies within the service impacting provision. Completed feedback indicates >75% of staff accessing the service reported the support they received as helping them to remain in work rather than going off sick due to stress/mental health. In addition to self-referrals (i.e., individuals)

Well Led - Workforce (3)



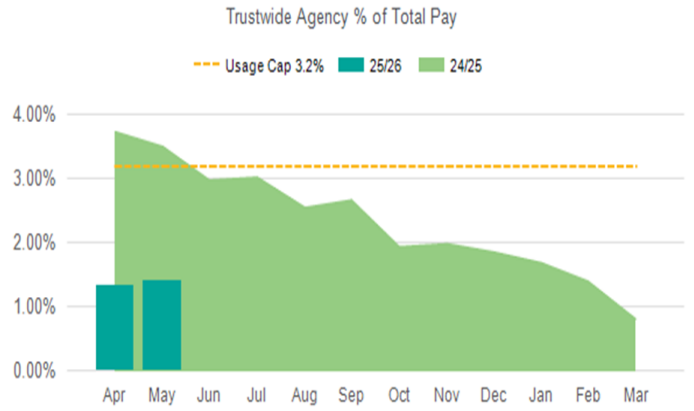


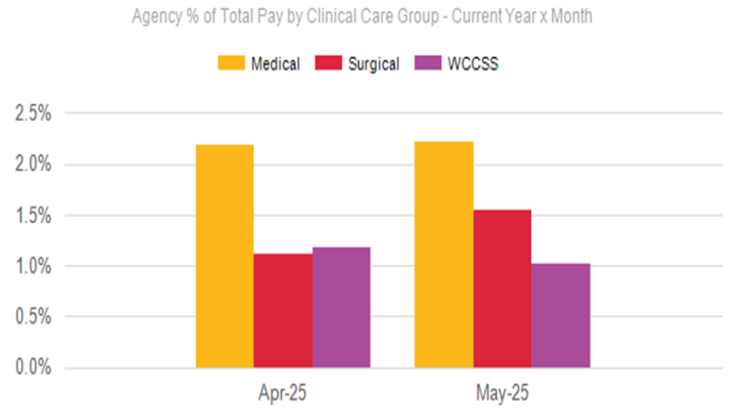
Performance

- There has been a small increase in in-month agency spend to 1.4% of paybill in May (Month 2) from 1.3% March (Month 1). This remains well below the national 3.2% target. Year to date agency spend is 1.4%.

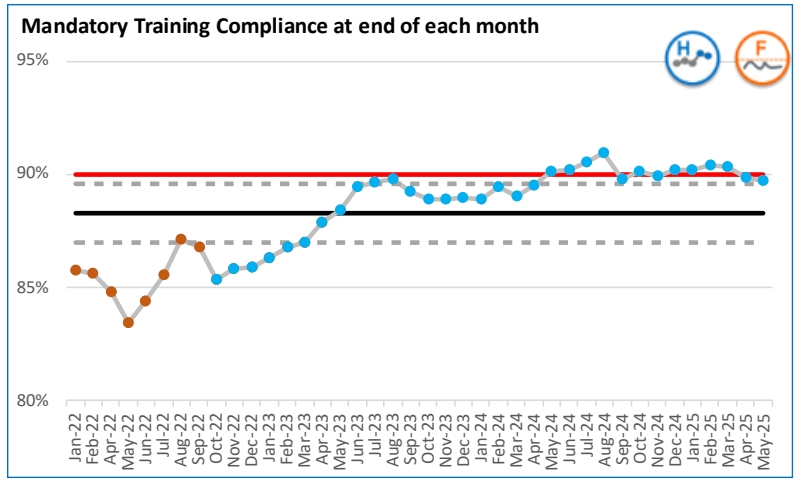
- Agency spend in the Medical Care Group remained at 2.2% in April 2025.
- The Surgical Care Group increased slightly to 1.6% (from a 1.1% in April).
- The Women's, Children, Cancer and Support Services Care Group has seen a small decrease to 1.0% (from 1.2%).

- The increase in Employer's National Insurance Contribution is being absorbed by the agencies and this may impact supply. Off-Framework charge rates have increased, although our use has remained minimal.
- Significant progress has been made with the agency reduction programme for Allied Health Professionals and Medical staff. Ratecard compliance is on track for all staff groups with just one locum Pharmacist placement supporting transformation above cap. This is due to end May 2025.
- The charts on the left clearly illustrate the shift away from using agency to increasing bank usage for our temporary staffing.





Well Led - Workforce (4)



Performance

Mandatory Training

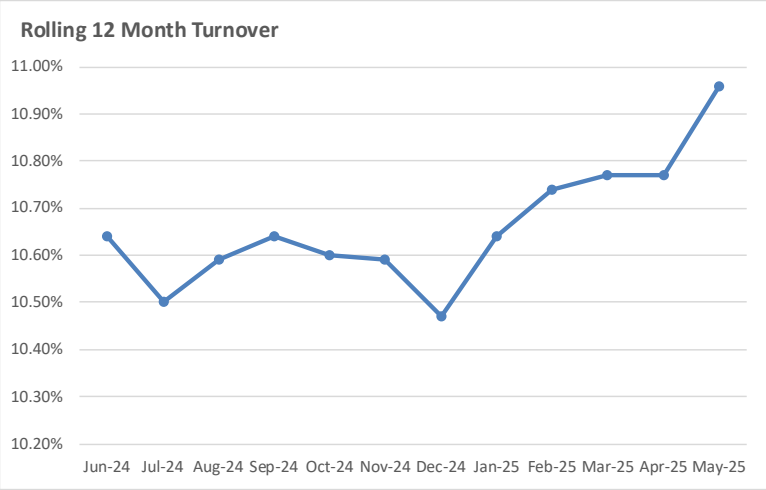
- Mandatory Training compliance just dipped below 90%, at 89.7% as at end of May 2025

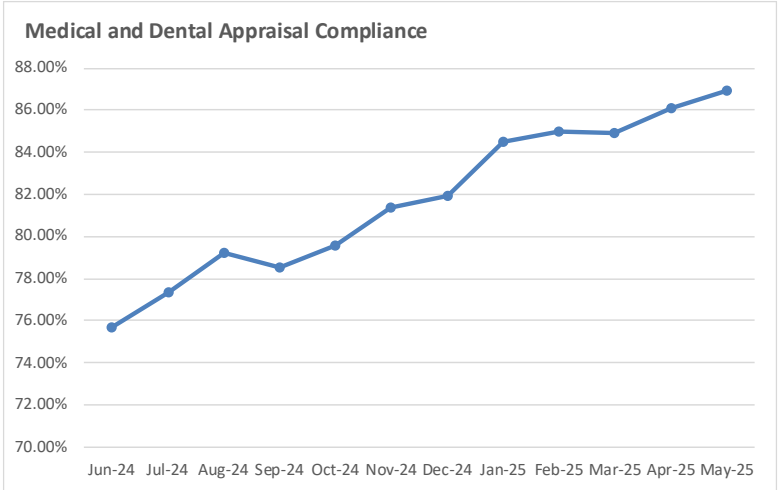
Turnover

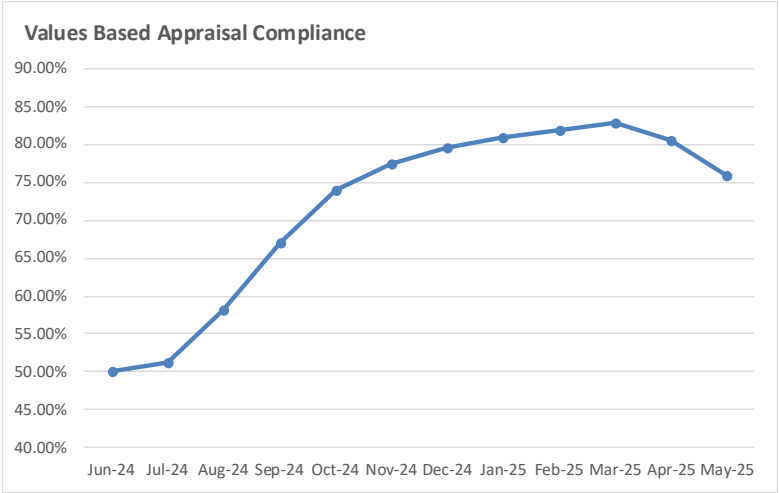
- The rolling 12-month staff turnover rate (excluding fixed term temp) has remained stable at 11.0% in May 2025, fractionally higher than previous month) (the vertical axis of this chart zooms in on 10% to 11%, as this has been where this very stable metric resides).

Appraisal

- Non-medical appraisal compliance is running at 75.9%, down from 81.3% previous month. This is now using a rolling 12 month rolling period. Medical and Dental compliance is steady at 87.0% (these charts have also been re-scaled and no longer start at zero).



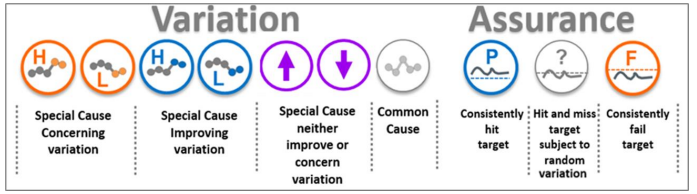




Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Apr 25	7.4%	-			7.1%	4.4%	9.8%
In Month Sickness Absence	May 25	4.4%	3.0%		F	4.9%	3.8%	6.0%
Mandatory Training Compliance at end of each month	May 25	89.7%	90.0%	H	F	88.3%	87.0%	89.6%
Temporary Hours Filled by Bank	May 25	66.4%	-			56.3%	51.2%	61.4%
Temporary Hours Filled by Agency	May 25	14.3%	-	L		20.6%	17.3%	23.8%
Agency Pay as Proportion of Total Pay	May 25	1.4%		L	?	3.8%	2.4%	5.1%



Population Health and System Working

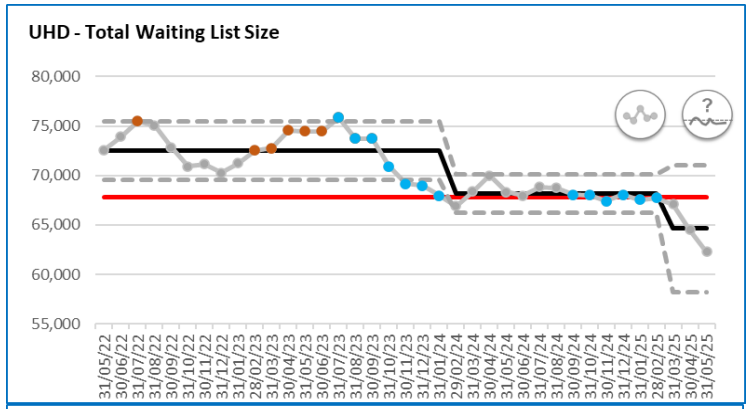
Mark Mould
Chief Operating Officer

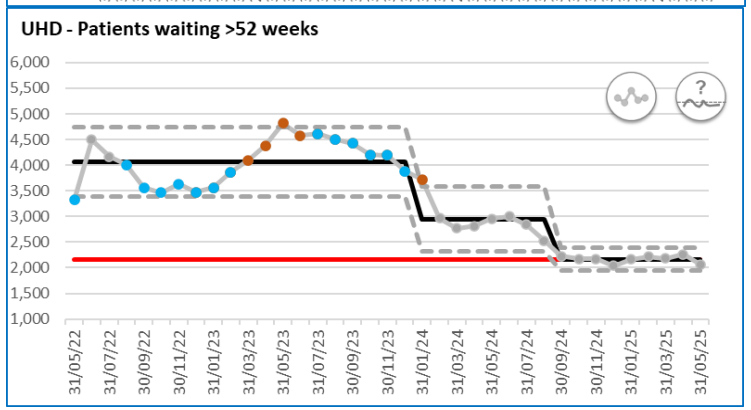
Operational Leads:
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Lisa Clarke – Group Director of Operations – Women's, Children, Cancer and Support Services
Adam Morris – Interim Group Director of Operations – Medical

Committees:
Finance and Performance Committee

University Hospitals Dorset
NHS Foundation Trust

Responsive – (Elective)
Referral to Treatment (RTT)





	Trajectory	UHD	% of pathways with a DTA
Referral To Treatment			
18 week performance against trajectory (92% standard)	61.5%	62.3%	
Waiting list size (and trajectory)	67,842	62,270	25%
Waiting List size % variance compared to trajectory		-8.2%	
No. patients waiting 26+ weeks		15,741	40%
No. patients waiting 40+ weeks		6,761	45%
%. patients waiting 52+ weeks v trajectory (1% target)	3.2%	3.3%	
No. patients waiting 52+ weeks	2,152	2,065	52%
No. patients waiting 65+ weeks	0	15	0%
No. patients waiting 78+ weeks	0	0	0%
% of Admitted pathways with a P code		99.39%	

Data Description and Target

Total number of patients waiting on an RTT elective waiting list and percentage of patients treated or discharged under 18 weeks (Target 66.1% by March 2026)
Number of patients on an elective RTT waiting list whose wait exceeds 52 weeks against the operational plan and as a proportion of the total waiting list (Target less than 1% by March 2026).
Number of patients on an elective RTT waiting list whose wait exceeds 65 weeks. National target 0 by Sept 2024.

