University Hospitals Dorset
NHS Foundation Trust



# Integrated Performance Report

Reporting month: July 2025

# Contents

# Key Achievements

## In 2025/26 achievements to date have included :

- The percentage of RTT pathways at 18 weeks or less continues to improve exceeding the trajectory.
- The DM01 target of 5% was delivered in July (performance 2.5%). In addition , the DM01 % constitutional standard (1%) has been achieved by CT, Dexa, MRI and Ultrasound this month.
- Provisional cancer results for July indicate a continued improvement with the operational plan trajectory and national targets for the Faster Diagnostic standard and 31 day standard being met.
- The Trust delivered 120% (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 continues to flag as special cause variation improvement.
- Sustained improvement in occupied bed day usage month on month .

# Performance at a Glance Indicators (1)

| | | | standard | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SAFE** | | | | | | | | | | | | | | | | | |
| Quality | Presure Ulcers (Hospital Acquired Cat 3 & 4) | | | 9 | 15 | 11 | 13 | 14 | 9 | 10 | 12 | 16 | 13 | 12 | 17 | 11 | 19 |
| | Inpatient Falls (Moderate +) | | | 2 | 6 | 8 | 7 | 10 | 7 | 7 | 11 | 6 | 11 | 9 | 8 | 3 | 6 |
| | Medication Incidents (All) | | | 177 | 165 | 151 | 176 | 161 | 123 | 153 | 161 | 162 | 164 | 150 | 144 | 162 | 184 |
| | Patient Safety Incidents (All) | | | 1092 | 1211 | 1173 | 1178 | 1334 | 1107 | 1219 | 1193 | 1216 | 1226 | 1115 | 1238 | 1174 | 1385 |
| | Hospital Acquired Infections | MRSA | | 0 | 2 | 2 | 0 | 0 | 0 | 3 | 1 | 0 | 2 | 1 | 0 | 0 | 0 |
| | | MSSA | | 4 | 8 | 8 | 5 | 5 | 3 | 5 | 3 | 7 | 8 | 4 | 4 | 6 | 2 |
| | | C Diff | | 8 | 7 | 11 | 11 | 11 | 10 | 14 | 18 | 6 | 8 | 10 | 11 | 5 | 7 |
| | | E. coli | | 9 | 14 | 13 | 7 | 9 | 12 | 14 | 18 | 14 | 19 | 18 | 13 | 14 | 12 |
| | | Kleb | | 1 | 3 | 12 | 8 | 8 | 3 | 7 | 8 | 5 | 8 | 3 | 6 | 3 | 4 |
| | | Pseudo | | 1 | 3 | 1 | 0 | 5 | 2 | 3 | 4 | 2 | 0 | 3 | 2 | 1 | 2 |
| | Hand Hygiene Compliance | | | 95.9% | 96.0% | 94.7% | 95.6% | 96.6% | 96.2% | 96.2% | 96.2% | 94.3% | 95.7% | 95.1% | 94.3% | 95.3% | 95.3% |
| | Infection Control Mandatory Training Compliance | | | 89.0% | 89.4% | 90.1% | 90.0% | 89.9% | 89.6% | 89.6% | 89.5% | 89.2% | 89.2% | 88.9% | 89.1% | 88.9% | 89.7% |
| **EFFECTIVE** | | | | | | | | | | | | | | | | | |
| Mortality | HSMR In Month (UHD) | Latest Feb 25 | | 113.5 | 94.3 | 87.3 | 104.7 | 88.8 | 93.2 | 90.3 | 93.2 | 89.1 | 97.2 | 90.8 | | | |
| | Deaths within 36hrs of Admission | | | 39 | 32 | 18 | 28 | 22 | 33 | 44 | 41 | 33 | 34 | 25 | 26 | 35 | 31 |
| | Deaths within 5 day readmission spell | | | 20 | 15 | 16 | 23 | 21 | 18 | 22 | 22 | 22 | 17 | 11 | 18 | 20 | 17 |
| **CARING** | | | | | | | | | | | | | | | | | |
| | Complaints Received | | | 68 | 64 | 58 | 76 | 75 | 63 | 54 | 65 | 54 | 54 | 79 | 58 | 68 | 78 |
| | Complaint Response Rate (Grade based target) | | | 54.9% | 59.3% | 48.6% | 56.6% | 64.7% | 42.2% | 33.9% | 41.3% | 31.5% | 43.8% | 51.7% | 67.2% | 48.3% | 73.3% |
| | Friends & Family Test | | | 95.0% | 94.5% | 94.9% | 99.5% | 94.3% | 94.2% | 96.2% | 96.0% | 94.3% | 93.5% | 93.0% | 94.3% | 93.9% | 94.4% |
| **WELL LED** | | | | | | | | | | | | | | | | | |
| Safety | Risks 12 and above on Register | | | 46 | 45 | 44 | 59 | 67 | 68 | 65 | 65 | 70 | 73 | 63 | 64 | 60 | 58 |
| | Risks 15 and above on Register | | | 21 | 22 | 20 | 19 | 20 | 19 | 21 | 22 | 23 | 23 | 19 | 19 | 18 | 14 |
| | Red Flags Raised | | | 9 | 20 | 13 | 26 | 31 | 15 | 21 | 51 | 19 | 24 | 5 | 5 | 1 | 1 |
| People | Turnover | | | 10.6% | 10.5% | 10.6% | 10.7% | 10.6% | 10.6% | 10.5% | 10.6% | 10.7% | 10.7% | 10.8% | 11.0% | 11.1% | 11.0% |
| | Vacancy Rate | Reported 1 month in arrears | | 8.3% | 8.8% | 8.6% | 8.2% | 6.6% | 5.0% | 5.1% | 5.1% | 4.8% | 4.4% | 7.4% | 7.7% | 7.6% | |
| | Sickness Rate (rolling 12 month) | | | 4.5% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.7% | 4.7% | 4.7% | 4.8% | 4.8% | 4.8% | 4.8% | 4.8% |
| | Statutory and Mandatory Training | | | 90.2% | 90.5% | 90.9% | 89.8% | 90.1% | 89.9% | 90.2% | 90.2% | 90.4% | 90.3% | 89.9% | 89.7% | 89.8% | 90.1% |
| | Appraisal Compliance - Values Based | | | 55.1% | 55.8% | 63.2% | 71.5% | 78.2% | 81.2% | 82.6% | 83.4% | 83.8% | 84.2% | 81.3% | 75.9% | 69.3% | 60.4% |
| | Appraisal Compliance - Medical & Dental | | | 78.1% | 79.7% | 80.8% | 77.9% | 81.0% | 82.8% | 82.7% | 84.8% | 83.4% | 85.0% | 86.2% | 87.0% | 86.6% | 85.5% |
| | Temporary Hours Filled by Bank | | | 61.3% | 61.4% | 62.1% | 62.4% | 60.7% | 61.8% | 57.5% | 62.3% | 63.9% | 65.6% | 65.8% | 66.4% | 66.9% | 70.9% |
| | Temporary Hours Filled by Agency | | | 19.2% | 18.5% | 19.0% | 19.4% | 18.7% | 18.2% | 18.1% | 15.6% | 14.2% | 13.0% | 13.8% | 14.3% | 12.6% | 8.2% |
| | Agency Pay as Proportion of Total Pay | | | 3.0% | 3.0% | 2.6% | 2.7% | 1.9% | 2.0% | 1.9% | 1.7% | 1.4% | 0.8% | 1.3% | 1.4% | 1.2% | 0.9% |

# Performance at a Glance Indicators (2)

| | | | standard | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RESPONSIVE** | | | | | | | | | | | | | | | | | | |
| RTT | 18 week performance % (92% standard) | 62.4% (July 2025) | | 61.1% | 61.2% | 61.1% | 61.4% | 60.8% | 61.1% | 60.5% | 60.6% | 59.9% | 60.9% | 60.8% | 62.3% | 63.6% | 63.4% | RAG rated based on trajectory |
| RTT | Waiting list size | 67,615(July 2025) | | 67,977 | 68,825 | 68,760 | 68,039 | 67,993 | 67,413 | 68,079 | 67,553 | 67,733 | 67,109 | 64,489 | 62,270 | 62,703 | 62,203 | RAG rated based on trajectory |
| RTT | No. patients waiting 52+ weeks | 1,850 (July 2025) | | 2,999 | 2,841 | 2,532 | 2,226 | 2,177 | 2,172 | 2,044 | 2,167 | 2,216 | 2,184 | 2,261 | 2,065 | 2,099 | 1,959 | RAG rated based on trajectory |
| RTT | No. patients waiting 65+ weeks | | | 472 | 459 | 351 | 65 | 48 | 16 | 16 | 29 | 32 | 10 | 5 | 15 | 14 | 18 | |
| RTT | No. patients waiting 78+ weeks | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | RAG rated based on trajectory |
| RTT | % waiting <18 weeks for 1st attendance | 69.96% (July 2025) | | | | | | 67.84% | 67.96% | 67.93% | 68.16% | 69.17% | 70.18% | 70.30% | 71.70% | 73.60% | 74.50% | |
| Theatre | Theatre utilisation (capped) | | 85% | 81.4% | 81.2% | 82.9% | 80.3% | 80.6% | 81.9% | 78.7% | 78.3% | 80.5% | 80.9% | 81.5% | 81.3% | 79.5% | 80.2% | |
| Theatre | NOFs (Within 36hrs of admission rom ED - NHFD) | | 85% | 50% | 47% | 32% | 80% | 73% | 72% | 62% | 74% | 68% | 47% | 54% | 49% | 73% | 67% | |
| Outpatients | **Outpatient metrics** | | | | | | | | | | | | | | | | | |
| Outpatients | Overdue Follow up Appts | | | 25,642 | 25,492 | 25,407 | 25,706 | 25,658 | 25,982 | 27,881 | 28,813 | 27,688 | 26,571 | 26,821 | 27,349 | 27,351 | 27,842 | |
| Outpatients | % DNA Rate | | 5% | 5.1% | 5.1% | 5.7% | 5.5% | 5.3% | 5.6% | 5.7% | 5.1% | 4.9% | 4.8% | 5.2% | 5.1% | 5.2% | 5.2% | |
| Outpatients | Patient cancellation rate | | | 11.6% | 11.3% | 11.2% | 11.5% | 11.2% | 9.9% | 11.4% | 10.5% | 10.4% | 10.3% | 10.2% | 10.5% | 10.9% | 10.6% | |
| Outpatients | % non face to face (telemedicine) attendances | | 25% | 17.1% | 17.2% | 16.6% | 17.7% | 17.3% | 17.4% | 18.0% | 17.8% | 17.3% | 17.8% | 17.2% | 17.5% | 17.6% | 17.0% | |
| DM 01 | **Diagnostic Performance (DM01)** | | | | | | | | | | | | | | | | | |
| DM 01 | % of >6 week performance (1% std) | | 5% | 11.6% | 12.5% | 14.7% | 13.2% | 9.8% | 10.6% | 12.6% | 14.5% | 11.2% | 7.5% | 9.6% | 9.7% | 3.7% | 2.5% | |
| Cancer | 28 day faster diagnosis standard (75%) | 78.0% (July 25) | | 73.1% | 73.4% | 65.5% | 69.0% | 75.6% | 75.3% | 78.1% | 75.1% | 81.2% | 79.8% | 72.1% | 72.6% | 77.9% | *78.6%* | *July cancer position provisional and* |
| Cancer | 31 day standard (96%) | 96.1% (July 25) | | 96.7% | 96.7% | 96.6% | 94.4% | 96.2% | 95.1% | 94.5% | 92.3% | 96.8% | 96.6% | 96.3% | 76.8% | 96.9% | *96.0%* | |
| Cancer | 62 day standard (85% - 75% by March 2026 ) | 71.6% (July 25) | | 69.0% | 67.7% | 69.4% | 68.7% | 67.0% | 68.2% | 70.6% | 64.7% | 65.0% | 72.0% | 68.2% | 72.3% | 68.5% | *69.4%* | *RAG rated based on trajectory* |
| Emergency Dept | 4 hour care standard | 73% (July 2025) | | 72.2% | 73.5% | 74.6% | 72.5% | 70.3% | 70.0% | 64.1% | 70.6% | 69.8% | 72.1% | 70.6% | 70.8% | 71.2% | 71.4% | RAG rated based on trajectory |
| Emergency Dept | Arrival time to initial assessment | | 15 | 20.0 | 19.0 | 17.0 | 18.0 | 17.0 | 18.0 | 18.0 | 15.0 | 18.0 | 19.0 | 20.0 | 20.0 | 21.0 | 19.0 | |
| Emergency Dept | Clinician seen <60 mins % | | | 28.8% | 28.7% | 33.7% | 30.6% | 29.9% | 31.6% | 27.8% | 43.4% | 33.4% | 29.7% | 29.9% | 28.6% | 22.7% | 23.4% | |
| Emergency Dept | Patients >12hrs from DTA to admission | | 0 | 171 | 140 | 39 | 139 | 227 | 136 | 428 | 510 | 294 | 305 | 207 | 142 | 91 | 75 | |
| Emergency Dept | Patients >12hrs in dept | | | 785 | 702 | 400 | 705 | 924 | 652 | 1312 | 1163 | 946 | 1043 | 873 | 684 | 694 | 626 | |
| SWAST SCAST | Ambulance handovers | | | 4082 | 4052 | 4165 | 4087 | 4250 | 4151 | 4318 | 4048 | 3744 | 4197 | 4192 | 4223 | 4117 | 4346 | |
| SWAST SCAST | Ambulance handovers - average hours lost UHD | | | 31 | 28 | 24 | 30 | 32 | 27 | 40 | 36 | 34 | 38 | 36 | 36 | 27 | 26 | |
| SWAST SCAST | Ambulance handovers - average hours lost RBH | | | 36 | 33 | 26 | 31 | 36 | 28 | 45 | 39 | 38 | 38 | 40 | 40 | 29 | 28 | |
| SWAST SCAST | Ambulance handovers - average hours lost Poole | | | 27 | 24 | 23 | 28 | 27 | 25 | 35 | 32 | 33 | 37 | 32 | 32 | 24 | 24 | |
| SWAST SCAST | Ambulance handover >60mins breaches | | | 357 | 269 | 156 | 287 | 368 | 188 | 1072 | 476 | 421 | 541 | 494 | 523 | 188 | 131 | |
| Patient Flow | Bed Occupancy (capacity incl escalation) | | 85% | 92.7% | 93.6% | 89.1% | 91.6% | 92.3% | 92.0% | 93.6% | 94.5% | 95.1% | 93.0% | 91.5% | 92.6% | 91.1% | 89.2% | |
| Patient Flow | Stranded patients: | | | | | | | | | | | | | | | | | |
| Patient Flow | Length of stay 7 days | | | 510 | 545 | 507 | 529 | 518 | 505 | 532 | 571 | 559 | 555 | 541 | 529 | 505 | 495 | |
| Patient Flow | Length of stay 14 days | | | 327 | 343 | 329 | 337 | 324 | 320 | 322 | 369 | 354 | 346 | 339 | 328 | 309 | 302 | |
| Patient Flow | Length of stay 21 days | | 108 | 229 | 237 | 234 | 236 | 222 | 225 | 218 | 252 | 245 | 232 | 233 | 216 | 206 | 200 | |
| Patient Flow | Non-elective admissions | | | 6365 | 6668 | 6458 | 6161 | 6737 | 6823 | 6648 | 6573 | 5971 | 6724 | 6697 | 6798 | 6557 | 6805 | |
| Patient Flow | > 1 day non-elective admissions | | | 3957 | 4086 | 4011 | 3926 | 4179 | 4238 | 4202 | 4079 | 3701 | 4118 | 4078 | 4105 | 3895 | 4131 | |
| Patient Flow | Same Day Emergency Care (SDEC) | | | 2384 | 2581 | 2446 | 2234 | 2558 | 2584 | 2444 | 2492 | 2270 | 2603 | 2617 | 2689 | 2659 | 2673 | |
| Patient Flow | Conversion rate (admitted from ED) | | 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% | 27.70% | 28.10% | |