Performance

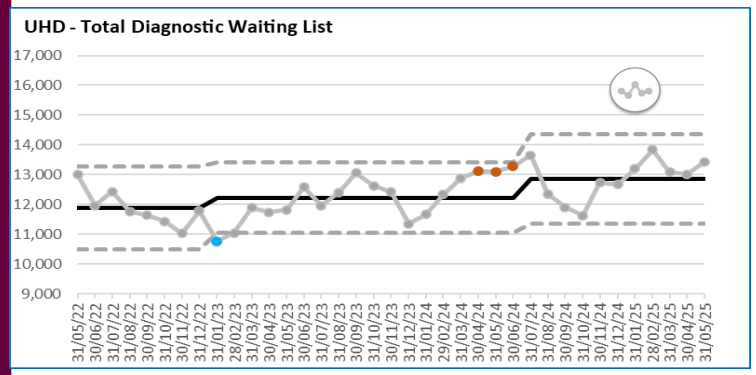
- The RTT waiting list size reduced in May 2025 (-2,219) to 62,270. This is a variation to the operational plan trajectory (67,842) of 8.2% ahead trajectory. A significant contributor is a waiting list validation sprint exercise that commenced in early April that has positively increased the number of removals from the waiting list. This sprint will continue into June/July 2025.
- The Trust delivered 113.9% value weighted elective activity in 2025/26 (May forecast), compared to the 2019/20 baseline period. This is above the operational plan trajectory (105.2%)
- 15 patients breached 65 weeks at the end of May. Neurology and ENT had the highest number of breaches due to capacity. All other breaches were due to patient complexity.
- Waits greater than 52 weeks reduced by 196 in May, achieving the operational plan trajectory. The proportion of the waiting list >52 weeks also improved moving from 3.5% to 3.3%, however the May target of 3.2% was marginally missed as a result of the reduction in the total waiting list (denominator) being greater than planned.
- 18 week Referral to Treatment (RTT) performance improved to 62.3% in May 2025, also achieving the operational plan trajectory.

Key Areas of Focus

The areas of focus in June are:

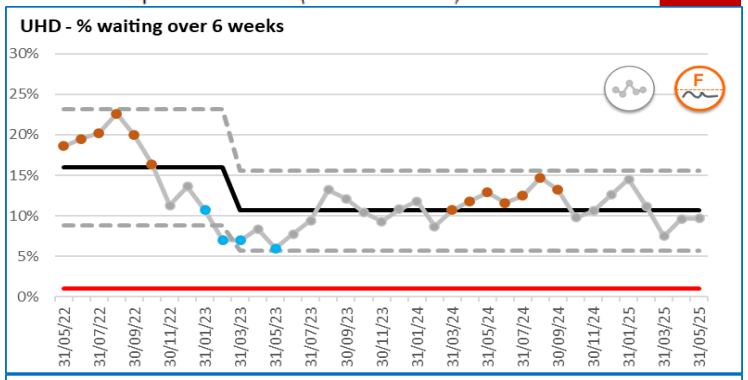
- To maintain delivery of elective activity aligned to the operational plan trajectory in 2025/26 (109% overall activity)
- Maximise use of capacity in theatres and outpatients; continuing work to reduce cancellations and DNA rates and to deliver an increase in the number of theatre cases and in the number of patients receiving first activity (appointment or diagnostic) within 18 weeks.
- Reducing the number of patients waiting greater than 52 weeks on a non-admitted pathway; targeting 0 in the majority of services.
- Continuing with further validation hubs as part of the validation sprint.

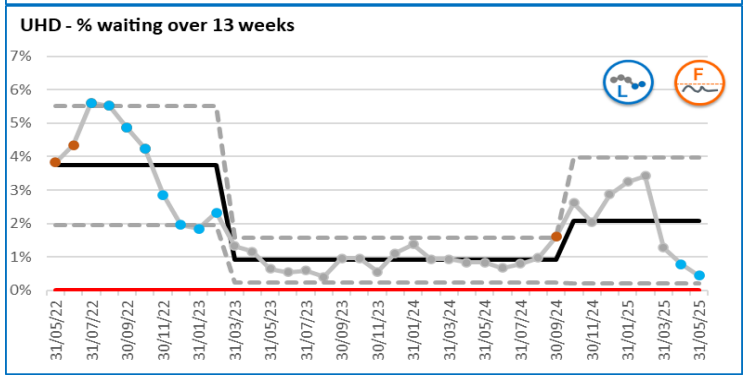
Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)

% of >6 week performance	(6+ Weeks / Total)	1%	1309/13426	9.7%





Data Description and Target

Total number of patients waiting a diagnostics test
Number of patients whose wait for a diagnostic test exceeds 6 weeks. Target 1%

Performance

May 2025 performance was 9.7% (9.6% at the end of April 2025). Overall waiting list is 13,426 patients.
Performance remains within the upper and lower process control limits; however further improvement is required to deliver the internal target of 5%. The Trust is benchmarking in the top 2 performers in the Southwest Region. Key areas to note;

- Echocardiography have 765 patients and neurophysiology have 203 patients waiting longer than 6 weeks.
- There are currently 59 patients waiting more than 13 weeks for a diagnostic test however this is down from 102 at the end of April and a special cause improvement has been triggered for the second month; the majority of these (38) are neurophysiology patients. Booking these long waiting patients is the focus for all modalities.

Endoscopy Performance moved to 4.3% at the end of May (from 4.0% at the end of April), delivering the 5% trajectory target.

- Further improvement is impacted by capacity issues with cystoscopy. In Endoscopy there is ongoing use of insourcing and waiting list initiatives (WLIs) to support delivery of the Community Diagnostic centre (CDC) activity plan pending opening of the new Endoscopy hub later this year.

Echocardiography performance has moved to 37.2% at the end of May (from 32.9% at the end of April).

- Ongoing vacancy gaps and unplanned sickness absence has reduced capacity. Insourcing is being used to support recovery.

Neurophysiology performance has improved to 29.3% at the end of May (from 42.1% at the end of April).

- Consultant vacancy (combined with maternity leave) has led to reduced capacity and longer waits within the department. There is ongoing use of locum cover, outsourcing and redistribution of other clinical work in the department to manage performance.

Radiology performance was 1.8% at the end of May (0.5% at the end of April), delivering the 5% trajectory target.

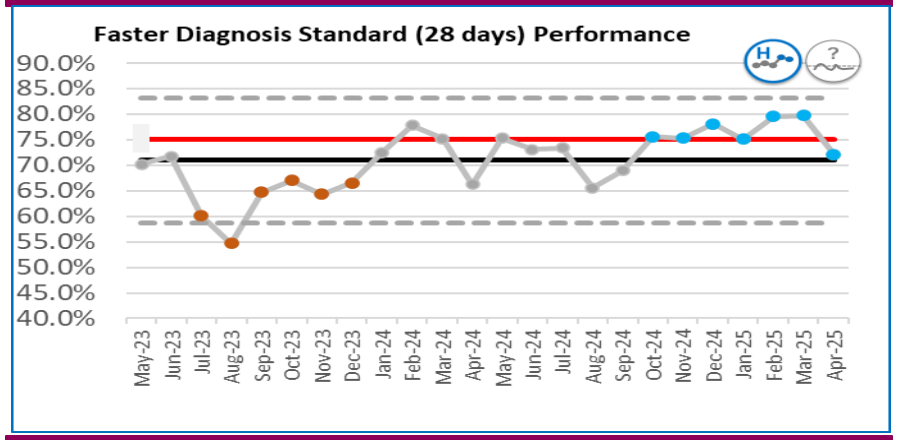
- CT and Dexa **achieved the 1% constitutional standard** at the end of May.

Key Areas of Focus

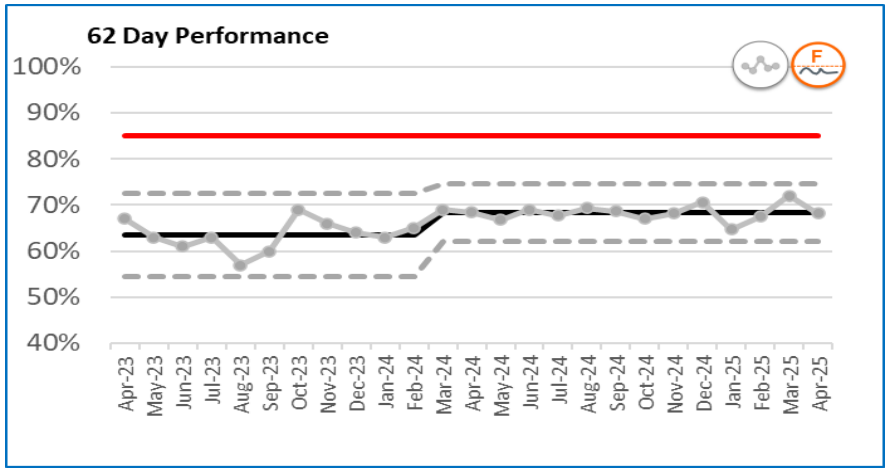
- **Endoscopy:** Cystoscopy is working to increase performance via private healthcare insourcing.
- **Echocardiography:** An additional insourcing provider was onboarded in March to support an increase in capacity. Further additional capacity is scheduled for June to recover the backlog in waits.
- **Neurophysiology**: Outsourcing to Haven Medical continues, alongside recruitment to internal Trust posts. A further improvement in performance is forecasted in June.
- **Sleep Studies**: A focused review of capacity and demand to identify the capacity needed to manage a backlog of 117 patients wating longer than 6 weeks at the end of May is underway, whilst also engaging with potential insourcing providers.
- **MRI**: Additional outsourcing through a combination of Nuffield, Harbour and Bournemouth University will help recover the backlog of 105 patients waiting longer than 6 weeks at the end of May.

Responsive (Elective)
Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard
(National Target 75.0%, raising to 80% by March 2026)
April Trust Trajectory 77.25%
Finalised UHD April 2025 Performance (72.1%)



62-Day Standard
(National Target 85%, Trust Trajectory 70.4%)
Finalised UHD April 2025 Performance (68.2%)



Data Description and Target

- Percentage of patients informed of diagnosis within 28 days from referral. Faster Diagnosis Standard = 75% (80% by March 2026).
- Percentage of patients who receive their 1st treatment for cancer within 62 days. 62 Day Standard = 85% (75% by March 2026).
- The proportion of patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, who then start that treatment within 31 days. 31 Day Standard = 96%.
- The number of patients waiting 62 days or more on their pathway – remain below 220.

Finalised April 2025 Performance

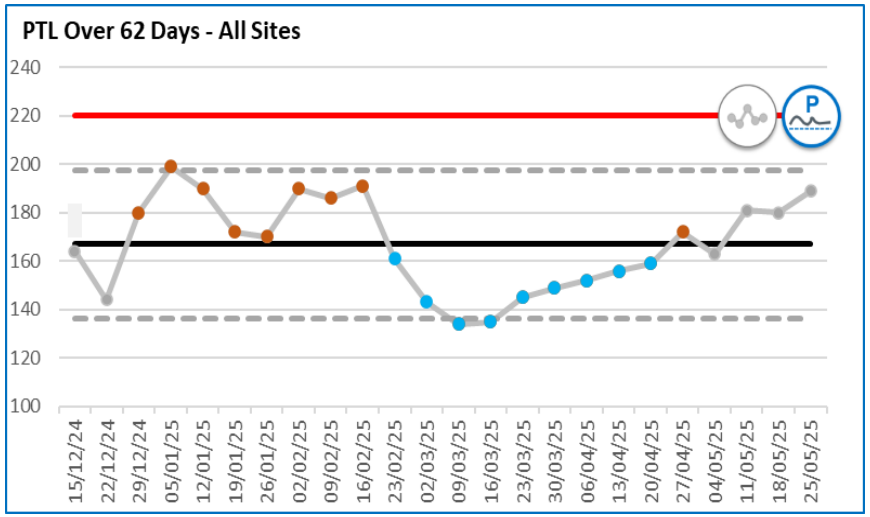
- **28 Day Faster Diagnosis Standard** - Performance in April 2025 was 72.1% and therefore did not meet the national standard or the Trust trajectory of 77.25%. Performance however is 7 points above the process mean showing sustain improvement in Q3/4 2024/25. Seven out of sixteen tumour sites achieved the national standard.
- **62 Day Standard** - Performance in April 2025 was 68.2% which was below both the Trust operational plan (70.4%) and the national recovery target of 75%. Despite reduced variation in performance since March 2024, the upper process control limit remains below the national standard. Care Groups are producing recovery plans by tumour site to realise performance improvements.
- **31 Day Standard** - Performance in April 2025 was 96.3% achieving the 96.0% national standard.
- **Patient Treatment List (PTL) Over 62 Days** – The finalised total number of patients on the over 62D PTL for April 2025 was 172 (48 below the 220 target).