# Statistical Process Control (SPC) – Explanation of Rankings


| Variation/Performance | Assurance: P | Assurance: ? | Assurance: F | Assurance: None |
|---|---|---|---|---|
| H | **Excellent** — **Celebrate and Learn**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• You are consistently achieving the target because the current range of performance is above the target. | **Good** — **Celebrate and Understand**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning** — **Celebrate but Take Action**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change. | **Excellent** — **Celebrate**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• There is currently no target set for this metric. |
| L | **Excellent** — **Celebrate and Learn**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• You are consistently achieving the target because the current range of performance is below the target. | **Good** — **Celebrate and Understand**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning** — **Celebrate but Take Action**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change. | **Excellent** — **Celebrate**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• There is currently no target set for this metric. |
| None | **Good** — **Celebrate and Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• HOWEVER you are consistently achieving the target because the current range of performance exceeds the target. | **Average** — **Investigate and Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning** — **Investigate and Take Action**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• HOWEVER your target lies outside the current process limits and the target will not be achieved without change. | **Average** — **Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• There is currently no target set for this metric. |
| H | **Concerning** — **Investigate and Understand**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• HOWEVER you are consistently achieving the target because the current range of performance is below the target. | **Concerning** — **Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• 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**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• Your target lies below the current process limits so we know that the target will not be achieved without change | **Concerning** — **Investigate**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• There is currently no target set for this metric. |
| L | **Concerning** — **Investigate and Understand**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• HOWEVER you are consistently achieving the target because the current range of performance is above the target. | **Concerning** — **Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• 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**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• Your target lies above the current process limits so we know that the target will not be achieved without change | **Concerning** — **Investigate**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• There is currently no target set for this metric. |
| None | | | | **Unknown** — **Watch and Learn**<br>• There is insufficient data to create a SPC chart.<br>• At the moment we cannot determine either special or common cause.<br>• There is currently no target set for this metric |

# Quality Outcomes & Safety Patient Experience

University Hospitals Dorset
NHS Foundation Trust

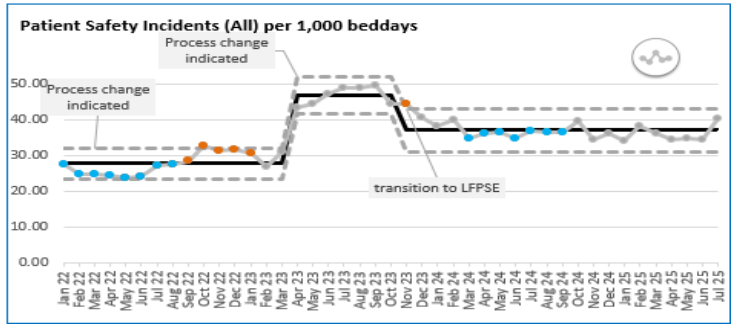

**Sarah Herbert**
Chief Nursing Officer
**Dr Peter Wilson**
Chief Medical Officer

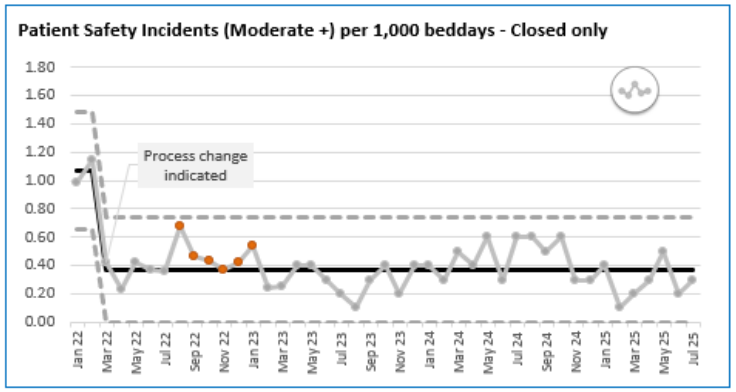
**Operational Leads:**
Vivian Alividza – Deputy Chief Nursing Officer (Workforce, Safeguarding, Clinical Practice)
Madeleine Seeley – Interim Deputy Chief Nursing Officer (Patient Experience)

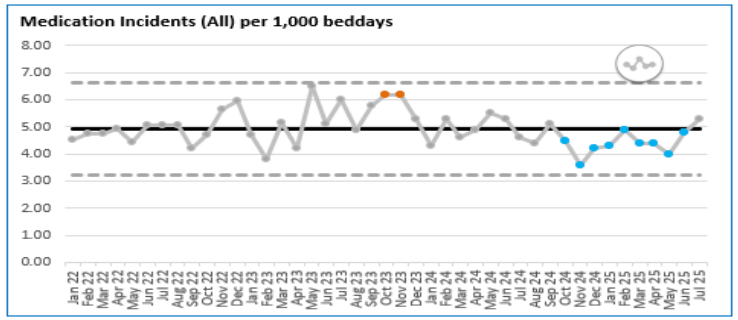
Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

**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

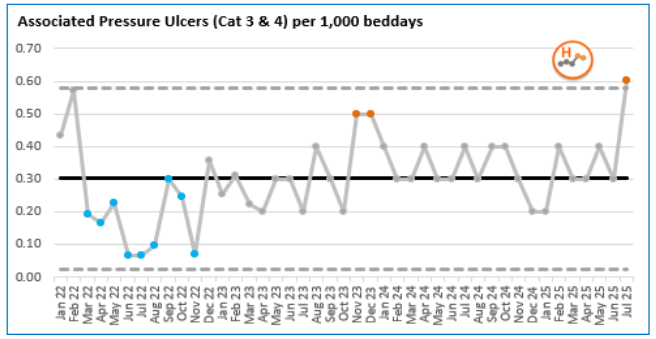
## Performance

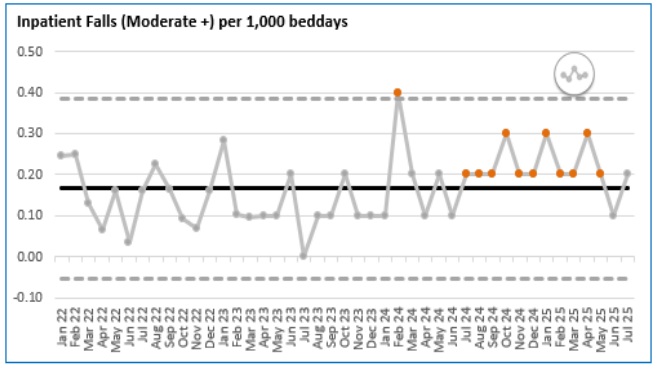
- The Trust transitioned to the Learn From Patient Safety Event (LFPSE) service in November 2023 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. The definition change significantly reduced the number of incidents reportable to LFPSE as a Patient 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. Weekly Care Group Rapid Review meetings consider, and triage, reported LERNs with appropriate learning responses agreed. A weekly UHD PSIRF Insight meeting is held to review potential PSIIs, themes and cross Care Group LERNS. A monthly PSIRF Oversight meeting reviews reported Thematic reviews, PSIIs and Trust wide learning responses and action plans.
- No new trend in LERNs noted in month.

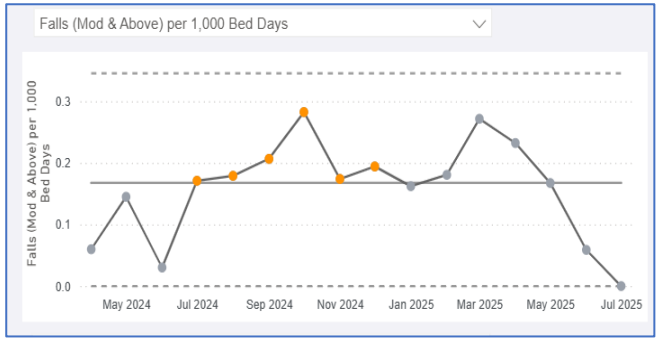
## Key Areas of Focus

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**:

- There were 9 hospital acquired Category 3 pressure ulcer incidents during June 2025 and one category 4. Pressure damage was located on the sacrum/ buttocks (n=8), heel (n=1) and elbow 1. Overall data remains within usual statistical variance and an after action review has been conducted regarding the Category 4 incident
- In 3 incidents all care was delivered as planned. Learning points from the remaining incident 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 Rate**: 6.0 per 1,000 bed days (↓ from 6.4 in July 2024) and **Moderate+ Harm Falls**: 0.1 per 1,000 bed days – within expected range, returning to baseline. **Average Daily Falls**: 7. **Overall figures** remain within expected parameters
- **Medical Care Group**: 76% of UHD falls; within expected range, stable harm rates
- **Surgical Care Group**: Seasonal harm spikes – autumn monitoring advised – expected increase in falls (seasonal shift).
- **WCCSS**: Low, stable rates; summer/autumn show more variability
- **Rolling NAIF Audit**: Post-fall care improving; assessment quality score at 17% (↓ national average of24%)
- **NICE NG249 (April 2025)**: UHD not fully compliant, especially with updated falls assessment standards

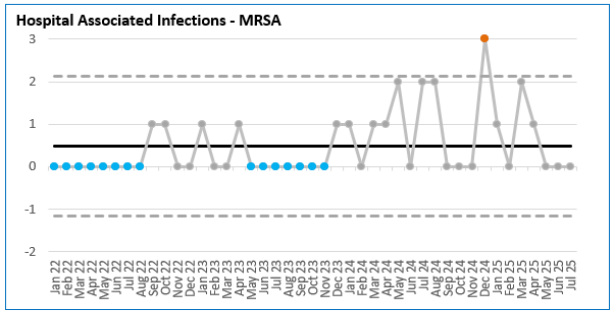
## Key Areas of Focus

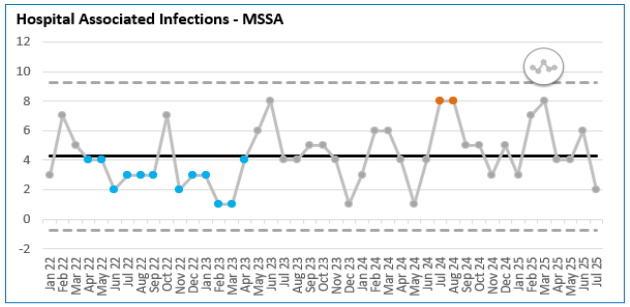
•**Ongoing collaboration** with care groups continues to streamline the falls PSIRF learning response pathway, ensuring timely, accurate, and proportionate responses.

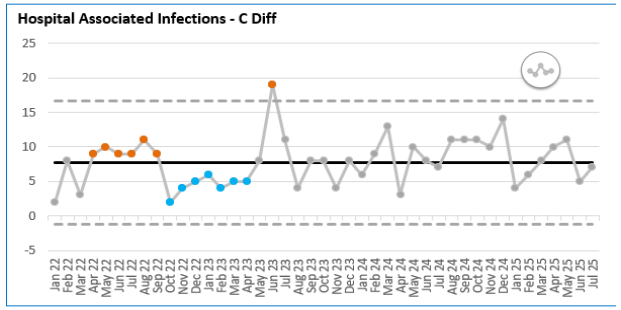
•The **Falls Team** is leading the *Fundamentals of Care* working groups on **Safer Activity** and **Continence Care**, aiming to improve care quality and support departments with meaningful assessments and care plans to document delivered care.

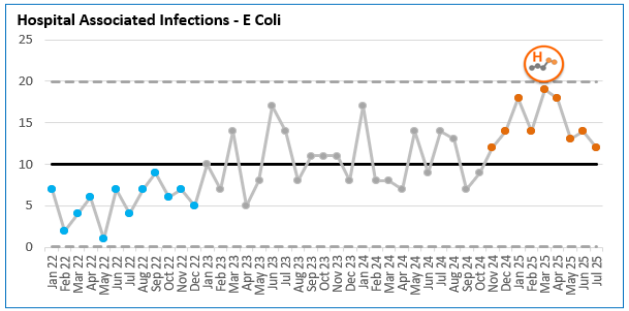
- **Falls Strategic Focus**: Action recommendations from the **PSIRF Falls Thematic Review** are guiding the Falls Team's priorities.
- Themes regarding learning from pressure ulcer incidents remain unchanged. Education sessions continue
- Themes from the pressure ulcer validation report (April 2024-March 2025), will be used to focus improvement projects.

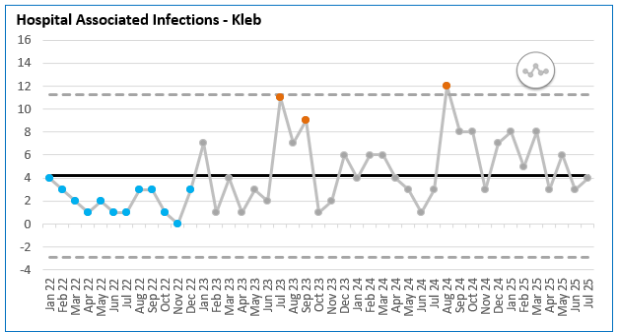
# Quality (3) – Safe

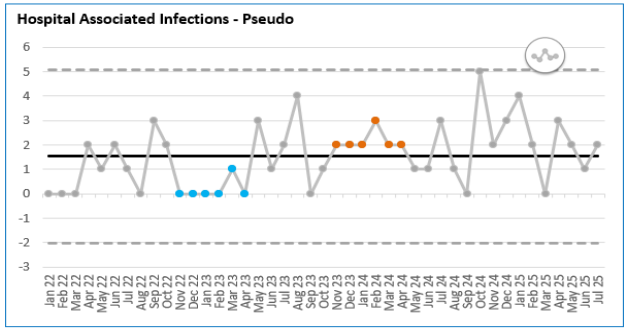



## Background/target description

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 July 2025.
- There were 2 cases of MSSA bacteremia in July 2025, an decrease from June 2025.
- *Clostridioides difficile* cases increased slightly in July 2025 but remains below the mean level.
- Cases of *Escherichia coli* bacteraemia decreased slightly in July 2025 compared to June 2025.
- Total number of cases of *Klebsiella* increased in June 2025 compared to July 2025, but remain below the mean level.
- Cases of *Pseudomonas* increased slightly in July 2025 compared to June 2025, moving above the mean level.

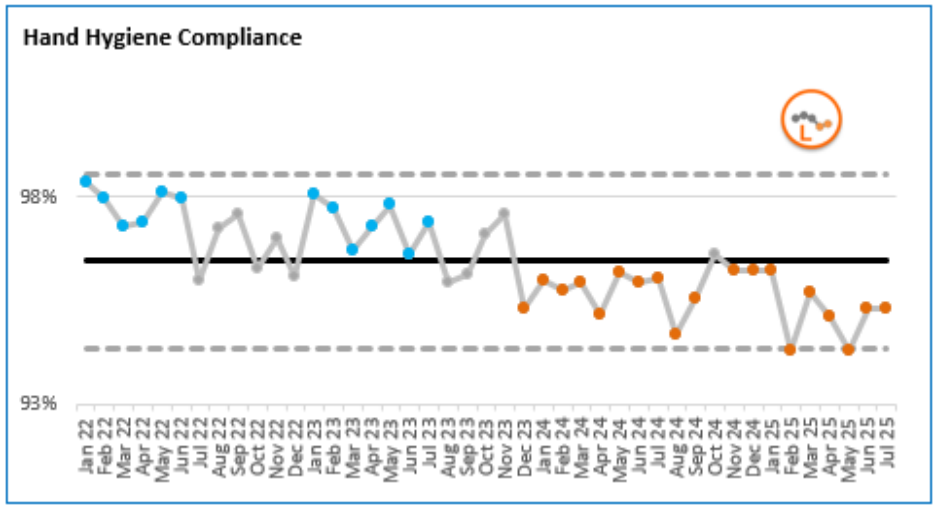
## Key Areas of Focus

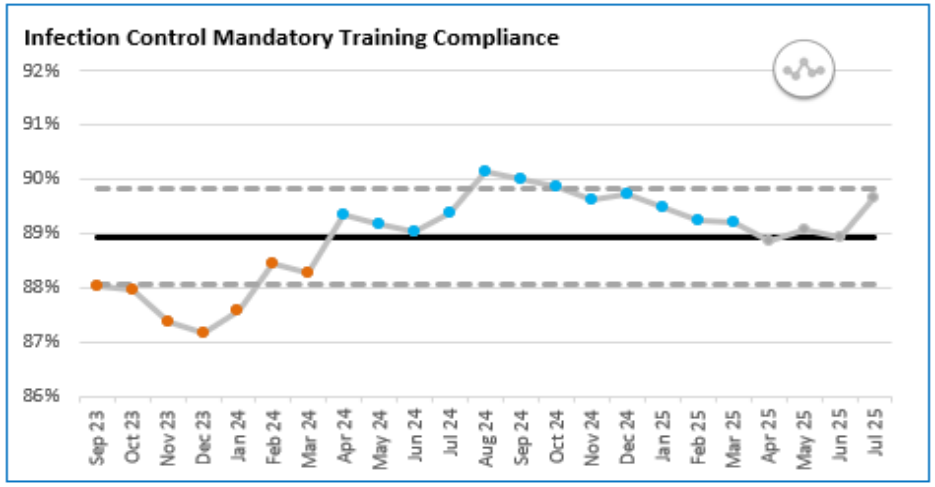
- Full implementation od PSIRF model for investigation of HCAI

**Hospital Associated Infections Summary for IPR**

| Organism | Aug-24 | Sep-24 | Oct-24 | Nov- | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRSA | 2 | 0 | 0 | 0 | 3 | 1 | 0 | 2 | 1 | 0 | 0 | 0 |
| MSSA | 8 | 5 | 5 | 3 | 5 | 3 | 7 | 8 | 4 | 4 | 6 | 2 |
| C Diff | 11 | 11 | 11 | 10 | 14 | 4 | 6 | 8 | 10 | 11 | 5 | 7 |
| E Coli | 13 | 7 | 9 | 12 | 14 | 18 | 14 | 19 | 18 | 13 | 14 | 12 |
| Kleb | 12 | 8 | 8 | 3 | 7 | 8 | 5 | 8 | 3 | 6 | 3 | 4 |
| Pseudo | 1 | 0 | 5 | 2 | 3 | 4 | 2 | 0 | 3 | 2 | 1 | 2 |
| Outbreaks | 2 | 1 | 0 | 0 | 4 | 5 | 5 | 0 | 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 95.5%, Variation in hand hygiene compliance continues with peer auditing across care groups giving greater confidence in results obtained.

**July 2025**

- Medical care group: 92.9% compliance
- Surgical care group: 97.3% compliance
- WCCSS care group: 95.5% compliance

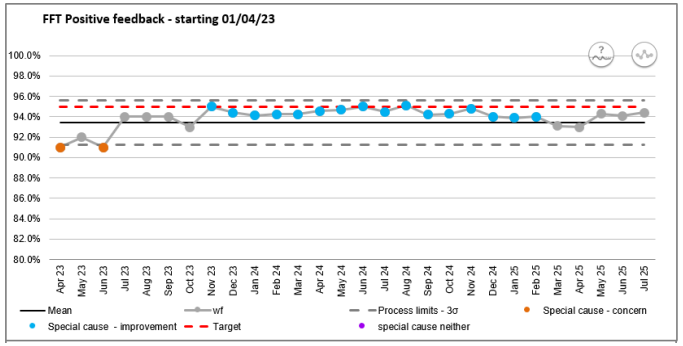
Infection Control Mandatory Training Compliance summary

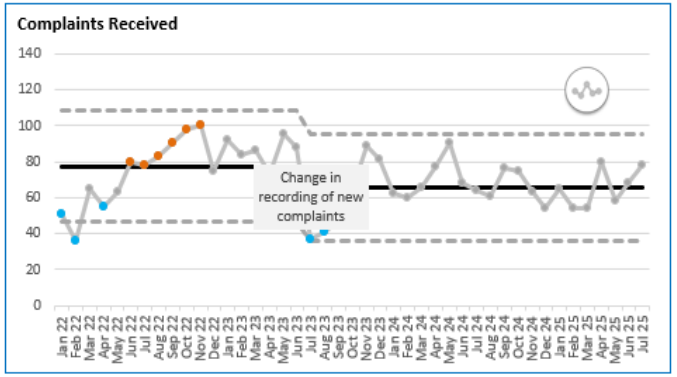
- Overall Trust compliance with Level 1 IPC training (all staff): 95.59%
- Overall Trust compliance with Level 2 IPC training (staff with patient contact): 86.82%

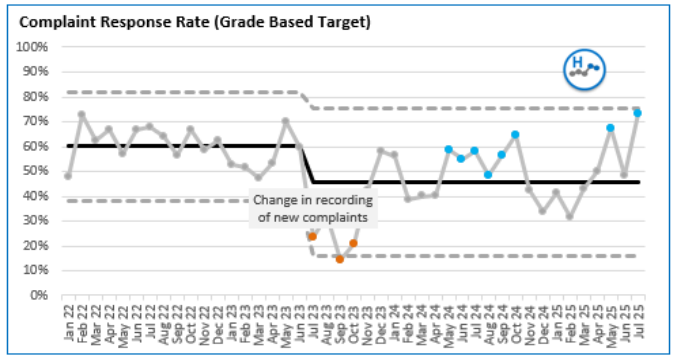
## Key Areas of Focus

- IPC to commence rolling programme of hand hygiene and personal protective equipment audit to provide regular observational feedback directly to ward level to advise action plans and improvements going forwards.

# Quality (5) – Caring




## Performance and Areas of Focus

**Patient Advice and Liaison Service (PALS) and Complaints Data for July 2025:**

**Overview:**

- 743 PALS concerns raised
- 34 new formal complaints
- 44 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed was 63

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. As of 04 August there were 9 over 55 day responses. The average response turnaround for July was 28.19 days. Meetings with GDoNs and HoN continue to focus on earlier resolution.