Provisional May 2025 Performance (un-finalised)

- **28 Day Faster Diagnosis Standard -** Performance in May 2025 is currently 72.1% which is below the national standard of 75.0% and the operational plan of 77.5%.
- **62 Day Standard -** Performance in May 2025 is currently 67.6% which is below the national recovery target of 75% and operational plan of 70.8%. Validations will continue throughout the month as treatments are reported.
- **31 Day Standard** - Performance in May 2025 is currently 96.2% and is compliant with the national standard.
- **Patient Treatment List (PTL) Over 62 Days** - The month end position for May 2025 was finalised at 189 patients over 62 days which is 31 below the 220 target for the Trust.

Responsive (Elective)
Cancer Over 62 Day Breaches

Over 62 Day PTL (Target: 220)
Finalised UHD May Performance: 189



High Level Performance Indicators

Cancer Standards	Standard	Final	Provisional
		Apr-25	May-25
28 Day Faster Diagnosis Standard	75%	72.1%	72.1%
31 Day Standard	96%	96.3%	96.2%
62 Day Standard	85%	68.2%	67.6%
PTL Over 62 Days (Final)	220	172	189

Key Areas of Focus

In 2025/26 the key areas of focus for the Trust will be the delivery of the year end operational plans:
- 28 Day Standard – 75% working to deliver 80% performance by March 2026 (stretch target).
- 62 Day Standard – 85% but planning to deliver 75% performance by March 2026 (national improvement target).
- 31 Day Standard – maintain the 96% threshold throughout 2025/26.

Key areas of focus in the 3 most challenged tumour sites:

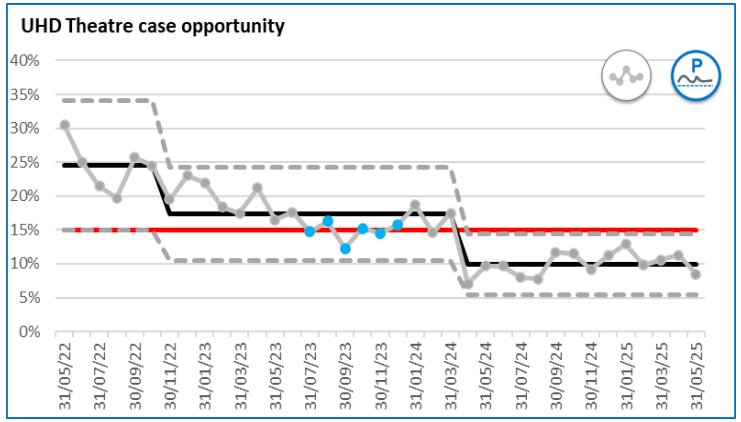
Breast:
- Securing and sustaining additional radiology capacity to enable delivery of one stop fast track clinics by end of Q1 2025/26 to recover the 28 Day Faster Diagnosis Standard.
- Completion of a capacity and demand modelling refresh with a 12-month forecast view to ensure variation is minimised.
- Recovering the backlog of patients waiting for a 1st appointment by end of June 2025 through waiting list initiative activity.
- Continue improvement workstream with Histopathology to optimise the diagnostic pathway.
- Complete the recruitment of an Advanced Nurse Practitioner (ANP) for the Breast Pain Pathway.

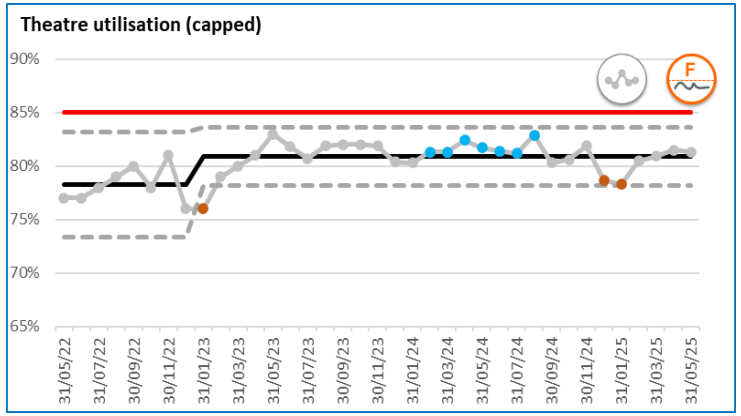
Urology:
- Delivery of waiting list initiative clinics to clear the backlog of patients waiting for 1st appointment by end of June 2025.
- Completion of capacity and demand modelling refresh with 12-month forecast view for Urgent Suspected Cancer Referral (USCR) activity.
- Progress recruitment in relation to the nurse led prostate diagnostic pathway.
- Continued work with SW Region regarding the provision of Robot-Assisted Radical Prostatectomy and Robot – Assisted Laparoscopic Prostatectomy in conjunction with the trust-wide theatre utilisation project.

Skin:
- Progressing the delivery of the dermatology workforce review to provide increased capacity and reduce reliance on additional insourcing activity.
- Continued robust contract monitoring with insourcing provider to ensure timely delivery of outpatient clinics in order to minimise in month fluctuation in performance.
- System-wide agreement regarding the use of AI within tele-dermatology obtained until 18th October 2025 - service to utilise the benefits of this for referral capacity.

All services have been asked to provide summer operational plans to maintain activity and to improve performance.

Responsive (Elective)
Theatre Utilisation





Data Description and Target

Trust is pursuing a **capped utilisation** of 85% which takes into consideration downtime between patients.
Case opportunity is a measure of the time lost to inefficiency and expressed as the number of additional patients that could have been treated (Target below 15%).
Day case rate (Target 85%), includes only those procedures classified by the British Association for Day Case Surgery (BADS)

Performance

Theatre Utilisation - Overall capped theatre utilisation in May 2025 is 81.3%, maintaining performance in line with the process mean.

- Colorectal, Vascular and UGI consistently achieved > 85% in month exceeding required target.
- Performance in BESS, Urology and OMF maintaining > 80% in month
- Orthopaedics, ENT and Gynaecology remain slightly below 80% target but remain above 75%
- Cancelations in month within 72hrs reduced to 7.1% (improvement target 4.4%). An improvement plan is being designed respond to this improvement measure.

Day Case Procedures - The latest published Daycase (BADS) rate (Feb 2025) was slightly under the national target at 84.4%.

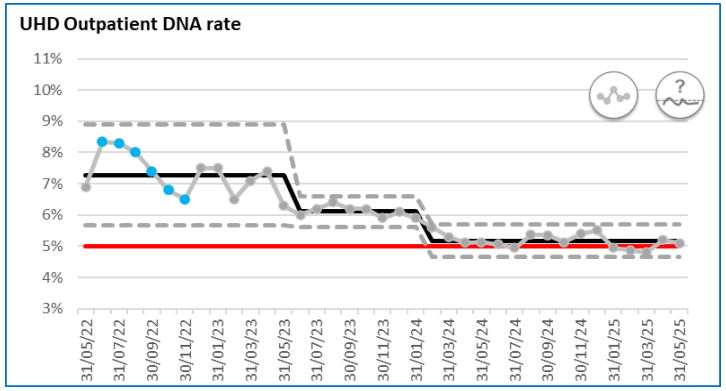
- Day surgery improvement programme ongoing
- Specialities are supporting pathway changes for day case procedures – including the launch of Day Case Laparoscopic hysterectomies and pelvic repairs at RBH.
- Conversion rate of planned inpatients to day case continues to exceed national average of 13.2%. The improvement programme will address booking practices to support 'day case by default' where appropriate
- Endocrine, BESS, General surgery, Paediatric and Urology all remain above the national target for planned day case procedures.
- ENT, Ophthalmology, OMF and Gynaecology all improved their daycase position and are now within 3% of achieving the national target; an improvement on April's position

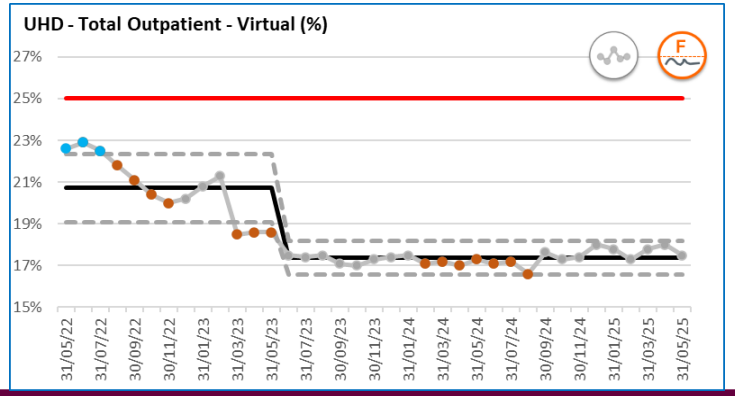
Key Areas of Focus

- Review of pathways with high short notice theatre cancelations (within 72hrs) and development of an improvement plan
- Deliver High Volume Low Complexity (HVLC) lists – Urology planned for June
- Theatre Improvement programme established: Workstreams devised, linking with theatre user/steering group (to be formed as part of the improvement programme) – Dr A Burton supporting as clinical lead.

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	20171	-1.3%
Total Referrals Rate year on year		-0.5%	31860	1.4%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				27349
New Attendances				22580
Follow-Up Attendances				31830
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	2909 / 54410	5.1%
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*		12270 / 77776	15.8%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*		8187 / 77776	10.5%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	9526 / 54410	17.5%





Data Description and Target

- Time to first appointment (numerator and denominator), waiting for first event and of those waiting % waiting less than 18 weeks (target 73% by March 2026).
- Reduction in Did Not Attend (DNA) rate (first and follow up) to <5% (Trust stretch target moving to 3% in 2025/26)
- 25% of all attendances delivered virtually
- Reduction in overdue follow up appointments

Performance

- The proportion of patients waiting less than 18 weeks for a first activity (OPA or diagnostics) - new metric in 25/26 - was 71.7% against an operational plan trajectory of 67.9%.
- The DNA rate in May (5.2%) maintains normal variation and the target remains achievable.
- Use of virtual appointments was 17.5% for May and remains within the limits of normal variation. Virtual appointments continue to be promoted where clinically appropriate.
- The number of patients overdue their target date for a follow up appointment increased (+528) in May with 27,349 patients overdue. A Trust-wide project to rationalise and implement a single electronic follow up waiting list management system has commenced to improve the focus on follow-ups.

Key Areas of Focus

Key areas of focus in June 2025 are:

- Following the successful relocation of the Beales Outpatient Assessment Centre to the St Mary's site at Poole, the focus in June is to expand the volume of clinics offered at the facility.
- Extend weekly specialty planning meetings to include Colorectal, Upper Gastrointestinal surgery, Urology and Rheumatology – these support the optimisation of clinic capacity.
- Continue to support delivery of a Trust-wide clinic utilisation rate of >90%
- Reducing short notice clinic cancellations
- Centralising the Outpatient Booking Team at Canford House on 16 June 2025 to support the standardisation of Trust-wide booking processes.
- Widen the use of Basic Rescheduling which has now been switched to live in 61% of all clinics. This allows patients to cancel their appointments digitally rather than needing to call the department creating a better patient experience.
- Deliver according to the agreed timeline the next stage of the follow up reduction programme.

Responsive - (Elective) Screening Programmes

Breast Screening

High Level Board Performance Indicators **MAY** position :

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	87%
Screening to first offered assessment appointment within 3 weeks	98.00%	98%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	37
UPTAKE – Jan – March 25	70%	65%
Mammograms Delivered		3020

Background/target description
To ensure the breast screening access standards are met.

Performance:
- Two monthly targets have been successfully met, but the screen to assessment target continues to breach.
- The quarterly uptake remains below the 70% standard, but this is not an accurate picture due to open appointments used.

Underlying issues:
- The reduction in round length was predicted due to low screening throughput over the last year. It is anticipated this target will be breaching for a few months to come until the benefit of the increased screening volume is felt.
- Sickness has resulted in less assessment appointment availability due to covering symptomatic work.