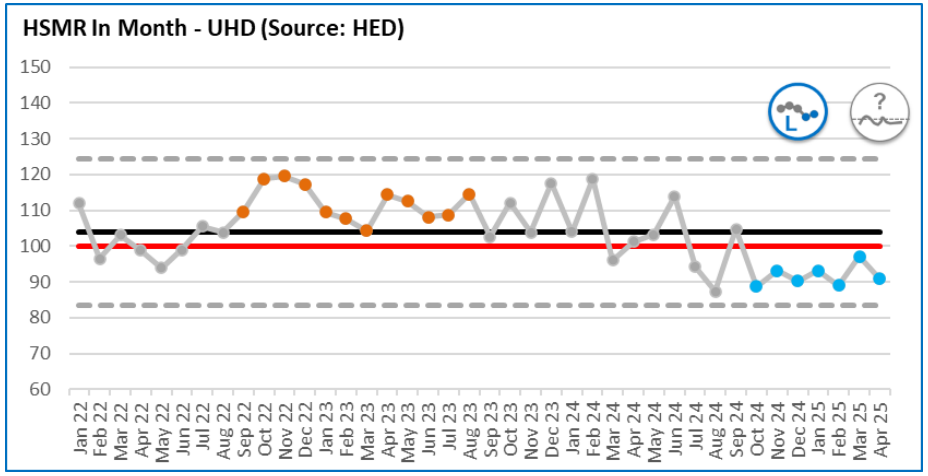
**Friends and Family Test (FFT)**

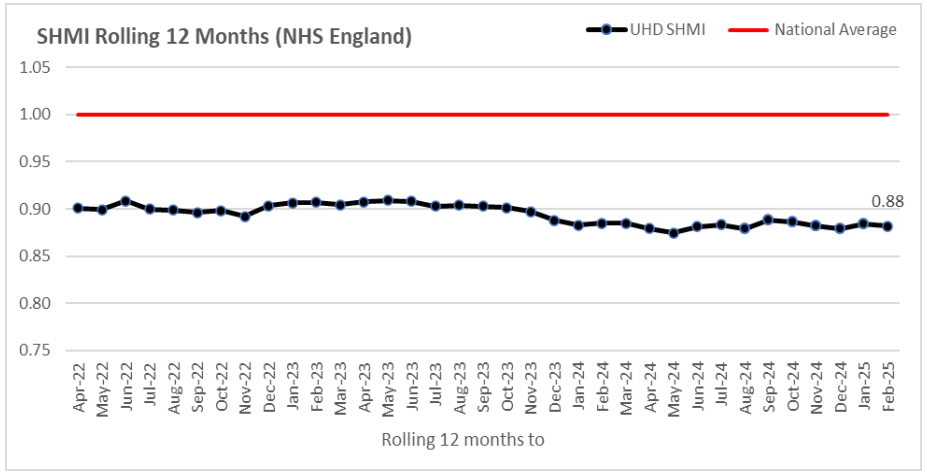
**FFT results:** There was an increase in the number of FFT responses being received; June received 4986 and July received 7542 with a stable overall positive score  Note  mapping of FFT to areas continues to be reviewed in detail to improve data accuracy for location and in preparation for departmental location moves.

**Mixed Sex Accommodation Breaches**

There were 0 reported breaches of mixed sex accommodation in July 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 April 2025 is 90.8, below the national average of 100 for the last 7 data points. Our rolling 12 month (to April 2025) position is 94.29.

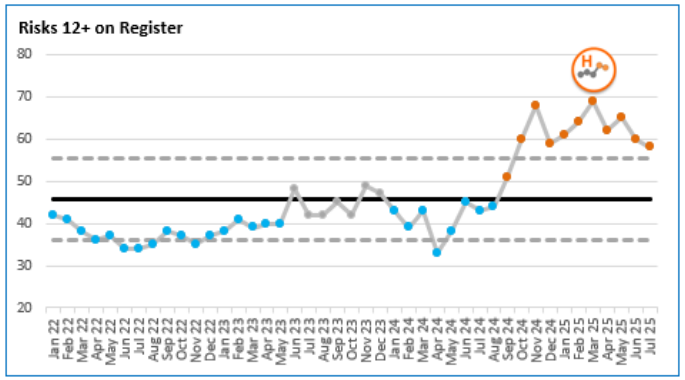
We continue to remain well below the national average in our SHMI (0.88) and is deemed 'expected'. UHD is in the top 13 trusts of the 119 included in the SHMI publications.

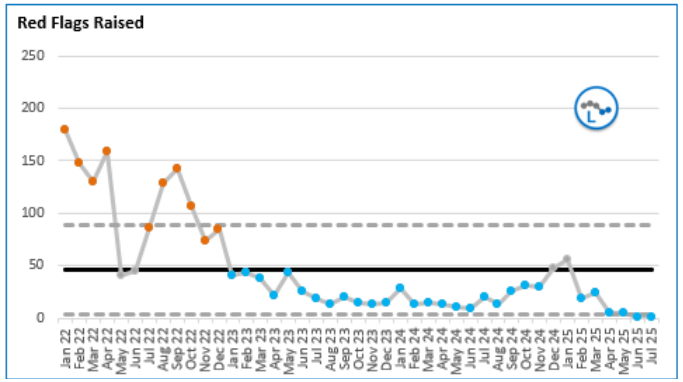
*The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust (within 30 days) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

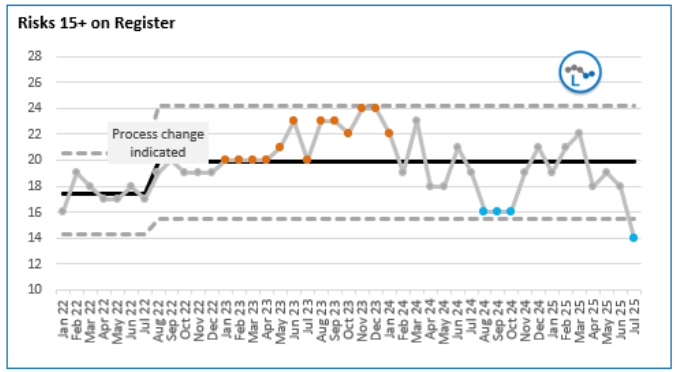
## Areas of Focus

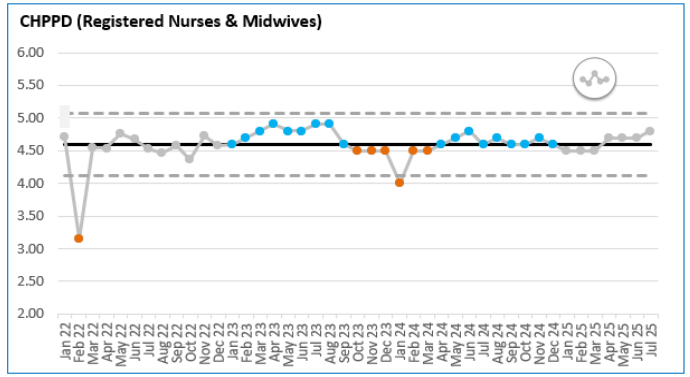
The Learning from Death process changed on the 11 November 2024. Deaths are now be selected against a clear set of criteria set out in the updated Learning from Deaths Policy – the aim is to ensure a sample size of circa 30% of total deaths. The Learning from Deaths Policy allows a 3 month time period for completion of required mortality reviews. Care Group compliance forms part of SDR process.

# Quality (7) – Well Led




## Performance

- July 2025 care hours per patient day (CHPPD) for registered nurses and midwives combined is 4.8. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for July was 1 raised in month due to patient at risk as unable to provide enhanced care.
- Overall percentage rota fill rate against planned staffing (day & night) was 95.2%

## Key Areas of Focus

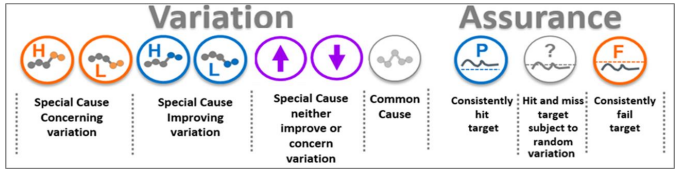
- Separate risk report provided to Trust Management Group (TMG) Quality Committee and Trust Board
- New UHD Trust Risk management strategy approved with greater focus on risk appetite, risk tolerance and risk escalation. Risks rated up to 12 can now be approved at Care Group level and do not require Exec sponsorship and approval at Board.
- This process change was introduced in October 24 and initially 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) July 2025/26**

| Hospital Site name | Patient Count | Registered Nurses/Midwives | | | |
|---|---|---|---|---|---|
| | | Total monthly planned staff hours | Total monthly actual staff hours | Fill Rate % | CHPPD |
| Poole Hospital | 13160 | 65893.6 | 60650.5 | 92.0% | 4.6 |
| Bournemouth & Christchurch | 18782 | 100691.5 | 91724.9 | 91.1% | 4.9 |
| UHD Total | 31942 | 166585.1 | 152375.3 | 91.5% | 4.8 |

# Performance at a glance
# Quality - Key Performance Indicator Matrix

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Patient Safety Incidents (All) per 1,000 beddays | Jul 25 | 40.30 | - | | | 37.02 | 31.07 | 42.96 |
| Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only | Jul 25 | 0.30 | - | | | 0.37 | 0.00 | 0.74 |
| Medication Incidents (All) per 1,000 beddays | Jul 25 | 5.30 | - | | | 4.91 | 3.21 | 6.62 |
| Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays | Jul 25 | 0.60 | - | | | 0.30 | 0.02 | 0.58 |
| Inpatient Falls (Moderate +) per 1,000 beddays | Jul 25 | 0.20 | - | | | 0.17 | -0.05 | 0.39 |
| Hospital Associated Infections - MRSA | Jul 25 | 0 | - | | | 0 | -1 | 2 |
| Hospital Associated Infections - MSSA | Jul 25 | 2 | - | | | 4 | -1 | 9 |
| Hospital Associated Infections - C Diff | Jul 25 | 7 | - | | | 8 | -1 | 17 |
| Hospital Associated Infections - E Coli | Jul 25 | 12 | - | | | 10 | 0 | 20 |
| Hospital Associated Infections - Kleb | Jul 25 | 4 | - | | | 4 | -3 | 11 |
| Hospital Associated Infections - Pseudo | Jul 25 | 2 | - | | | 2 | -2 | 5 |
| Hand Hygiene Compliance | Jul 25 | 95.3% | - | | | 96.4% | 94.3% | 98.5% |
| Infection Control Mandatory Training Compliance | Jul 25 | 89.7% | - | | | 88.9% | 88.1% | 89.8% |
| Friends & Family Test | Jul 25 | 94.4% | - | | | 92.4% | 89.9% | 94.8% |
| Complaints Received | Jul 25 | 78 | - | | | 65 | 36 | 95 |
| Complaint Response Rate (Grade Based Target) | Jul 25 | 73% | - | | | 46% | 16% | 75% |
| Mixed Sex Accommodation Breaches | Jul 25 | 0 | - | | | 8 | -12 | 27 |
| HSMR In Month - UHD (Source: HED) | Apr 25 | 90.80 | 100.00 | | | 104.01 | 83.60 | 124.42 |
| Deaths Within 36hrs of Admission | Jul 25 | 31 | - | | | 34 | 13 | 55 |
| Deaths Within Readmission Spell (5 day readmission) | Jul 25 | 17 | - | | | 21 | 9 | 33 |
| Risks 12+ on Register | Jul 25 | 58 | - | | | 46 | 36 | 55 |
| Risks 15+ on Register | Jul 25 | 14 | - | | | 20 | 16 | 24 |
| Red Flags Raised | Jul 25 | 1 | - | | | 46 | 4 | 89 |
| CHPPD (Registered Nurses & Midwives) | Jul 25 | 4.80 | - | | | 4.59 | 4.11 | 5.07 |



# Maternity (1)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: Lisa Clarke GDO / Lorraine Tonge Director of Midwifery and Neonatal Services /James Balmforth Clinical Director

| 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:**<br>There were no new PMRT (MBRRACE reportable) cases in July 2025:<br><br>**MNSI**<br>There were no new MNSI cases in July2025 and no ongoing or outstanding MNSI cases. | **Patient Safety Incident Response Framework (PSIRF)**<br>has been implemented in maternity.<br><br>In July there were no incidents requiring escalation through PSIRF.<br><br>**Top incidences LFPSE:**<br>Term admissions to NICU – ATTAIN at 3.96 % in July<br>PPH >1500mls 40.8 per 1000 in July above target of 30 per 1000<br>Increase in Opel 3 and 4 status throughout the month – flow and function workstream underway.<br>Incomplete monitoring, Theme noted of missed postnatal visits in the community. Work underway looking at failsafe options.<br><br>**Top non LSPSE incidents for July**<br>Service provision – there was 3 occasions of OPEL 4 and 5 occasions of OPEL 3(which is a slight decrease from June) escalation was followed in all incidences.<br>There was 4 incidences in delay in Elective caesarian section, due to second team capacity ongoing work and business case to increase elective lists with staff available to meet the increasing need.<br><br>**Safety champions reviews this month:**<br>• Quarter 1- Mat Neo safety and quality report<br>• Quarter 1- ATAIN report and QI progress<br>• Presentation of audit of Consultants attendance as per RCOG guidance. | CQC action plan -<br>Assure:<br>Action Plan now closed as completed – monitoring standards continuously.<br><br>Maternity incentive scheme year 7 -<br>Release of year 7 in April. Standards increased – assurance processes continue ICB mid-point assessment in August.<br><br>Insight and 3-year delivery plan -<br>Assure<br>Actions for year 3 in place.<br><br>2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022.<br><br>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 Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: Lisa Clarke GDO / Lorraine Tonge Director of Midwifery and Neonatal Services / James Balmforth Clinical Director