Actions:
- Smart clinics have now been introduced across our mobile units and in the main unit when assessment clinics are not operating to help increase capacity (addressing Round length)
- Additional Saturday clinics are supporting to reduce the symptomatic backlog.
- Radiologist interviews are due to take place on July 25th

Bowel Screening

Bowel Screening Standard	Target	May Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	100%

Background/target description
To ensure the bowel screening access standards are met.

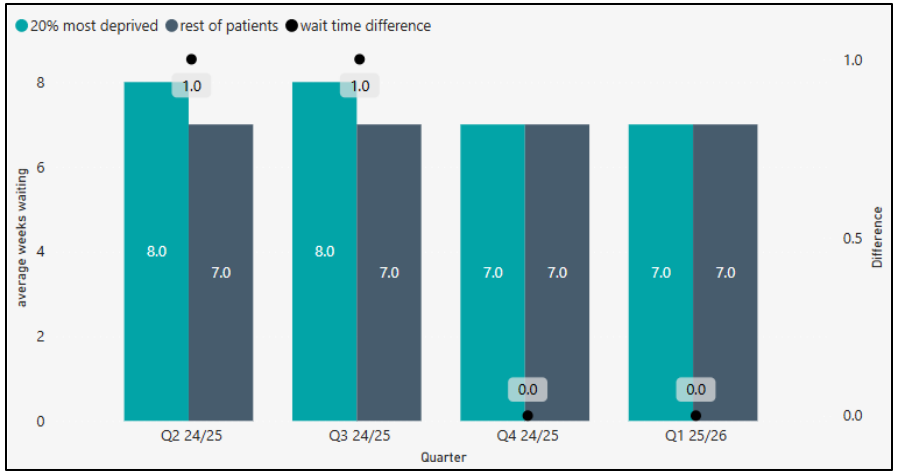
Performance:
- Specialist Screening Practitioner (SSP) Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at100% in Mayl 2025..

Underlying issues:
- Succession plan being worked through but will take time for aspirant screeners to gain accreditation.
- Age extension fully rolled out. Now fully inviting all the 50+ age group .

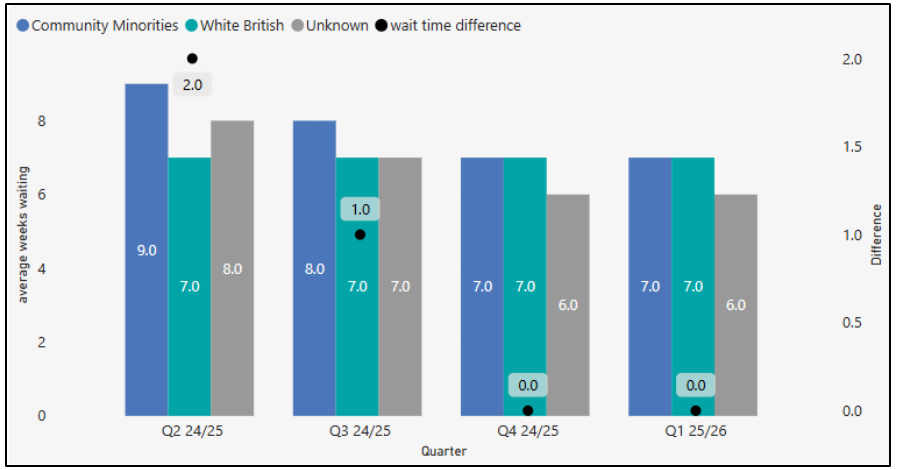
Actions:
- Planning underway for the future FIT@80 roll out. This may increase demand by up to 40% across the system. SSP training needed but awaiting date and funding. Likely roll out April 2026. Support identified for roll out via 18month Programme support role which has been recruited into and started April 2025.
- Deliver plans with Dorset County to use additional insourcing capacity.
- Support accreditation process for 4 Aspirant screeners.

Health Inequalities

Average Weeks (elective) waiting by Deprivation Group



Average Weeks (elective) waiting by Ethnicity Group



Data Description and Target

Analysis of variation in weeks waiting on an elective waiting list according to the patient's Index of Multiple Deprivation, age and ethnicity grouping to understand areas of variation.
Emergency department admissions by Index of Multiple Deprivation (IMD) decile

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing elective waits for Quarter 1 2025/26, 9% of patients on the waiting list live in the 20% most deprived areas of Dorset (IMD 1-2). The average weeks waiting at the point of treatment for people in IMD 1-2 shows no variation compared to people from IMD 3-10, demonstrating maintenance of Q4 2024/25 performance. Analysing the same data by age band identifies one week's variation for children (<18 yrs) within the 20% most deprived being seen one week sooner, however Children within the 20% most deprived wait one week longer than adults.

Waiting list by ethnicity: 12% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the average weeks waiting by ethnicity grouping identifies no variation between patients within community minority groups and white British populations in Q1. One weeks' variation is seen in patients with an unknown ethnic group, who on average are waiting one week less than those who's ethnicity is recorded. The waiting time variation for <18-year-olds from community minority groups seen in Q1 shows waiting times have increased slightly for white British but decreased for community minorities. Children of unknown ethnicity have the longest wait, remaining at an average waiting time of 10.5 weeks; this is however an improvement from 12 weeks wait seen previously. White British are experiencing a 10 week wait (increased from 9) and Community Minorities waiting time average has reduced by one week to 8 weeks wait.

Key Areas of Focus

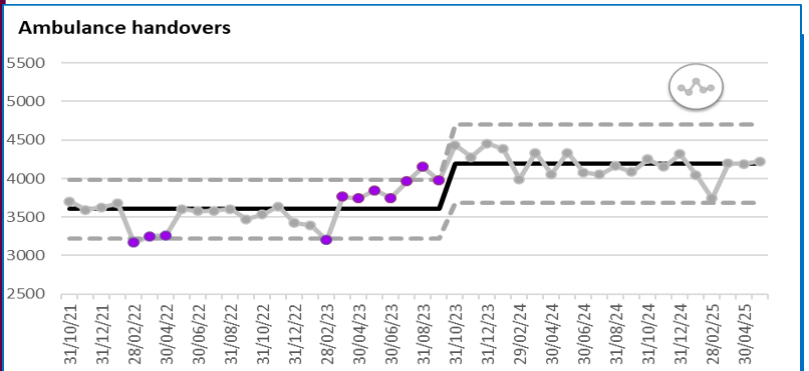
- The Trust's is continuing to deliver against the duties outlined within the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) to collect, analyse and publish information on health inequalities.
- Active engagement with Dorset ICS emerging delivery groups on addressing health inequalities and population health.
- Continue analysis of the Dorset DiiS Population Health System Core20Plus5 PHM dashboard for adults and children via the Dorset ICS delivery group on variation.
- Promote awareness raising on health inequalities and population health through education and training opportunities.
- Promoting ethnicity recording.

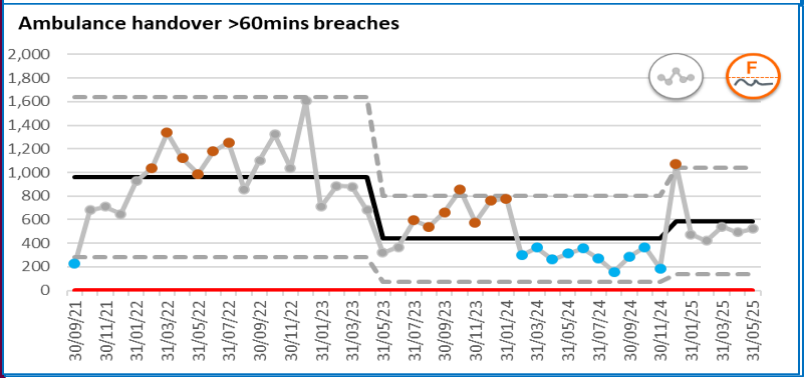
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Matrix

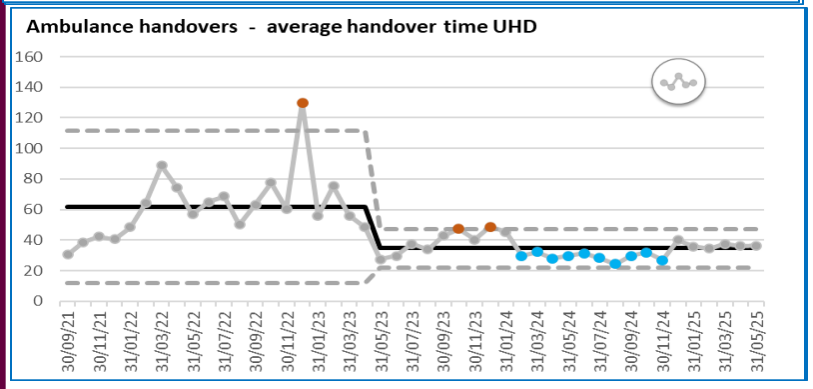
UHD Elective Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	May 25	62270	67842			64623	58187	71059
UHD - % Patients waiting >52 weeks (1%) against trajectory	May 25	3.3%	3.2%	L		3.6%	3.1%	4.1%
UHD - Patients waiting >78 weeks	May 25	0	0			0	0	0
UHD - Patients waiting >65 weeks	May 25	15	0	L	P	26	-8	60
UHD - Patients waiting >52 weeks	May 25	2065	2152	L		2168	1949	2387
UHD - Patients waiting >52 weeks non admitted	May 25	984	0	L	F	1258	977	1539
UHD - RTT Performance against trajectory for 18 week standard (92%)	May 25	62.3%	61.5%	H	F	58.8%	56.6%	60.9%
UHD - Total Diagnostic Waiting List	May 25	13426	-			12864	11365	14363
UHD - % waiting over 6 weeks	May 25	9.7%	1.0%		F	10.7%	5.7%	15.6%
UHD - % waiting over 13 weeks	May 25	0.4%		L	F	2.1%	0.2%	4.0%
UHD - Faster Diagnosis Standard (FDS) 28 days	Apr 25	72.1%	75.0%			72.3%	61.4%	83.2%
UHD 62 day standard	Apr 25	68.2%			F	66.1%	58.5%	73.8%
Trauma Admissions	May 25	413	-			372	313	432
% of NOF patients operated on within 36 hrs (admission from ED)	May 25	49.3%	85.0%			60.1%	33.4%	86.8%
% Outpatient appointments with procedures	May 25	21.8%		H		17.7%	16.0%	19.4%
UHD - Total Outpatient - Virtual (%)	May 25	17.5%	25.0%		F	17.4%	16.5%	18.2%
UHD Outpatient DNA rate	May 25	5.1%	5.0%			5.2%	4.7%	5.7%
Theatre utilisation (capped)	May 25	81.3%	85.0%		F	80.9%	78.2%	83.6%
UHD Theatre case opportunity	May 25	8.5%	15.0%		P	9.9%	5.4%	14.4%

Responsive – (Emergency) Ambulance Handovers







Data includes both SWAST and SCAS for handovers to ED

Data Description and Target

- Number of ambulance handover delays greater than 60 minutes from arrival to a receiving Emergency Department. 15 minutes is the target for an Ambulance to handover to a receiving ED from arrival. There should be no ambulances waiting over 60 minutes.
- Number of ambulance hours lost due to handover delays. There is a site level recovery trajectory for lost ambulance hours per day.

Performance

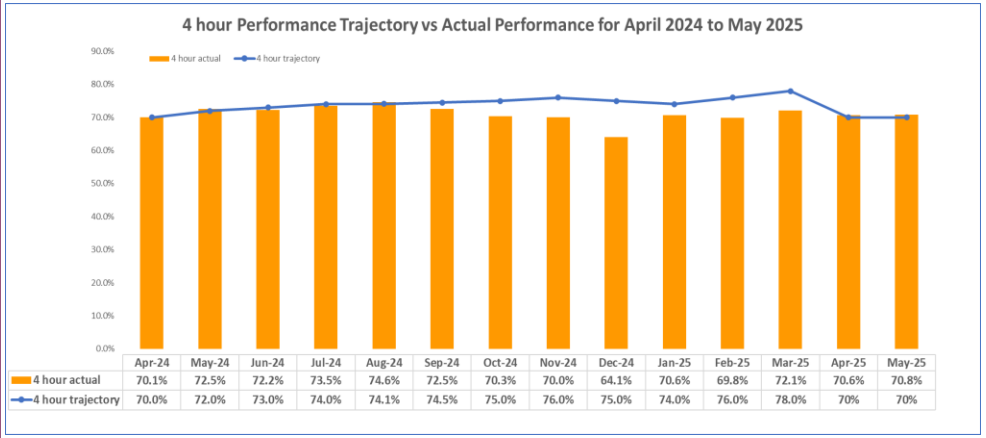
- In May, the RBH ED relocated to the new facility within the BEACH building.