## Perinatal Quality Surveillance

### Maternity and Neonatal Dashboard

| Provider | UHD | | | | | |
|---|---|---|---|---|---|---|
| MetricName | Metric Id | Latest Date | Value | Target | Variation | Assurance |
| Number of babies born | 6 | Jul 25 | 355 | | | |
| Number of women delivered (multiple births where at least one unregistrable and one registrable) | 3 | Jul 25 | 0 | | | |
| Number of women delivered (unregistrable) | 2 | Jul 25 | 2 | | | |
| Number of women delivered (all births) | 1 | Jul 25 | 347 | | | |
| Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated) | 14 | Jul 25 | 34.4 | 28 | | |
| Rate per 1,000 women with PPH 1500ml or more (previous 3 months aggregated) | 13 | Jul 25 | 18.5 | | | |
| % of women smoking at delivery (previous month) | 10 | Jul 25 | 5.54% | 6% | | |
| % of women with a CO measurement at time of 36 weeks gestation | 38 | Jul 25 | 83.5% | 95% | | |
| % of women (IMD-1) placed on a continuity of carer pathway | 19 | Jul 25 | 16.7% | | | |
| % of Black and Asian women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation | 18 | Jul 25 | 42.9% | | | |
| % of women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation | 17 | Jul 25 | 6.93% | | | |
| % of women with a CO measurement at time of booking | 37 | Jul 25 | 94.0% | 95% | | |
| % of women smoking at booking | 9 | Jul 25 | 6.15% | | | |
| % of bookings booked <10 Weeks | 16 | Jul 25 | 64.6% | | | |

## 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 5months

**3rd and 4th degree tears** : Levels remain low locally and nationally

Improvement in **PPH >1500mls** rate per 1000 on a downward trajectory – PPH intense QI project launched

## Key Areas of Focus

**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

**Watch metrics:**
Increase in still birth rate – possible fluctuation but will be monitored through a thematic review underway in August and September.

(New metric on dashboard) Pre birth optimisation – To monitor data and work with the teams on improvement in pre- term delayed cord clamping and pre- term antenatal steroids.

# Maternity (3)

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

## Perinatal Quality Surveillance

### Maternity and Neonatal Dashboard

| Provider | UHD | | | | | |
|---|---|---|---|---|---|---|
| MetricName | Metric Id | Latest Date | Value | Target | Variation | Assurance |
| Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth) | 27 | Jul 25 | 0 | | | |
| 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) | 26 | Jul 25 | 0 | | | |
| % of babies receiving breast milk at discharge from midwifery 10-28 days | 36 | Jul 25 | 62.1% | | | |
| % of babies receiving breast milk at first feed | 35 | Jul 25 | 75.5% | | | |
| Rate per 1,000 registerable live birth babies who died <28 days from birth | 41 | Jul 25 | 0 | | | |
| Number of registrable livebirth babies who died < 28 days from birth | 12 | Jul 25 | 0 | | | |
| % of term babies admitted to NNU | 8 | Jul 25 | 4.27% | | | |
| Rate per 1,000 births which are preterm ( < 37 week's gestation) | 33 | Jul 25 | 61.0 | 60 | | |
| 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. | 23 | Jul 25 | 3 | | | |
| Annual rate of stillbirths per 1,000 births - rolling 12mths | 20 | Jul 25 | 4.04 | 2.5 | | |
| Number of still births | 11 | Jul 25 | 1 | | | |
| % of babies <3rd birthweight centile, born >37+6 weeks | 22 | Jul 25 | 50% | | | |

# Maternity (4)

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

## Perinatal Quality Surveillance

### Maternity and Neonatal Dashboard

| Provider | UHD | | | | | |
|---|---|---|---|---|---|---|
| MetricName | Metric Id | Latest Date | Value | Target | Variation | Assurance |
| % of babies born below 34 weeks of gestation who receive their own mother?s milk in the first 2 days of life | 49 | Jul 25 | 63.5% | 60% | | |
| % of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5-37.5oC and measured within one hour of birth | 48 | Jul 25 | 80.8% | 80% | | |
| % of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after on minute after birth | 47 | Jul 25 | 67.3% | 75% | | |
| % of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth | 45 | Jul 25 | 77.8% | 90% | | |
| % babies <34 weeks who receive full course of AN steroids within 1 weeks of birth | 43 | Jul 25 | 36.5% | 55% | | |
| % of singleton infants < 27 weeks gestation/multiples < 28 weeks gestation/any gestation fetal weight of < 800g, neonatal intensive care unit on site | 42 | Jul 25 | 0% | | | |
| Incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) preterm (from 24+0 to 36+6 weeks as a % of all singelton births | 55 | Jul 25 | 4.88% | 6% | | |
| Incidence of women with singleton pregnancy giving birth (live/stillborn) in the late 2nd trimester (16+0 to 23+6 wks) as a % of all singelton births | 54 | Jul 25 | 0% | 1% | | |
| % of babies born < 32 weeks gest. age with a) Germinal matrix/ intraventricular haemorr. / Post haemorr. Vent. Dil. / Cystic peri. Leuk. | 52 | Jul 25 | 0% | | | |
| % of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner) | 51 | Jul 25 | 0% | | | |
| % 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. | 30 | Jul 25 | 2.48% | | | |
| Percentage head count of midwives leaving the trust in the last 12 rolling months | 29 | Jul 25 | 8.07% | | | |
| Percentage of FTE days absent for midwives | 28 | Jul 25 | 7.37% | 3% | | |
| Number of incidents of Hypoxic-Ischemic Encephalopathy (HIE) in babies | 25 | Jul 25 | 0 | | | |
| Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar) | 62 | Jul 25 | 19.9 | 13 | | |

# 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 | 9085.4 | 9040.3 | | | | | | | | |
| | Plan | 9086.0 | 9099.0 | 9072.3 | 9064.3 | 9055.3 | 8999.2 | 8979.2 | 9015.2 | 8965.6 | 8903.6 | 8855.6 | 8770.9 |
| Bank | Actual | 643.3 | 647.5 | 669.5 | 678.2 | | | | | | | | |
| | Plan | 609.0 | 591.0 | 564.0 | 565.0 | 560.0 | 557.0 | 495.0 | 495.0 | 492.3 | 543.6 | 541.6 | 520.6 |
| Agency | Actual | 135.8 | 148.1 | 129.3 | 83.4 | | | | | | | | |
| | Plan | 158.0 | 135.0 | 135.0 | 136.0 | 137.0 | 139.0 | 141.0 | 146.0 | 151.0 | 144.0 | 128.0 | 116.7 |

| Staff Type | Plan/Actual | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Staff | Actual | 9877.2 | 9866.1 | 9884.2 | 9801.9 | | | | | | | | |
| | 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 |

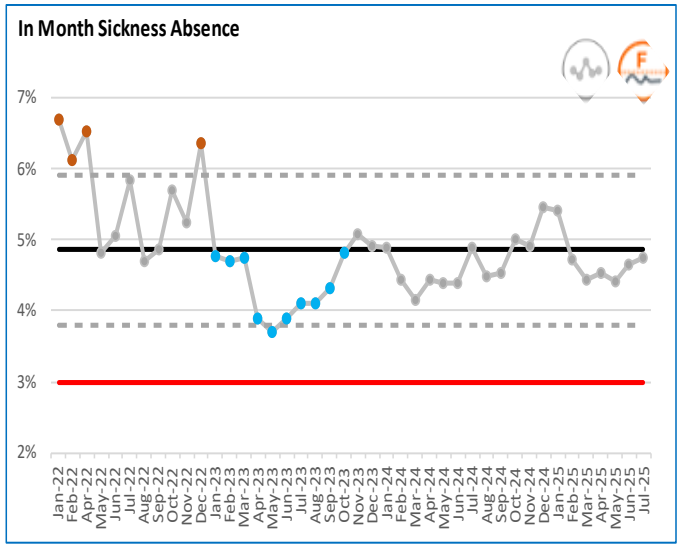
**Operational Plan Monitoring**

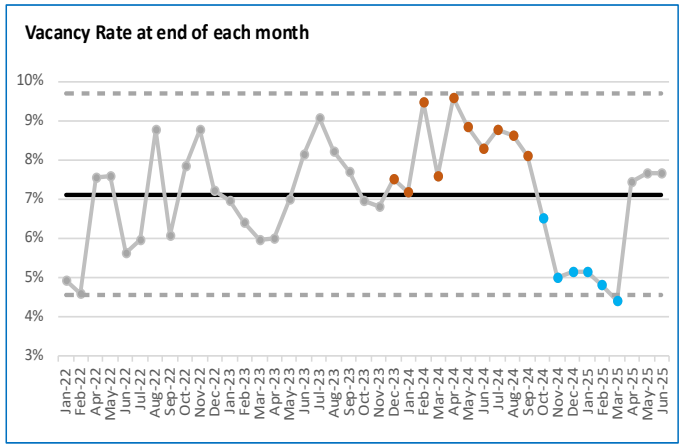
The workforce trajectories for full year (FY) 2025/26 have been planned to achieve reduced demand for workforce from the start point in April 2025 through to March 2026 (measured in whole time equivalents WTE).

Performance against the Workforce Plan as at M04 shows 36.64 WTE adverse variance above plan (£2.7m) 9801.9 WTE against a plan of 9765.3 WTE.

The primary driver for this variance in M04 is Bank usage, which continues to be significantly above plan (113 WTE above in M04, 107 WTE above in M03); this over-usage was exacerbated in M04 by the need to cover the Resident Doctors strikes. With sickness absence at 4.7% some Bank usage is to cover sickness absence.

# Well Led - Workforce (2)




## Performance

**Sickness Absence and Wellbeing**
In month sickness absence for July 2025 was 4.7%, lower than the winter sickness rate common with seasonal variation, and slightly lower than last year. The latest rolling 12-month rate is 4.77% which is the same as last month.

**Vacancy Rate:**
The vacancy rate at the end of June 2025 stands at 7.64%, which is a small decrease from 7.66% in May – reviewing employed WTE in post there was a decrease of 21 WTE equivalent between April and May. The increase in vacancy rate against establishment indicates workforce controls impacting backfill of vacancies. (Vacancy rate is reported a month in arrears).

**Applications and Adverts:**
In July 2025, the Trust received 6,429 applications and posted 246 new vacancies; which equates to an average of 26 applications per vacancy, which is an increase on the previous months. Number of new vacancies advertised has decreased from June's figure of 351.

**New Starters and Offers**:
There were **105 new starters** in M04, (down from 150 in M03), of which 60 were **internal appointments**.

**Occupational Health (OH), Psychological Support and Counselling Service (PSC)**
The KPI of 3 days from submission of pre-placement form to completion has been met in M04; with an average of 2.8 days across the month (a continued reduction from 7.8 days in May). The Thrive Live Programme has launched, with increased promotion across UHD in coming weeks.

**Self-referrals to the Psychological Support and Counselling Service (PSC)**
Referrals were up at 12 per week in M04.
The primary reasons reported for referral remain high stress (↑95%) and depression (↓45%) with ↑18% reported as signed-off work by their GP.
Waiting times for an initial assessment remain within the target of less than 2 weeks. 47 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.
**MSK Staff physiotherapy** continues to show improvement on meeting KPI of 10 days from submission of referral to 1st appointment offered - 88% of referrals submitted where offered an appointment within 10 days. Of these referrals 58 where in work and 11 off sick- showing support to aid staff remain in work.

# Well Led - Workforce (3)

## Performance

- Bank usage above planned levels increased again in M04 to 113 WTE above plan (M03 was 107 WTE above plan); this problem was exacerbated by increased use of Bank cover during the Resident Doctor's strike in July. With sickness absence at 4.7% some Bank usage is to cover sickness absence.

Bank usage detail - Medical care group:

- 259.91wte non- medical bank used against a vacancy of 218.07wte and a rolling12-month sickness rate of 4.87%
- 105.27wte was for adult nursing bank which was a slight increase from M03.
- There was a reduction in use of bank use for support to clinical staff.
- Non-medical bank spend increased in M04 to the highest point this financial year. This was solely driven by Older Persons & Acute Care directorate

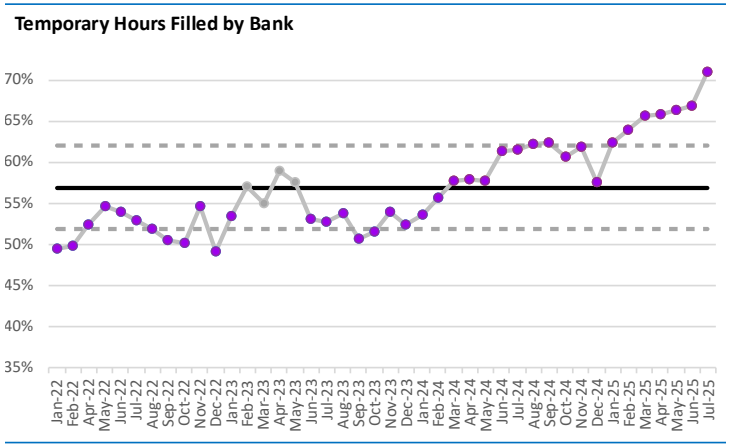
Bank usage detail - Surgical care group

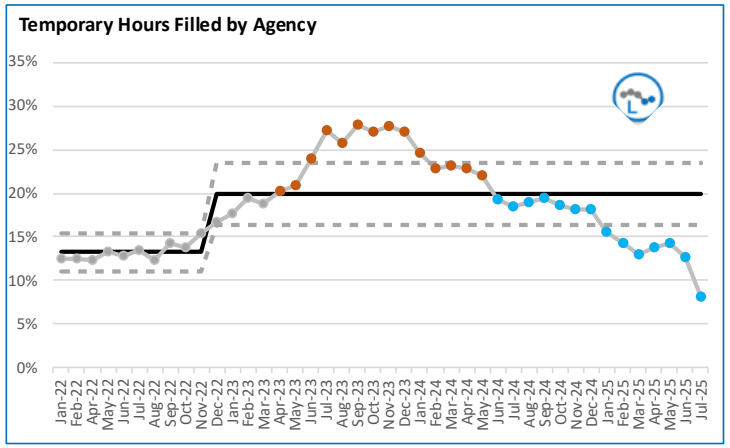
- · 107.04wte non-medical bank used against a vacancy of 238.97wte and a rolling 12-month sickness rate of 5.30%.
- · There was a reduction of 7.29wte in use of bank for nursing from M03.
- · There was an increase of 2.9wte from M03 in the use of bank for NHS Infrastructure, but this is predicted to reduce in M05.

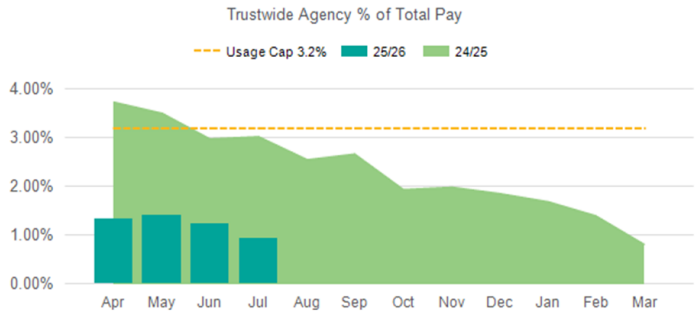
Bank usage detail - WCCSS

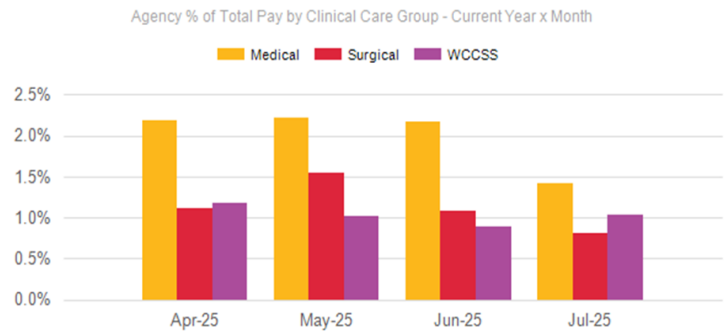
- WCSS has reduced non-medical bank spend but there were increase in M04 in spend in radiology, maternity and gynae.
- Bank shift requests for both short- and long-term sickness remained the same M03 to M04.
- Facilities reduced bank use in M04 v M03. However, predicted increase in facilities bank use in M05 of 16.62wte (note based on one payroll so subject to change).
- Enhanced care cost reduced in M04 (Network Medicine reduced from a high of £32k (12wte) in M02 to £1.5k (0.48wte) in M04. Increase of £12k seen in Older Persons & Acute Care in M04 v M03.

- There has been a small decrease in in-month agency spend to 0.9% of pay bill in July (Month 4) from 1.2% June (Month 3). This remains well below the national 3.2% target. Year to date agency spend is 1.2%.

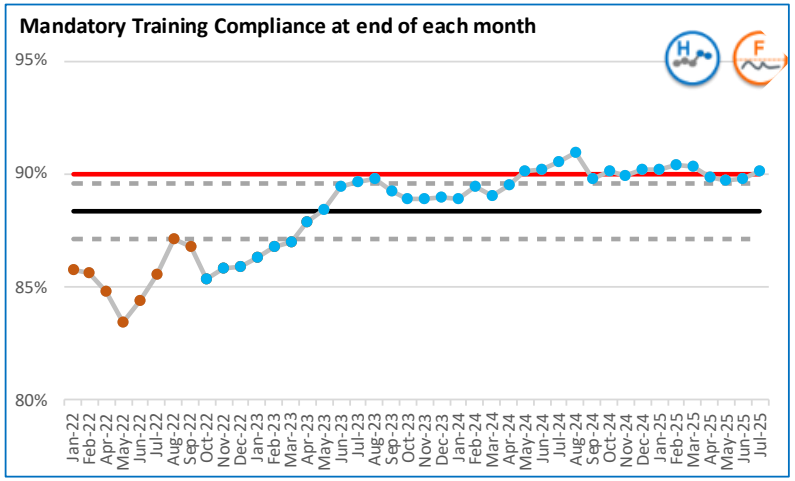


# Well Led - Workforce (4)




## Performance

### Mandatory Training

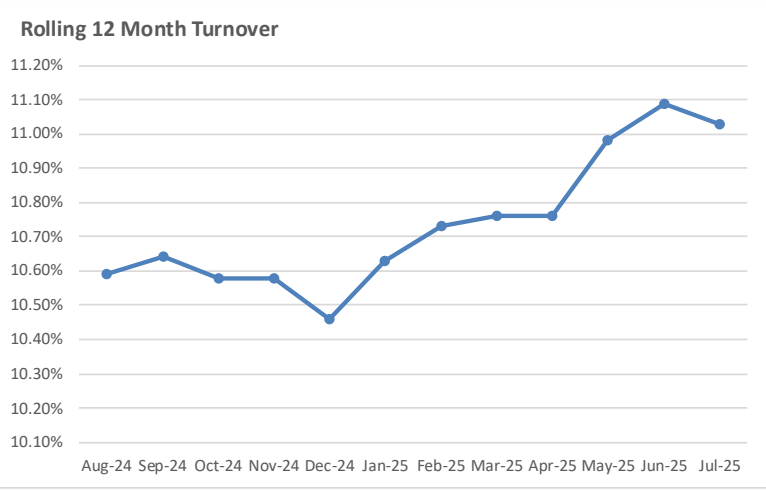
- Mandatory Training compliance has just risen above 90%, at 90.1% as at end of July 2025

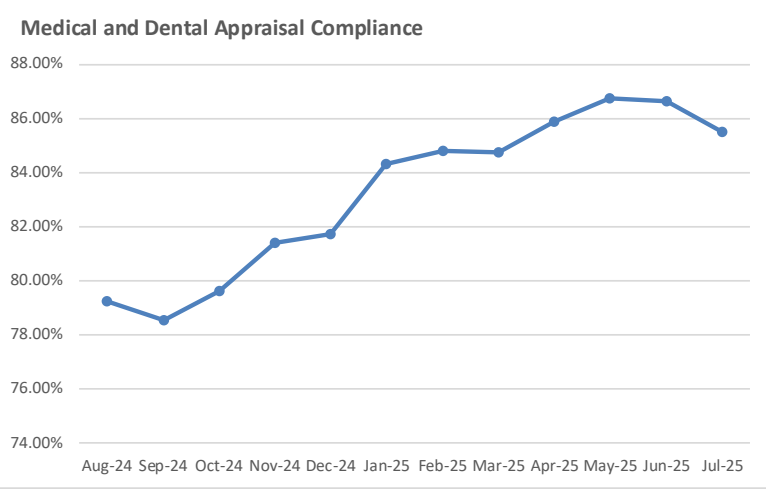
### Turnover

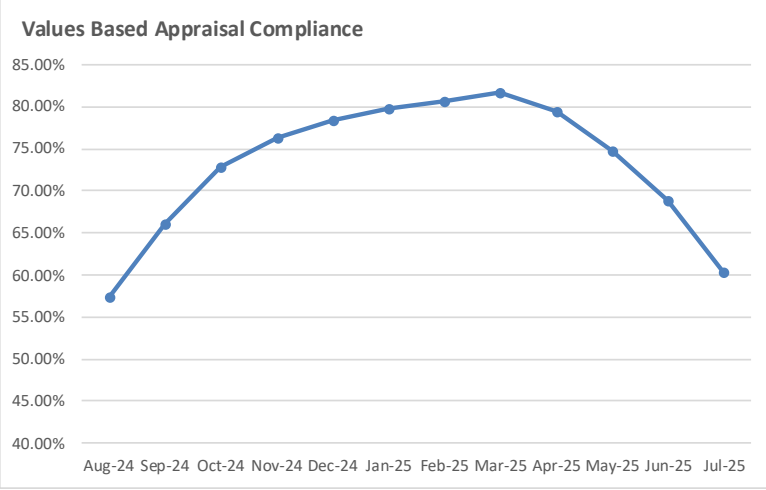
- The rolling 12-month staff turnover rate (excluding fixed term temp) has remained stable at 11.0% in July 2025, fractionally lower than previous month) (the vertical axis of this chart zooms in on 10% to 11%, as this has been where this very stable metric resides).

### Appraisal

- Non-medical appraisal compliance is running at 60.4%, down from 69.3% previous month. This is now using a rolling 12 month rolling period. Medical and Dental compliance is steady at 85.5% (these charts have also been re-scaled and no longer start at zero).



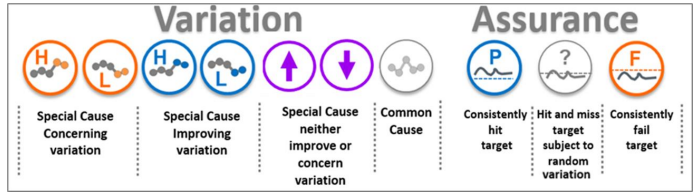



# Performance at a glance
# Well Led - Key Performance Indicator

## UHD Workforce

| KPI | Latest month | Actual | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Vacancy Rate at end of each month | Jun 25 | 7.6% | - | | | 7.1% | 4.5% | 9.7% |
| In Month Sickness Absence | Jul 25 | 4.7% | 3.0% | | F | 4.9% | 3.8% | 5.9% |
| Mandatory Training Compliance at end of each month | Jul 25 | 90.1% | 90.0% | H | F | 88.3% | 87.1% | 89.6% |
| Temporary Hours Filled by Bank | Jul 25 | 70.9% | - | | | 56.9% | 51.8% | 62.0% |
| Temporary Hours Filled by Agency | Jul 25 | 8.2% | - | L | | 19.9% | 16.4% | 23.5% |
| Agency Pay as Proportion of Total Pay | Jul 25 | 0.9% | | L | ? | 3.6% | 2.3% | 4.9% |



# Population Health and System Working

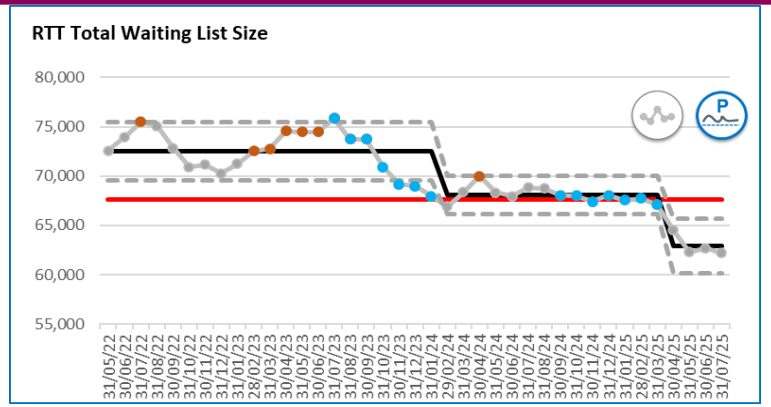
**Mark Mould**
Chief Operating Officer

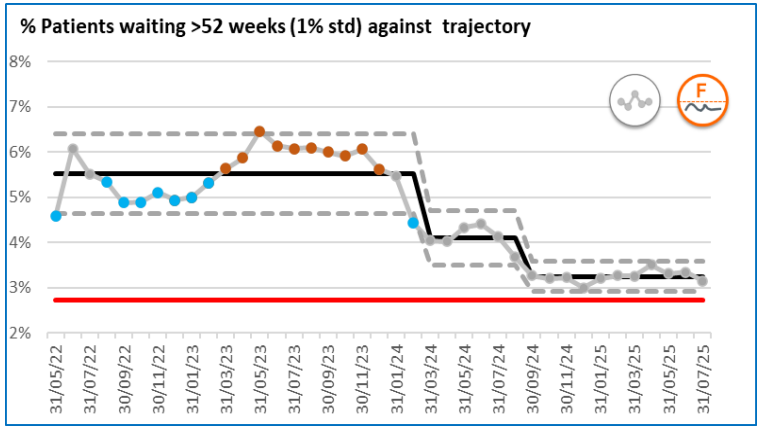
**Operational Leads:**
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Lisa Clarke – Group Director of Operations – Women's, Children, Cancer and Support Services
Adam Morris – Interim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