- The total number of Ambulance handovers were broadly similar in May with 4,170 conveyances compared to April in which there were 4,289 conveyances.
- Ambulances waiting longer than 60 minutes has increased from 461 in April to 496 in May.
- Average handover duration at Poole 32.3 and RBH 39.81 minutes, UHD average 36.29 mins. This continues to be lower than the regional average which remains at circa 60-70 minutes.
- Days of poor performance continue to be driven by overcrowding within the ED with the department consistently lodging patients in non-clinical areas (corridor). The predominant reason for delayed handover remains insufficient capacity.
- Poole reported a total of 322 lost hours over 30 mins in May compared to 325 April. Bournemouth saw 538 in May compared to 458 in April.

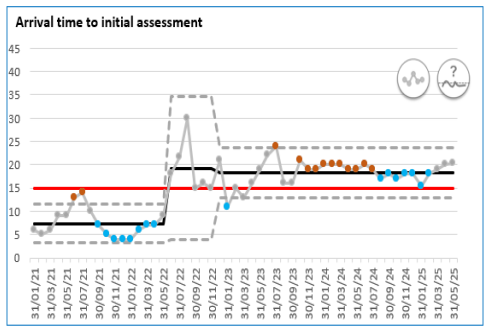
Key Areas of Focus

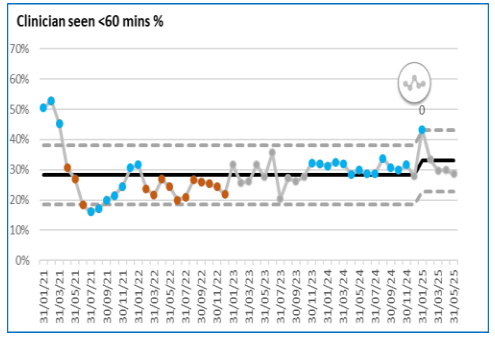
- Mitigating Key risks: ED occupancy and Provision of care in non-clinical areas (corridor) shows correlation with hospital occupancy. Key area of focus are on waiting to be seen times and internal ED processes alongside patient flow, to avoid overcrowding and to maintain capacity in ED to offload ambulances.
- Enactment of Timely Handover Process: Embedding internal ED and wider Trust response to Timely Handover Process enactment by Ambulance services.
- Refresh of 25/26 operating and improvement plans based on the emergency front door to include newly developed flow strategy for emergency hospital, integration with future care and developing the THP SOP in conjunction with Regional developments.

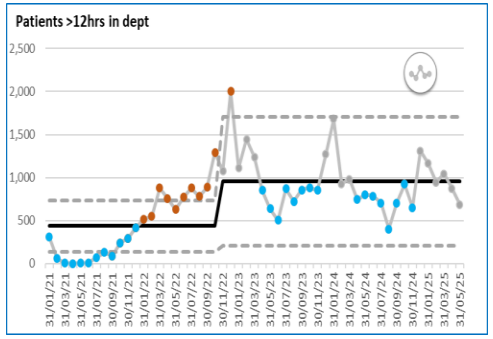
Responsive (Emergency) Care Standards

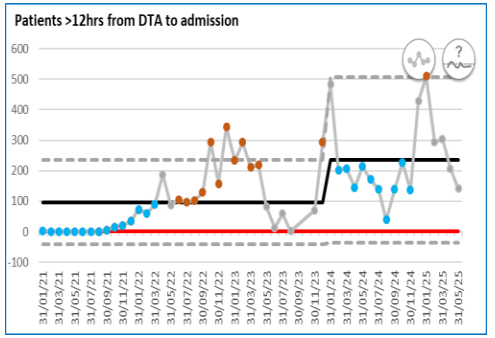


	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
4 hour actual	70.1%	72.5%	72.2%	73.5%	74.6%	72.5%	70.3%	70.0%	64.1%	70.6%	69.8%	72.1%	70.6%	70.8%
4 hour trajectory	70.0%	72.0%	73.0%	74.0%	74.1%	74.5%	75.0%	76.0%	75.0%	74.0%	76.0%	78.0%	70%	70%









Data Description and Target

UHD has now returned to reporting against the national 4-hour standard. The national requirement is to achieve 78% of all patients leaving ED within 4 hours for 2025/26.

Performance

Performance continues to be challenging through April delivering 70.8% against an internal trajectory of 70%.

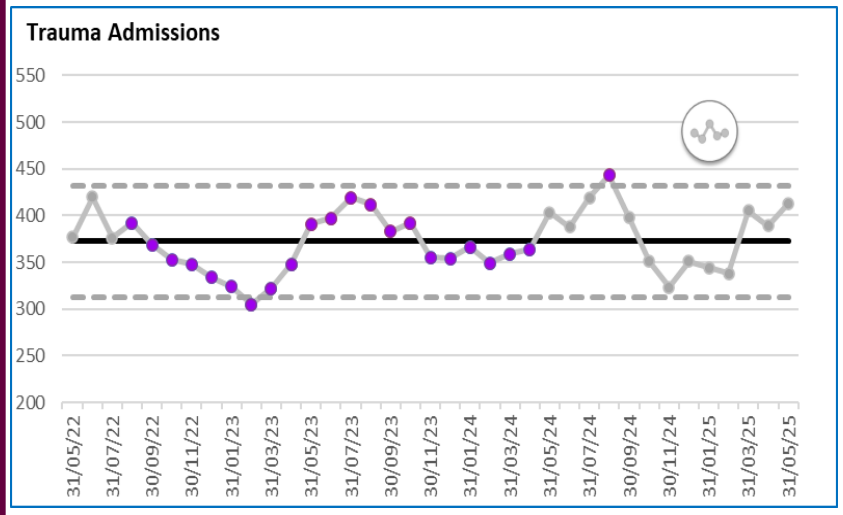
Key headlines:

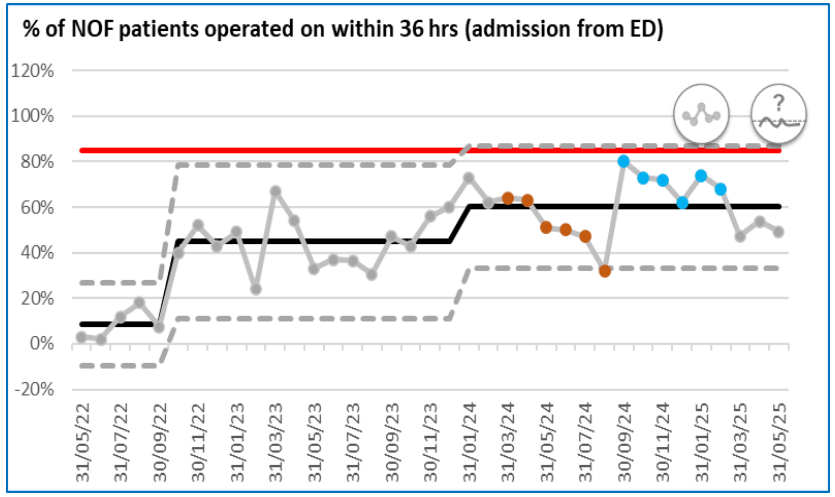
- Numbers of breaches increased by 281 against a decrease in Type 1 (5597 April to 5885 in May).
- Non referred performance was 72.74% (a decline of 0.26% over that of April 25)
- Referred performance was 29.2% (a 1% improvement over that of April)
- Admitted performance improving at 30.3% against a target of 36%.
- Non-Admitted performance remains the leading driver accounting for 54.97% of the overall breaches (but accounts for 73.6% of the directorate activity).
- There was a significant decline in waits to be seen (WTBS) in April with only 30.94% seen in 60mins (this increases to 44.52% when review by a Rapid Access Team (RAT) clinician is considered)
- Decision to admit and WTBS times remains a focus of the directorate action plan.
- Minors' performance was in excess of 93.6%.
- Predicted mortality decreased slightly from 27.17 in May from 29.2 in April.

Key Areas of Focus

- Mitigation of key risks: ED occupancy and Provision of care in non-clinical areas (corridor) and High Occupancy driven by number of patients with 'No Criteria to Reside,' (NCTR) noting sustained improvement during May 25.
- Continue to instil internal professional standards across Care Groups
- Improvement plan against 25/26 trajectories with a focus on emergency hospital front door ED and first 72-hour admission avoidance services.
- Continue to work towards expansion of SDEC services (specialty and extended hours/weekends).
- Developing close working with Future Care.
- Executive led enhanced support mechanism in place in accordance with accountability framework.

Responsive (Emergency)
Trauma Orthopaedics





Data Description and Target

National Hip Fracture Database (NHFD) Best Practice Tariff Target: Fractured neck of femur (#NoF) patients to be operated on within 36 hours of admission. NHFD average 59%
Quality Target: 95% of fractured neck of femur (#NoF) patients to be operated on within 36 hours of ***ED admission*** and being clinically appropriate for surgery.

Performance

May performance for time to theatre for fractured neck of femur (#NoF) patients: 73.4% achieving surgery within 36 hours of being fit for surgery and 49.3% operated on within 36 hours from ED admission.

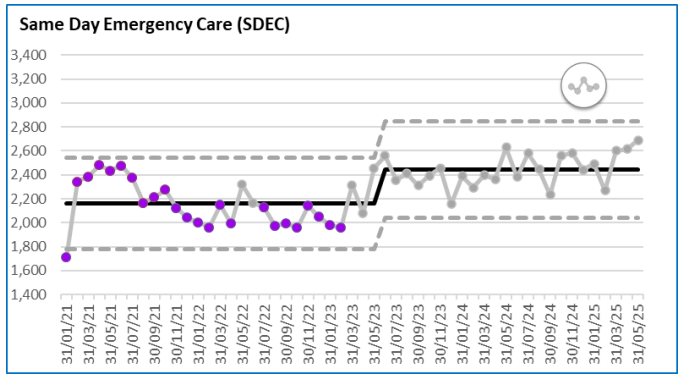
- There was an increase in admissions for trauma in May in line with the seasonal trend seen over the last 2 years with 413 admissions compared to 389 in April. In response the Trust carried out 253 operations compared to 227 in April. 83 patients with a fractured neck of femur (NoF) were operated on compared to 80 in April.
- Our attainment to surgery within 36 hours of admission has reduced slightly in May (49.3% in May, 53.75% in April), though the number of patients with a fractured NoF attending surgery within 36 hours of being fit or surgery increased despite more admissions.
- A peak of 15 fractured NOF admissions in 3 days during the month created a backlog of trauma cases awaiting surgery
- Delays were also due to day cases being prioritised as patients were being referred from clinic for surgery whose fractures were close or at their 2-week window following injury.
- 24% of our NoF's admitted in May were not fit for surgery on admission (increase from April which was 17.5%).
- 15 patients required additional operations resulting in an extra 15 operations.
- 16 patients were treated through the hand hub in May.
- We started the month in stage 2 of escalation remaining there for 2 weeks then escalated in to stage 3; additional theatre lists prior to the bank holiday weekend were scheduled.
- Planned radiology support continued to be a constraint in May due to workforce capacity.

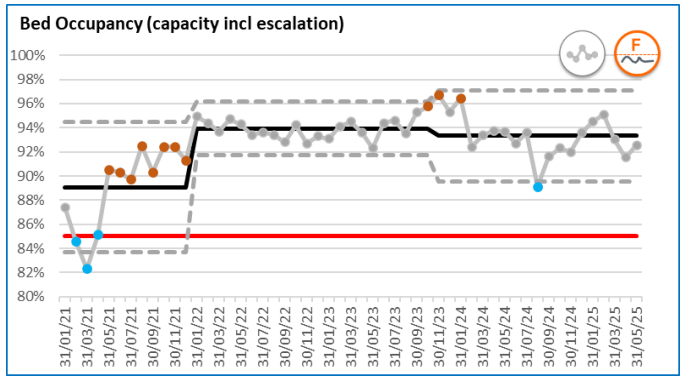
Key Areas of Focus

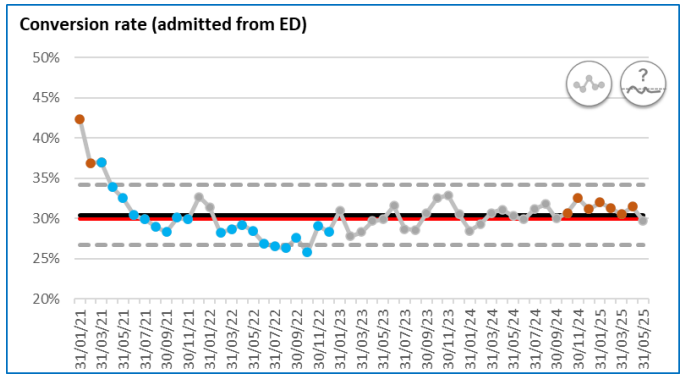
The opening position of June (as of 7th) is 100% of all fractured NOF patients having been operated on within 36 hours.
Maintaining this position, the key areas of focus in June are:

- A review of non-trauma outliers within trauma beds is being undertaken and the teams are working this through with clinical site and Care group bronze on a daily basis
- Care Group support to the T&O directorate to focus on covering medical anaesthetic gaps for all trauma theatre activity
- Early directorate response when trauma capacity is exceeding demand
- New Consultant interviews are taking place in June to increase theatre consultant cover and consultant trauma percentage covered
- Continued focus on maximising trauma theatre efficiency and mitigating periods of escalated service demand.
- Plans are being developed to future proof trauma for phase 3 moves to Poole and working up simulated data on how to reconfigure services in early 2026 whilst maintaining trauma flow and managing RTT performance.

Responsive – (Emergency) Patient Flow







Data Description and Target

88% bed occupancy would support flow and delivery of rapid progression from the Emergency Department within an hour of being clinically ready to proceed. The ICB operational plan uses 92% occupancy as its ambition.

Performance

In May, an average of 1,072 beds were occupied daily, this is a decrease of 18 in comparison to April, with an average occupancy of 92.6%. Bed occupancy reduced to c.90% on several days during the month.

Virtual Ward capacity is at 100 beds. The occupancy rate in May was 76.26% which shows opportunity to further develop virtual ward pathways. It should be noted that the number of patients going through Virtual Wards for frailty has increased to the highest in 12 months from an average of 730 to 858 in May.

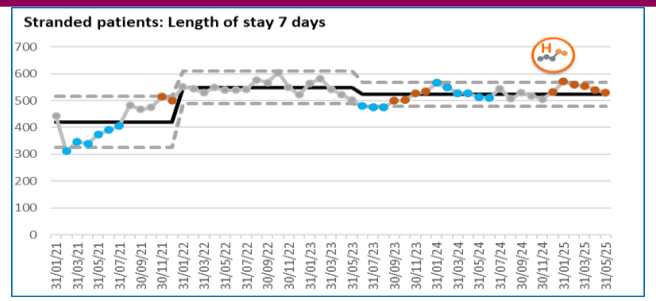
The average number of NCTR (patients with No Criteria to Reside) during May was 182 a further decrease from April which was reported as 196. This reduction was felt operationally unlocking flow through the organisation.

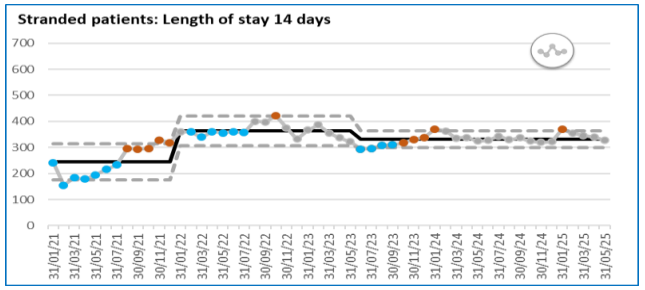
Despite the NCTR position, the occupied bed days continue to track favourably compared to the previous year.

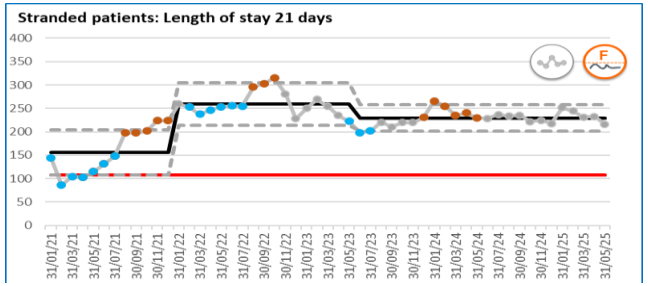
Key Areas of Focus

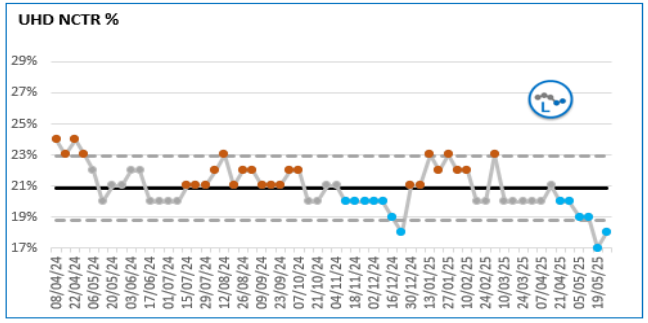
- A refreshed flow strategy is underway to pull together the multiple areas of work that contribute to flow including a significant piece of work to improve Health of the ward and people's engagement with the system. This forms part of a wider piece of work building the Care Coordination Hub and connecting multiple operational systems to help to more effectively manage flow using real time information.
- Reducing / optimising Length of Stay and reducing the consumption of Occupied Bed Days (OBDs) via Care Group bed mitigation plans.
- Transfer of Care Hub has launched on the RBH site with a trial on Ward 22.

Responsive – (Emergency /Elective)
Length of Stay & Discharges









Data Description and Target

The number of patients with a length of stay greater than 7, 14 and 21 days.

The proportion of delays in discharge for whom the patient has no criteria to reside.

Performance

Key Performance Headlines May 25,

- 21+ day length of stay position shows the Trust as significantly beyond the target of a maximum of 108 patients. There is a strong correlation between the NCTR position and > 21day patients. Poole Hospital has seen a resumption of an improving position however Royal Bournemouth site is showing a deteriorating position.
- A 0.6 day length of stay improvement has been delivered compared to previous year.
- Weekend discharges continue to show improvement particularly on a Saturday where P0 discharges have consistently been above 100 in May.

Key Areas of Focus

- As part of the UHD Capacity plan, patients who have been in hospital longer than 21 days with a criteria to reside will be reviewed and tracked.
- 'Patient First,' approach has helped to enhance the escalation process. The process also includes the allocation of a 'discharge navigator,' at day 50 and a senior sponsor at day 75.
- The trust has started to roll out 'my care needs' across Older People's Wards, which supports early discharge planning and again, should help to prevent long lengths of stay for patients, through early identification of a delay. There is interest in this initiative from other colleagues across Dorset.
- The Trust is very engaged in the Future Care programme to affect discharge across Dorset. This will have a focus on a number of areas including Transfer of Care Hubs (TOCs) aimed at reducing NCTR and increasing the rate of discharges from the Trust (Pathway 1-3).
- Transfer of care hub has launched on the RBH site, with a specific focus on Ward 22.

Performance at a glance – (Emergency)
Key Performance Indicator Matrix

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Arrival time to initial assessment	May 25	20	15		?	18	13	24
Clinician seen <60 mins %	May 25	29%	-			33%	23%	43%
Patients >12hrs from DTA to admission	May 25	142	0		?	235	-37	506
Patients >12hrs in dept	May 25	684	-			956	211	1701
4 hour safety standard	May 25	70.8%	70.0%		?	67.2%	61.5%	72.9%
Ambulance handovers - average handover time UHD	May 25	36.3	-			34.6	21.9	47.3
Ambulance handovers - average handover time RBH	May 25	39.8	-	H		37.2	22.8	51.5
Ambulance handovers - average handover time Poole	May 25	32.3	-	H		32.1	19.5	44.6
Ambulance handover >60mins breaches	May 25	523			F	588	137	1038
Ambulance handovers	May 25	4223	-			4189	3680	4699
Bed Occupancy (capacity incl escalation)	May 25	93%	85%		F	93%	90%	97%
Stranded patients: Length of stay 7 days	May 25	529	-	H		524	480	568
Stranded patients: Length of stay 14 days	May 25	328	-			332	300	364
Stranded patients: Length of stay 21 days	May 25	216	108		F	230	202	258
Non-elective admissions	May 25	6798	-			6157	5280	7034
> 1 day non-elective admissions	May 25	4105	-			3843	3291	4395
Same Day Emergency Care (SDEC)	May 25	2689	-			2443	2038	2847
Conversion rate (admitted from ED)	May 25	29.7%			?	30.4%	26.7%	34.1%

Sustainable Services

University Hospitals Dorset
NHS Foundation Trust

Pete Papworth
Chief Finance Officer

Operational Lead:
Adrian Tron, Deputy Chief Finance Officer

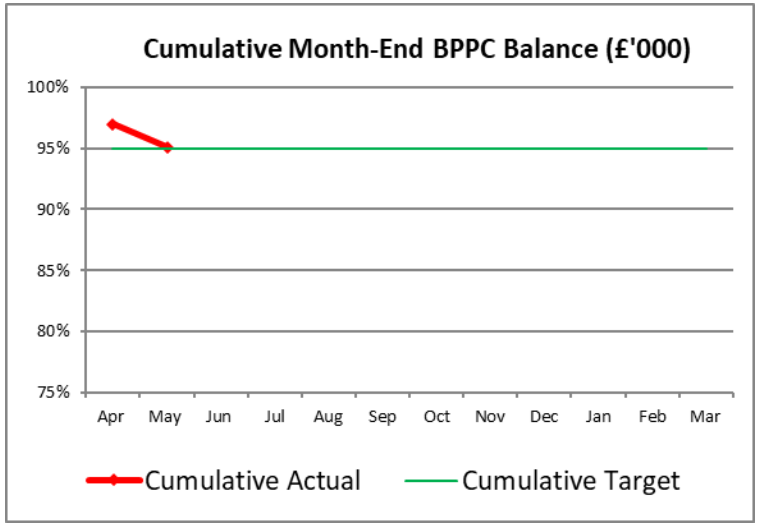
Committees:
Finance and Performance Committee

Finance – Key Financial Indicators

Summary I&E	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Total Income	**147,493**	**147,407**	**(86)**	**880,974**		
Employee expenses	(99,781)	(99,921)	(140)	(585,755)		
Clinical supplies expenses	(12,076)	(12,299)	(223)	(71,049)		
Drugs expenses	(14,687)	(14,540)	148	(91,099)		
Purchase of healthcare and social care	(2,340)	(3,179)	(839)	(12,681)		
Depreciation and amortisation expense	(5,928)	(5,928)	(0)	(36,005)		
Clinical negligence expense	(3,150)	(3,150)	0	(18,898)		
Premises & fixed plant	(5,788)	(5,861)	(73)	(35,119)		
Other operating expenses	(6,171)	(5,498)	673	(102,472)		
Operating Expenses	**(149,921)**	**(150,376)**	**(454)**	**(953,078)**		
Net finance costs	(2,434)	(2,265)	169	(14,603)		
Other adj to control total basis	247	570	323	86,707		
Control Total Surplus/ (Deficit)	**(4,616)**	**(4,664)**	**(49)**	**0**	**0**	**0**

Capital	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Estate Schemes	3,172	3,172	0	16,189	16,189	0
IT Schemes	3,217	3,848	(631)	10,838	10,838	0
Medical Equipment	834	203	631	6,053	6,053	0
Total Operational CDEL	**7,223**	**7,223**	**0**	**33,080**	**33,080**	**0**
Total Donated Assets	**340**	**340**	**0**	**1,401**	**1,401**	**0**
CDC - Endoscopy Hub Build	1,145	1,145	0	6,000	6,000	0
CDC - Outpatient Assessment Centre	570	570	0	22,200	22,200	0
CIR - Critical Infrastructure Funding	9	9	0	2,780	2,780	0
DDP - Digital Pathology	0	0	0	0	0	0
ELR - Elective Recovery	62	62	0	78	78	0
EPR - Front Line Digitisation	0	0	0	2,784	2,784	0
NHP - FBCa / Enabling / FBCB	13,063	13,063	0	77,655	77,655	0
SOL - Renewables - Solar Partnership Schem	0	0	0	1,360	1,360	0
STPW1 - Beach & PH Theatres (ESL & C2)	3,130	3,130	0	21,141	21,141	0
UEC - Urgent Emergency Care	0	0	0	1,000	1,000	0
Total Central PDC	**18,040**	**18,040**	**0**	**139,816**	**139,816**	**0**
UHD Capital Total	**25,603**	**25,603**	**0**	**174,297**	**174,297**	**0**