**Committees:**
Finance and Performance Committee

NHS
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 | 62.4% | 63.4% | |
| Waiting list size (and trajectory) | 67,615 | 62,203 | 26% |
| Waiting List size % variance compared to trajectory | | -7.2% | |
| %. patients waiting 52+ weeks v trajectory (1% target) | 2.7% | 3.2% | |
| No. patients waiting 52+ weeks | 1,679 | 1,959 | 62% |
| No. patients waiting 65+ weeks | 0 | 18 | 50% |
| No. patients waiting 78+ weeks | 0 | 0 | - |
| % of Admitted pathways with a P code | | 99.26% | |

## 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.

## Performance

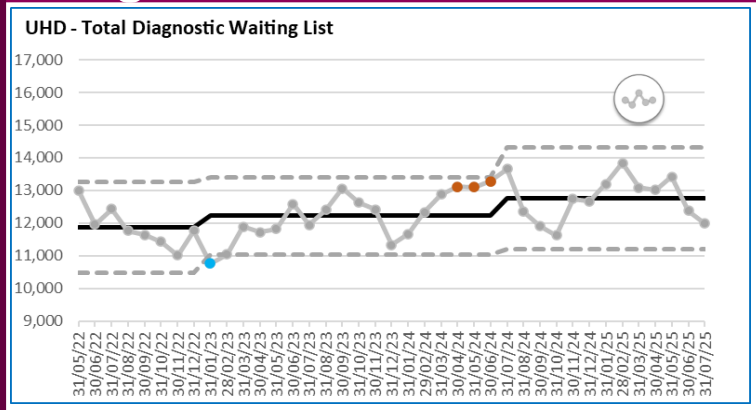
- The RTT waiting list size remains lower than the operational plan trajectory in July (67,615); at 62,203, this is 7.2% ahead of trajectory. The significant reduction in Quarter 1, 2025/26, follows a waiting list validation sprint exercise. A second sprint period is running in Quarter 2
- Elective activity: Year to date 120% (value weighted) elective activity has been delivered compared to the 2019/20 baseline period. This is above the operational plan trajectory (106.9%).
- 18 patients breached 65 weeks at the end of July. The main breach reasons were cancellations over the period of industrial action (4); patient choice to keep later appointments (7); and complex diagnostic pathways (5).
- The proportion of the waiting list >52 weeks reduced to 3.2% (3.3% in June). This represented 109 patients above the operational target (2.7%). Current performance demonstrates normal variation, and the target falls outside of the process limits. Further action is therefore needed to meet this target.
- 18 week Referral to Treatment (RTT) performance continues to exceed the operational plan trajectory.

## Key Areas of Focus

The areas of focus for action in August are:

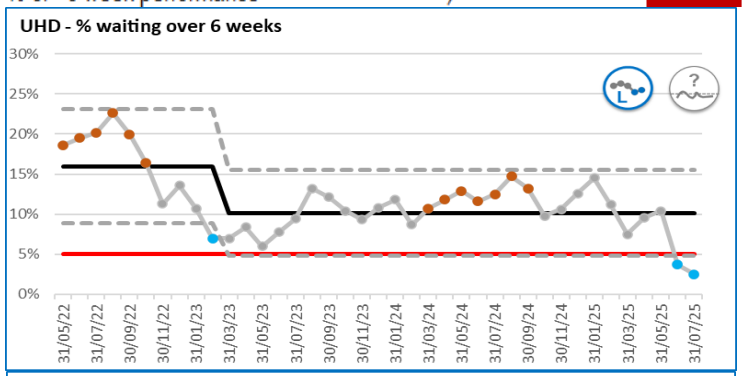
- To maintain delivery of elective activity aligned to the operational plan trajectory in 2025/26
- To reduce the number of patients waiting over 52 weeks, focusing particularly on the non-admitted pathway, targeting 0 patients >52week waiting a first outpatient appointment in all specialties by the end of August, with some specialities moving down to 48 weeks.
- 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.
- Continuing with further validation hubs as part of the validation sprint and to use this activity to balance performance against the operational targets.

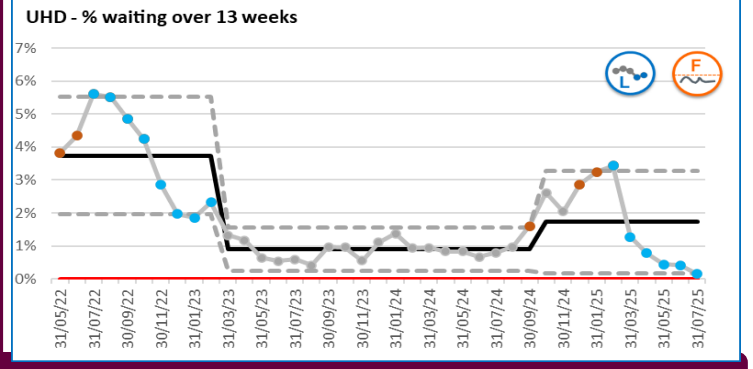
# Responsive – (Elective) Diagnostic Waits




**Diagnostic Performance (DM01)**

| % of >6 week performance | (+ Weeks / Total) | 1% | 303/11990 | 2.5% |
|---|---|---|---|---|




## Data Description and Target

Total number of patients waiting a diagnostics test
Number of patients whose wait for a diagnostic test exceeds 6 weeks. Internal target 5%. Constitutional standard 1%

## Performance

July 2025 performance was 2.5% (3.7% at the end of June 2025) delivering the internal target of 5%.
Overall waiting list is 11,990 patients.

Key areas to note;

- There are currently 18 patients waiting more than 13 weeks for a diagnostic test , this is down from 52 at the end of June and a special cause improvement has been triggered for the third month; the majority of these (10) are Cystoscopy patients. Booking these long waiting patients is the focus for all modalities.

**Endoscopy** Performance improved to 3.6% at the end of July (from 4.5% at the end of June), 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 in February 2026.

**Echocardiography** performance has improved significantly to 0.1% at the end of July, **achieving the 1% constitutional standard**, (from 9.4% at the end of June). Additional insourcing capacity has positively impacted the position, and this will continue in August.

**Neurophysiology** performance has improved significantly to 2.3% at the end of July (from 11.1% at the end of June).

- The additional resource has positively impacted performance in June, and this is anticipated to be maintained in August.

**Radiology** performance was 2.5% at the end of July (1.6% at the end of June), delivering the 5% trajectory target.

- CT, Dexa and Non-obstetric ultrasound **achieved the 1% constitutional standard** at the end of July.
- MRI is challenged in July with performance predicted to drop as the service cannot meet the current demand.

**Sleep Studies.**

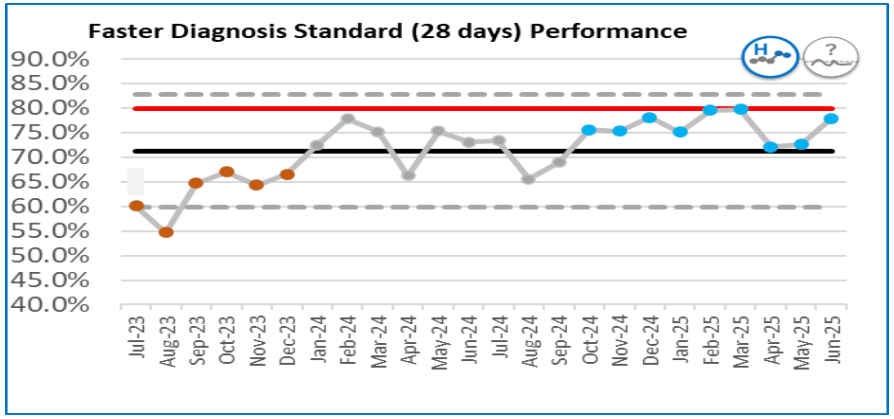
- The position for sleep studies improved in July, to 5.7% from 16.3% in June. Insourcing has commenced with some success, and it is anticipated the improved performance will continue in August.

## Key Areas of Focus

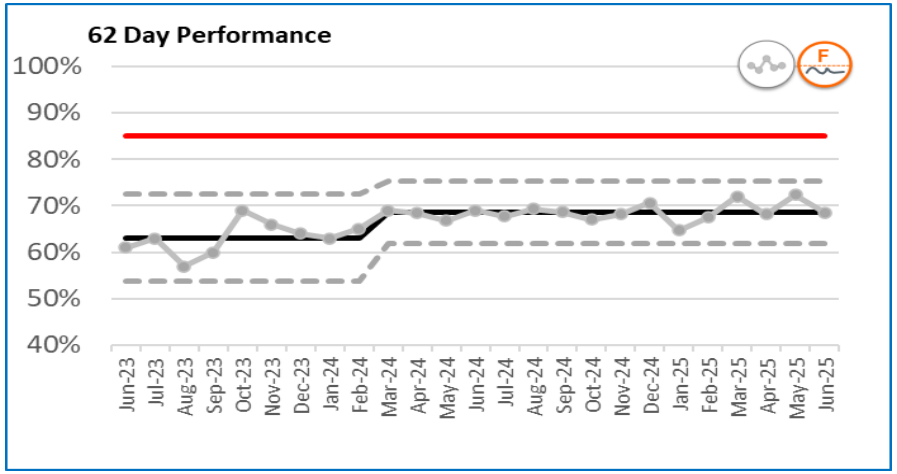
- **Echocardiography:** To utilise capacity to continue improvement in performance through August.
- **Neurophysiology**: Outsourcing to Haven Medical and insourcing from Mediservices continues, alongside recruitment to internal Trust posts.
- **Sleep Studies**: Capacity and demand work is continuing with a view to informing the future resourcing plan.
- **MRI**: Additional outsourcing through a combination of Nuffield, Harbour and Bournemouth University will help recover the backlog of patients. The service is also looking at options for a mobile unit for 8 weeks to support recovery of the position.

# Responsive (Elective)
# Cancer FDS & 62 Day Standard

**28 Day Faster Diagnosis Standard**
**(National Target 75.0%, raising to 80% by March 2026)**
**Trust Trajectory 78.0%**
Finalised UHD Jun 2025 Performance (77.9%)




**62-Day Standard**
**(National Target 85%, Trust Trajectory 71.2%)**
Finalised UHD Jun 2025 Performance (68.5%)




## 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 June 2025 Performance

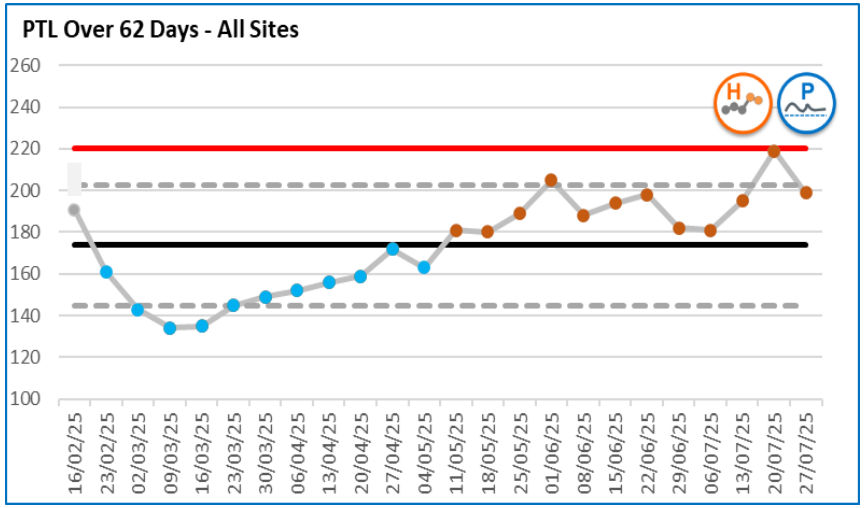
- **28 Day Faster Diagnosis Standard** - Performance in June 2025 was 77.9% which therefore met the national standard and the Trust trajectory of 77.5%.
- **62 Day Standard** - Performance in June 2025 was 68.5%, which did not meet the Trust's trajectory (70.8%). Despite reduced variation in performance since March 2024, the upper process control limit remains below the national standard. Care Groups are producing recovery plans by tumour site to realise sustained performance improvements in order to meet the national standard (75%) by March 2026.
- **31 Day Standard** - Performance in June 2025 was 96.9% 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 June 2025 was 182 (38 below the 220 target).