Balance Sheet	Prior Year	YTD	Forecast
	31/03/2025	30/04/2025	31/03/2026
	£'000	£'000	£'000
Total non-current assets	**610,382**	**616,898**	**746,424**
Inventories	9,934	10,494	9,000
Receivables	17,654	18,932	19,250
Cash and cash equivalents	102,496	98,805	74,976
Total current assets	**130,084**	**128,231**	**103,226**
Trade and other payables	(100,571)	(120,923)	(85,000)
Other current liabilities	(6,039)	(8,612)	(6,975)
Total current liabilities	**(106,610)**	**(129,535)**	**(91,975)**
Borrowings	(39,507)	(39,097)	(37,020)
Other non-current liabilities	(2,997)	(2,950)	(2,568)
Total non-current liabilities	**(42,504)**	**(42,047)**	**(39,588)**
Total net assets employed	**591,352**	**573,547**	**718,087**
Public dividend capital	585,114	590,498	724,981
Revaluation reserve	60,076	51,887	60,076
Other reserves	2,819	0	0
Income & expenditure reserve	(56,657)	(68,838)	(66,970)
Total taxpayers' and others' equity	**591,352**	**573,547**	**718,087**



At the end of May the Trust has reported a deficit of £4,664k, £49k behind plan

Income is £86k adverse to plan year to date. Key drivers of this are :

- Private patients income £182k adverse / NHSE income £46k favourable (cancer drugs fund income received) / Other operating income £124k favourable (mainly due to Locums nest recharges, offset with pay costs)

Operating expenditure is £454k adverse to plan year to date, with key drivers being:

- Clinical supplies £223k adverse (pathology non pay spend) / Purchase of healthcare £839k adverse (CDC, radiology insourcing, offset other spend lines), pay £140k adverse

The above adverse variances partly offset by:

- Drugs spend £149k favourable / Other operating expenses £673k favourable (CDC expenditure)

Finance costs are £169k favourable (bank interest)

Agency spend is £1,367k, and bank spend £8,111 million year to date. While Agency spend is well below planned spend YTD, bank spend increased in May and is now higher than planned YTD

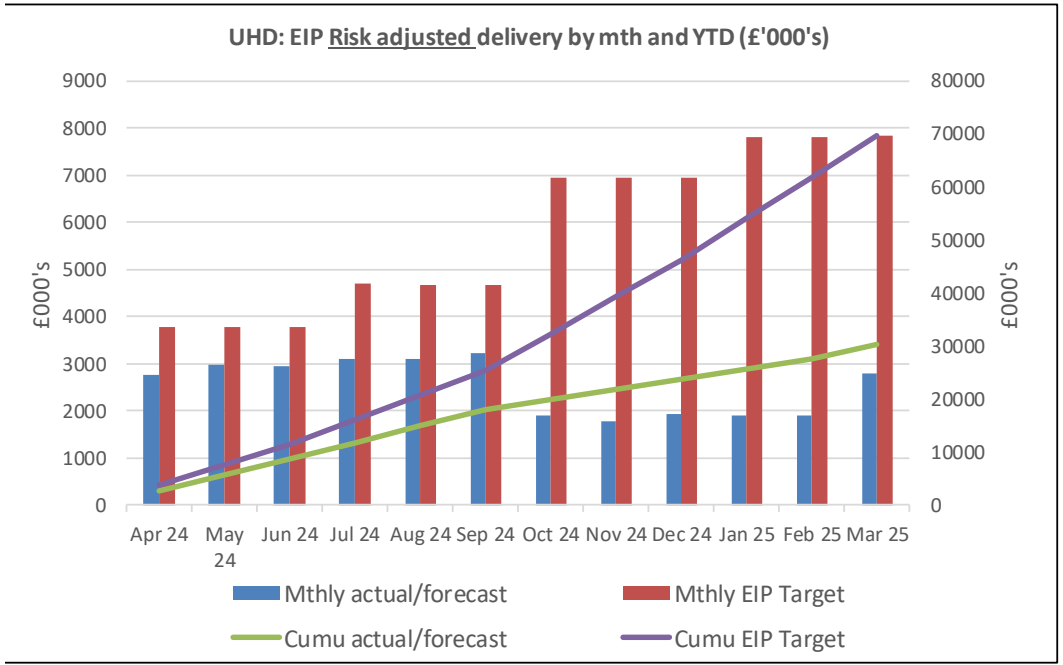
The Trust has reported **capital expenditure of £25.6 million YTD, in line with the plan**, and is **forecasting full achievement of the full year capital programme**

As at April 2025 the **Trust is holding a consolidated cash balance of £98.8 million** which is fully committed.

In relation to the **Public Sector Payment Performance the Trust is currently delivering performance of 95.1%** ahead of the national standard of 95%.

Finance – Efficiency Improvement Programme

	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	Forecast	Variation	Target	Forecast	Variation	% of target	Forecast	% of target	Forecast	Variation	% of target
Surgical	(1,312)	579	(733)	(8,551)	2,778	(5,773)	32%	4,609	54%	1,017	(7,534)	12%
Medical	(1,659)	1,739	80	(12,524)	5,922	(6,602)	47%	7,977	64%	3,111	(9,413)	25%
WCCSS	(1,829)	1,065	(765)	(11,318)	5,796	(5,522)	51%	6,651	59%	2,373	(8,945)	21%
Operations	(318)	121	(198)	(1,875)	785	(1,090)	42%	1,090	58%	397	(1,477)	21%
Corporate	(638)	949	310	(3,875)	4,312	436	111%	4,852	125%	2,617	(1,258)	68%
Trust Wide	(1,812)	2,139	327	(23,497)	16,461	(7,036)	70%	17,165	73%	8,600	(14,897)	37%
Dorset wide schemes	0	0	0	(7,986)	0	(7,986)	0%	7,986	100%	0	(7,986)	0%
UHD	**(7,569)**	**6,591**	**(978)**	**(69,625)**	**36,053**	**(33,572)**	**52%**	**50,330**	**72%**	**18,115**	**(51,510)**	**26%**



For the month ended May 2025, the trust is reporting a **forecast risk adjusted achievement of £36.0m** against the annual target of £69.6 million leaving a **gap of £33.6million still to identify**.

The **non risk adjusted forecast is reported as £50.3 million** leaving as gap of £19.3m.

Recurrently schemes amounting to £18.1 million have been identified leaving a £51.5 million recurrent shortfall against the recurrent target for the year.

Non-risk adjusted full year effects of new schemes identified in 25/26 amount to £8.6 million.

84% of schemes have completed the PID process and work is ongoing to draft and finalise the remaining 16%.

Discussions with the Care groups will take place to review non recurrent schemes and any potential to make them recurrent.

A Productivity & Efficiency workshop held on 30th April to support the Care Groups in identifying further cash and non-cash releasing schemes was well attended and received. Follow up actions are being worked through.

Digital

Beverley Bryant
Chief Digital Officer

University Hospitals Dorset
NHS Foundation Trust

Information Technology

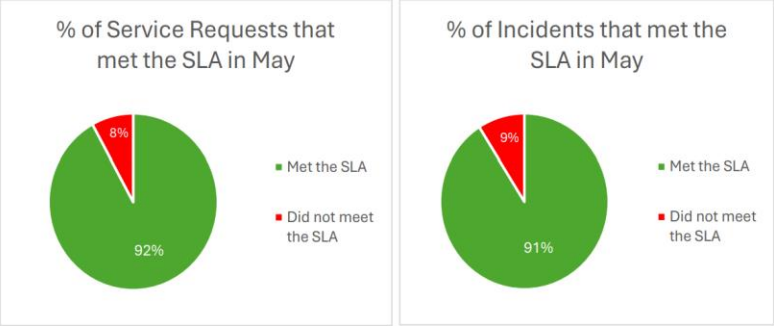
IT Tickets logged

Top Tickets logged per Service			
Service	Service Requests	Incidents	Total
Clinical Application	1,608	950	2,558
Service Desk	1,187	620	1,807
Password	0	1,403	1,403
Non-Clinical Software	819	84	903
Email	543	186	729
Hardware	255	223	478
Telecoms	64	91	155
Printing	0	94	94
Network	23	58	81
Mobile Device	7	27	34
IT / Cyber Security	6	7	13

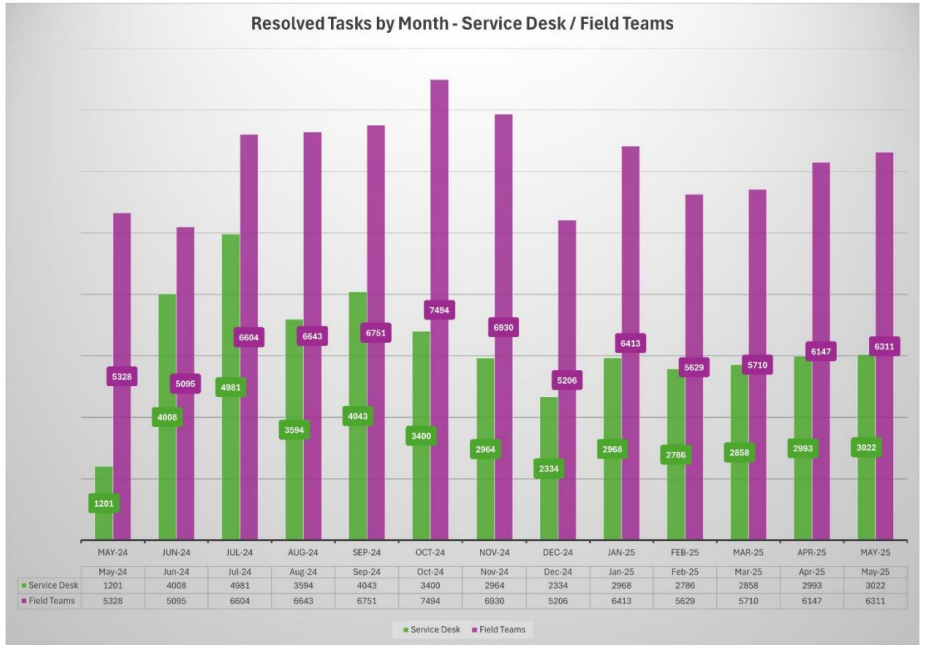
Monthly P1 Position

Priority 1 Incidents					
Incident Description	Ref Number	Fixed within current SLA?	Actual Fix Time (Hours)	Cause Resolution	3rd Party assistance
EPR outage	1251854	Yes	3.5	Took servers out of load balancer and reloaded servers. Graphnet DBA confirmed they could not identify a Database issue. Seems to be stable for 2,3 and 4 connections. Server 1 is still having issues and Graphnet will investigate to see if they can identify	Yes
EPR outage	1252718	Yes	3	Infrastructure to do extensive logging on server to identify cause.	Yes

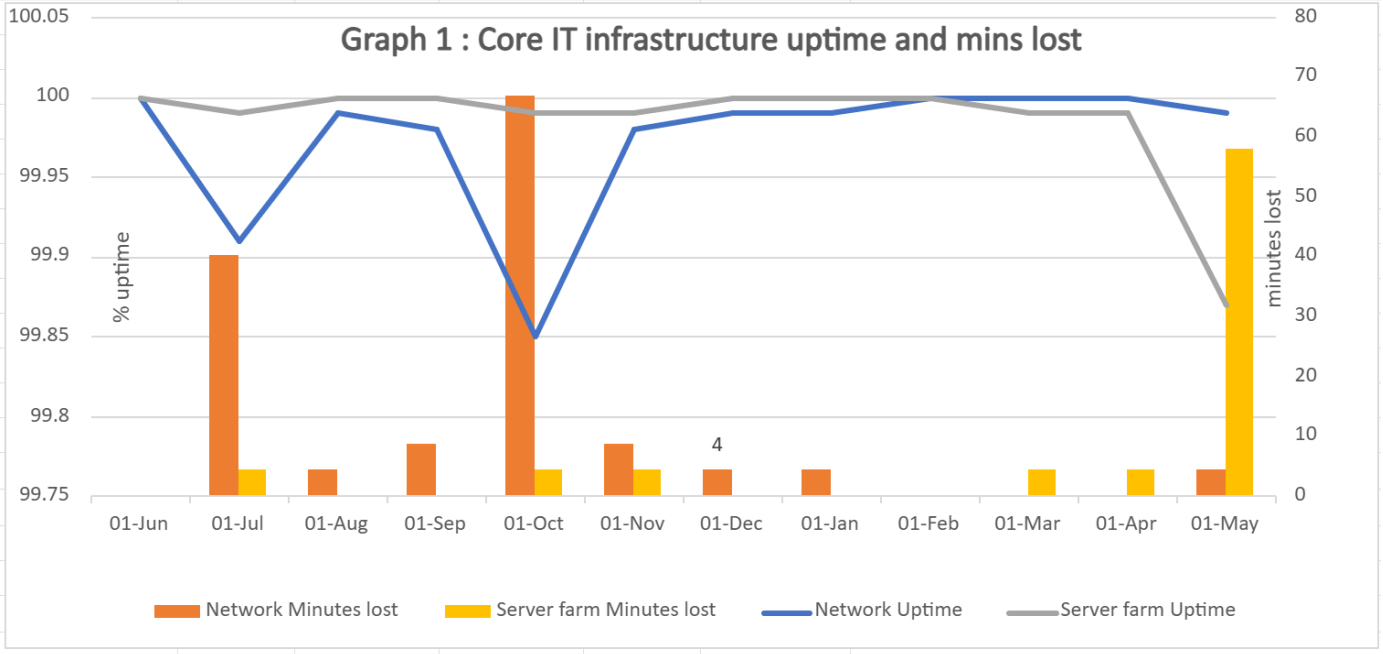
Service Call SLA Position



Resolved IT Tasks



Core Infrastructure Uptime



Information Governance & Cyber

Table 4: Freedom of Information compliance

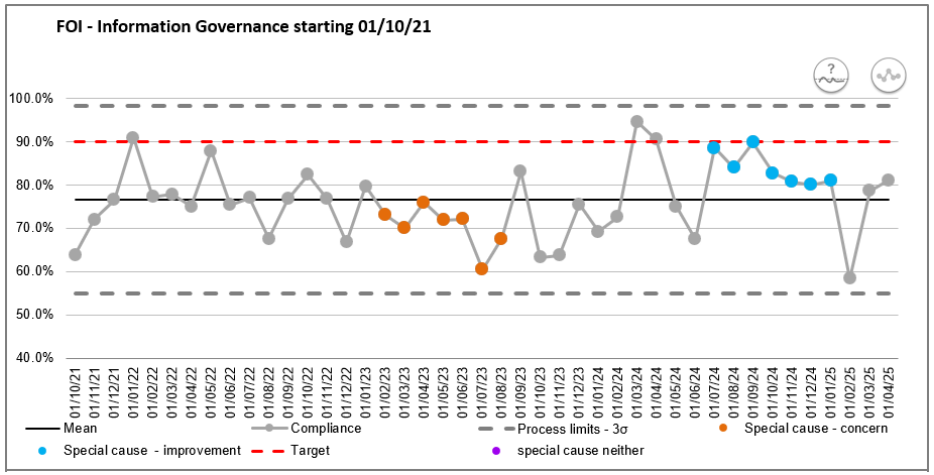
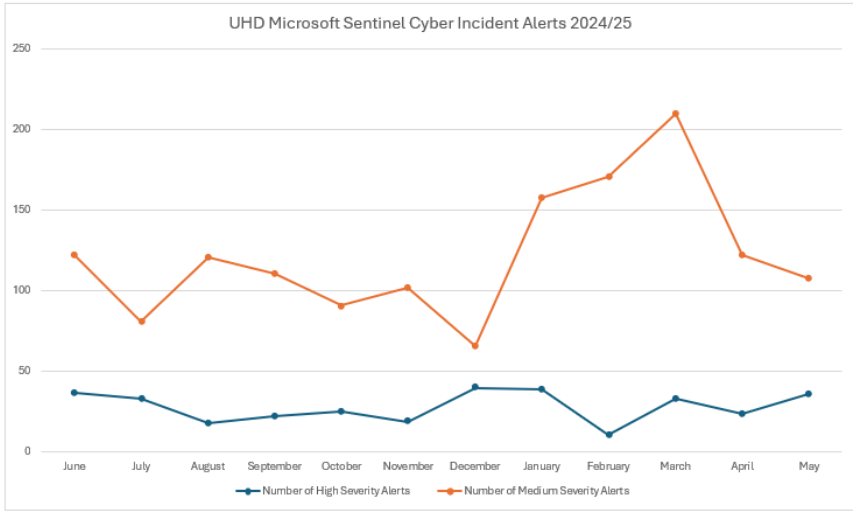


Table 5: SIEM Incident Alerts

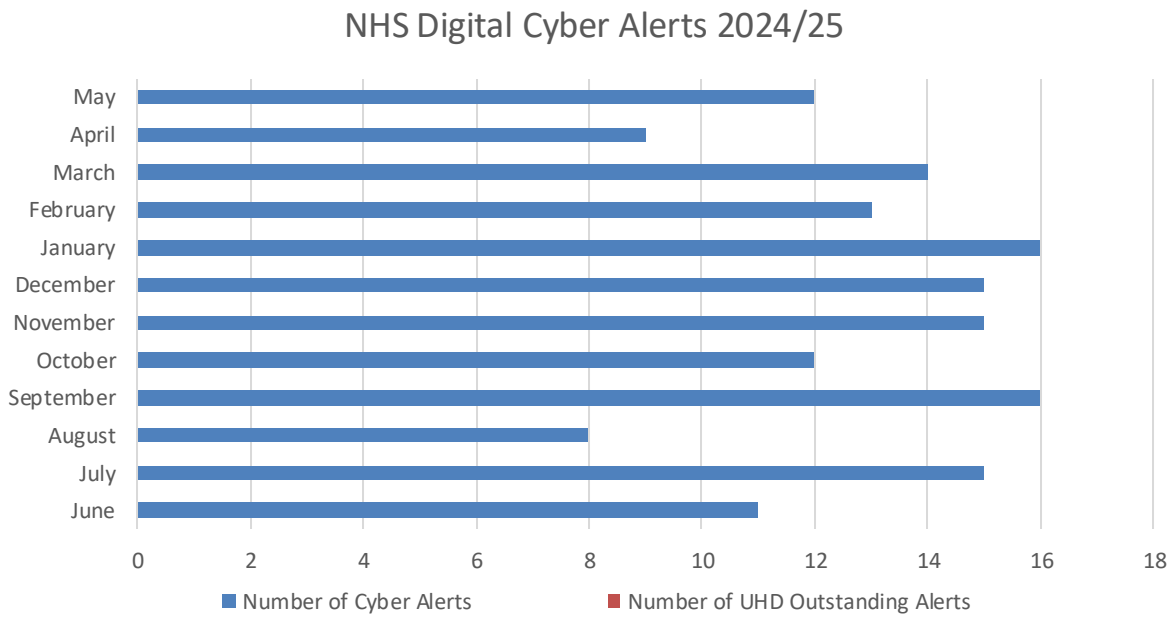


Microsoft Sentinel is a cloud-native security information and event management (SIEM) platform that uses built-in AI to help analyse large volumes of data across an enterprise. The alerts are based on potential suspicious activities.

Commentary

Table 4: shows a Statistical Process Control chart for the UHD Freedom of Information Act Compliance.
Chart 5: Show Microsoft Sentinel Cyber alerts trending for UHD
Table 6: Current position on NHS Digital Cyber Alerts

Table 6: NHS Digital Alerts

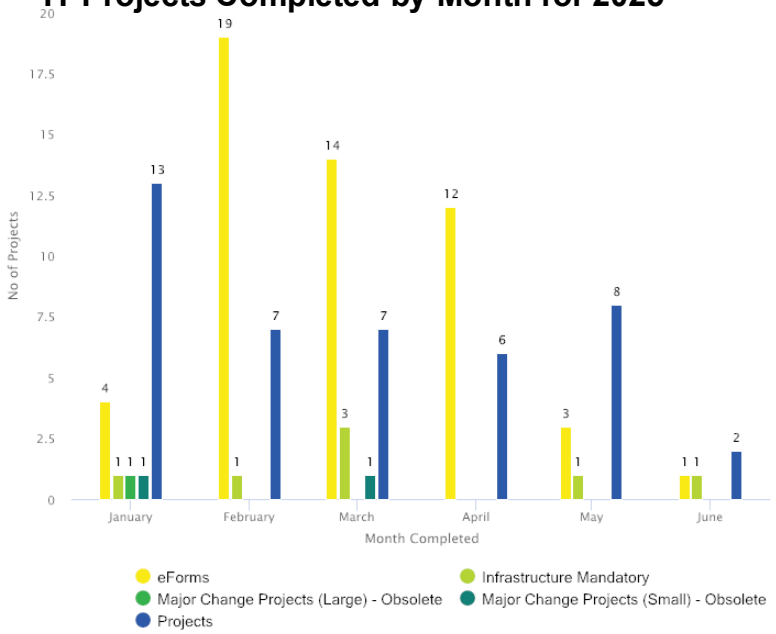


Development & Medical Records

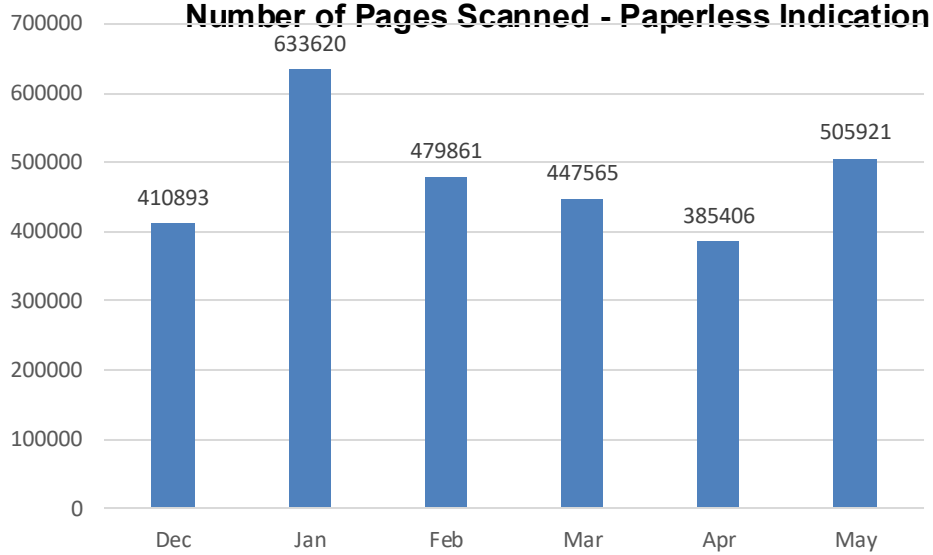
EHR Programme Timeline

Current Go live	November 2028
Previous Go Live	Feb 2028 October 2027 June 2027
Reason for Change	No change EPRIB Approval to proceed

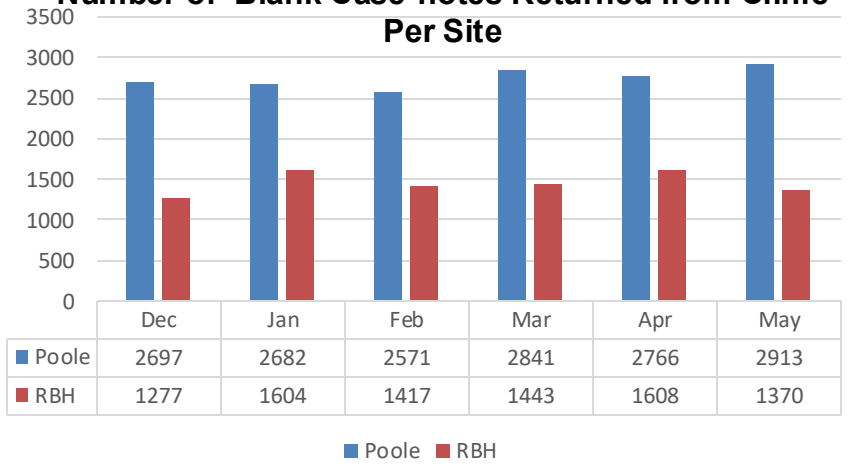
IT Projects Completed by Month for 2025



Number of Pages Scanned - Paperless Indication



Number of Blank Case-notes Returned from Clinic Per Site



	Dec	Jan	Feb	Mar	Apr	May
Poole	2697	2682	2571	2841	2766	2913
RBH	1277	1604	1417	1443	1608	1370

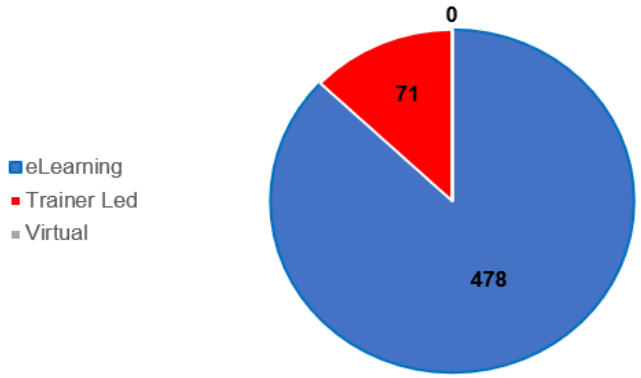
Training Statistics

Face to Face or eLearning Delivered

Total Trained - May 2025

549

Total by Course Delivery Mode:



Data Quality - Numbers of Merged Records per Month

An indication of Duplicate Records created and resolved

99.5% NHS number Compliant per month

Number of Merged Records each Month