## Provisional July 2025 Performance (un-finalised)

- **28 Day Faster Diagnosis Standard -** Performance in July 2025 is currently 78.6%, exceeding the national standard of 75.0% and delivering the operational plan of 78%.
- **62 Day Standard -** Performance in July 2025 is currently 69.4% which is below the national recovery target of 75% and operational plan of 71.6%. Validations will continue throughout the month as treatments are reported, with the aspiration to meet 71%.
- **31 Day Standard** - Performance in July 2025 is currently 96.1% and is compliant with the national standard.
- **Patient Treatment List (PTL) Over 62 Days** - The month end position for July 2025 was finalised at 199 patients over 62 days which is 21 below the 220 target for the Trust.

# Responsive (Elective)
# Cancer Over 62 Day Breaches

**Over 62 Day PTL (Target: 220)**
Finalised UHD July Performance: 199




## High Level Performance Indicators

| Cancer Standards | Standard | Final | Provisional |
|---|---|---|---|
| | | Jun-25 | Jul-25 |
| 28 Day Faster Diagnosis Standard | 75% | 77.9% | 78.6% |
| 31 Day Standard | 96% | 96.9% | 96.1% |
| 62 Day Standard | 85% | 68.5% | 69.4% |
| PTL Over 62 Days (Final) | 220 | 182 | 199 |

## 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.

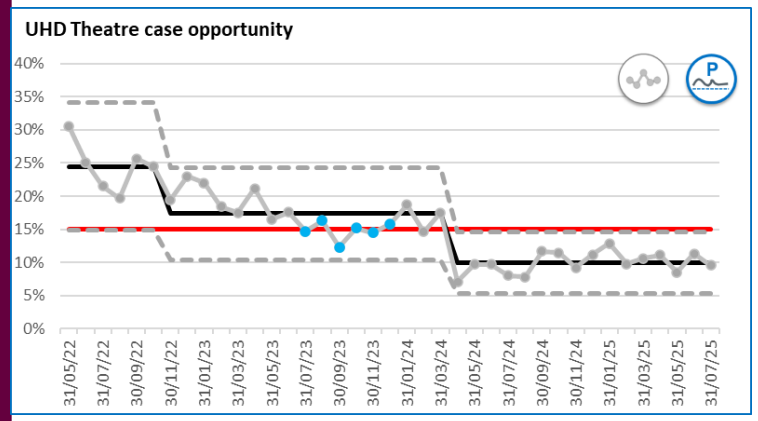
**Key areas of focus in the 3 most challenged tumour sites for this quarter:**

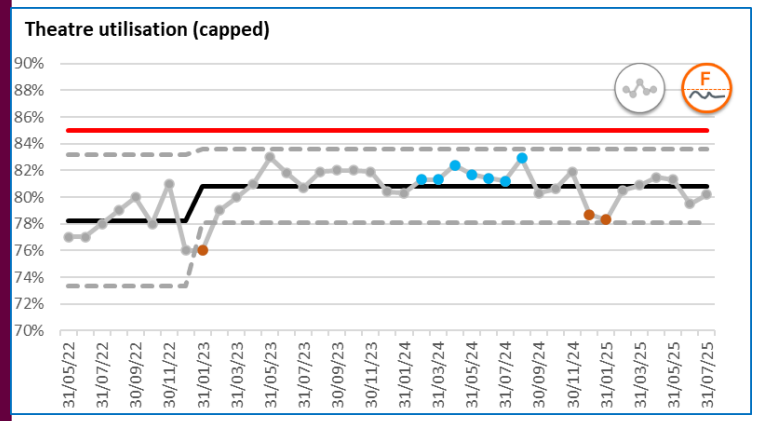
**Gynaecology:**
- Recruitment into key vacancies in the admissions team and pre-op assessments to optimise theatre capacity.
- Undertaking a second pathway analyser tool assessment with the cancer alliance following FDS improvements.
- Transformation project in place to remove one week out of the 62D pathway sustainably – led by Director of Operations and Head of Cancer Services. Includes escalation process review, patient treatment list (PTL) effectiveness, MDT observation, additional clinical reviews and prioritisation of theatre capacity.

**Skin:**
- Implementation of a robust summer plan for skin through additional insourcing support until the end of September 2025.
- Appointment of key clinical roles as agreed in the approved Dermatology staffing business case.
- Streamlining of cross-site admin processes to maximise support and efficiencies.
- Supporting the ICB on the future modelling of the Skin Analytics AI pilot to decide on the future commissioning arrangements to support the Dermatology demand.

**Urology:**
- Completion of capacity and demand modelling refresh with 12-month forecast view for Urgent Suspected Cancer Referral (USCR) activity by end of July 2025.
- Progress recruitment in relation to the nurse led prostate diagnostic pathway.
- Continued work with South-West Region regarding the provision of Robot-Assisted Radical Prostatectomy in conjunction with the trust-wide theatre utilisation project.

# 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 July increased to 80.1%.

Identified causes

- ***Gynaecology – Utilisation 73.5%*** - There was a reduced number of cases operated on in month, due to delays in access to pre-operative assessment which was challenged with capacity. The utilisation figure has improved but still below target so remains a focus.
- ***Orthopaedics – Utilisation 77.2% -*** both reduced number of sessions in month and an increase in early finishes and late starts, were contributing factors. The utilisation figure has improved in month but still remains below target so remains a focus.

Improvements in month

- Two specialities remain <75%, ENT has dipped to 71.5% owing to resource and capacity issues, a recovery plan is in place
- Colorectal, Breast and UGI achieved an improving monthly position exceeding the planned trajectory with Urology and Vascular dipping slightly but still exceeding 80% in July.
- The current cancellation rate within 72 hours of surgery is 7.4% against a baseline value of 8.1%. A reduction of 3% from the baseline is needed by March 2026.

**Day Case Procedures**

The latest published Daycase (BADS) rate (March 2025) was slightly under the national target at 85.3% (Target 85%).

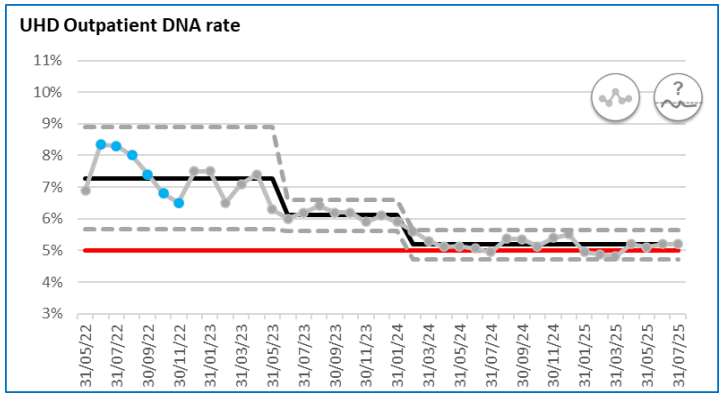
- Planned day cases converted to inpatient episodes remains below the national average at 5.7%. A Day surgery improvement programme continues, and pathway reviews are underway to support listing patient for 'daycase by default'.
- Endocrine, BESS, Emergency, General surgery, Paediatric and Urology all remain above the national target for planned day case procedures.

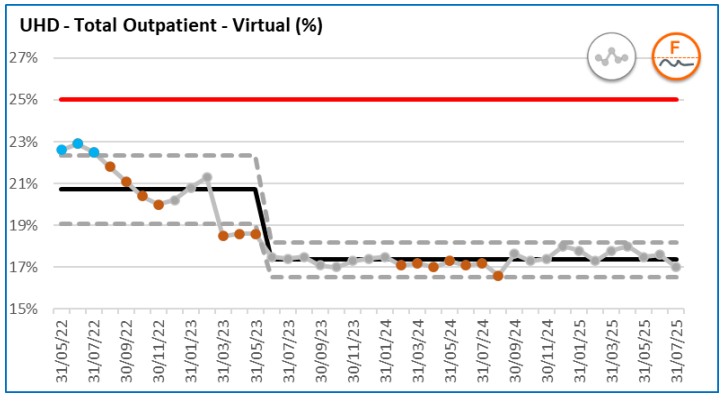
## Key Areas of Focus

- Review of pathways with high short notice theatre cancellations (within 72hrs) and development of an improvement plan – Gynae/Orthopaedics
- Pre-op Assessment capacity and support. Including review of capacity planning, workforce planning, and prioritisation
- Reduce turnaround times and late starts (Orthopaedics)

# Responsive (Elective) Outpatients

| Referral Rates (MRR Return) | | Standard | This Year | Trust Perf |
|---|---|---|---|---|
| GP Referral Rate year on year | | -0.5% | 41927 | 1.2% |
| Total Referrals Rate year on year | | -0.5% | 65917 | 3.5% |
| **Outpatient metrics** | | | | |
| Overdue Follow Up Appointments (Cons-Led Only) | | | | 27842 |
| New Attendances | | | | 25467 |
| Follow-Up Attendances | | | | 34263 |
| % DNA Rate | *(Total DNAs / New & Flup Atts)* | 5% | 3286 / 59730 | 5.2% |
| Hospital cancellation rate | *spital Canx / Total Booked Appts)* | | 14655 / 86867 | 16.9% |
| Patient cancellation rate | *atient Canx / Total Booked Appts)* | | 9196 / 86867 | 10.6% |
| **Reduction in face to face attendances (acute only)** | | | | |
| % telemed/video attendances | *(Total Non F-F / Total Atts)* | 25% | 10161 / 59730 | 17.0% |




## 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) in July was 74.5% against an operational plan trajectory of 69.9%; meeting the target.
- The DNA rate in July (5.2%) maintains normal variation and the target remains achievable within current processes.
- Use of virtual appointments was 17% for July 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 in June (+491) with 27,842 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 August 2025 are:

- Work continues to deliver 8 priority projects under the scope of the Trust's Corporate Outpatient Improvement project. This includes improvements to referral, pre-appointment, appointment and post appointment processes.
- To expand the volume of clinics offered at St Mary's Outpatient Assessment Centre and across Trust outpatient services.
- Continue to support delivery of a Trust-wide clinic utilisation rate of >90% and reduced short notice cancellations.
- Validation of the follow up waiting list.

# Responsive - (Elective) Screening Programmes

## Breast Screening

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

| BREAST SCREENING | STANDARD | ACHIEVED |
|---|---|---|
| Round Length within 36 months | 90.00% | 80% |
| 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 – Apr – June 25 | 70% | 72.7% |
| Mammograms Delivered | | 3371 |

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

**Performance:**
- The targets have been successfully met for appointment offered within 3 weeks and normal results within 14 days.
- The Round length metric has not been achieved.
- The quarterly uptake met the 70% standard, an improvement on the previous quarter.

**Underlying issues:**
- The dip in round length was predicted due to low screening throughput over the last year due to staffing issues.

**Actions:**
- It is anticipated that this target will be breaching for a few months to come until we feel the benefit of the increased screening volume. There is continued focus on increasing screening across all sites. Smart clinics are in operation across our mobile units and in the main static unit when assessment clinics are not operating to help increase capacity .
- A decision is awaited from the commissioners regarding a funding bid for some additional Saturdays to increase screening capacity further to assist with round length. An informal programme board meeting is planned on Friday 15th August.

## Bowel Screening

| Bowel Screening Standard | Target | July 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.

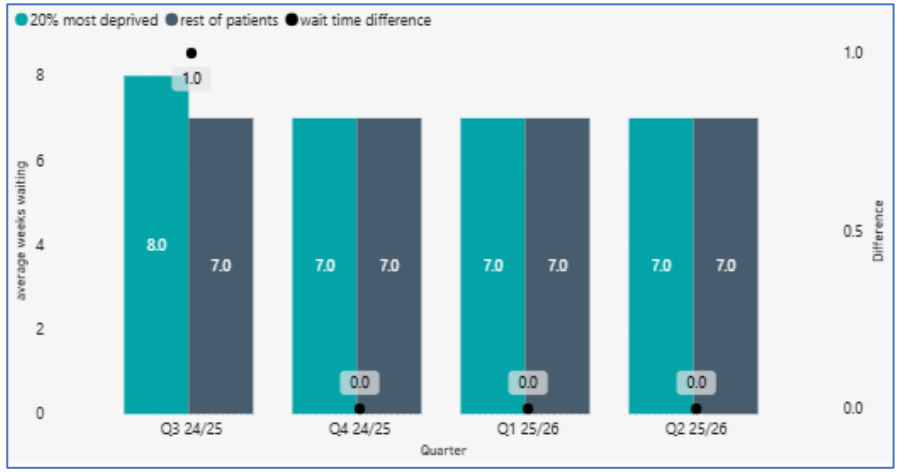
**Performance:**
- Specialist Screening Practitioner (SSP) Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 100% in July 2025.

**Underlying issues:**
- Need to increase accredited screener workforce: succession plan being worked through but will take time for aspirant screeners to achieve accreditation.

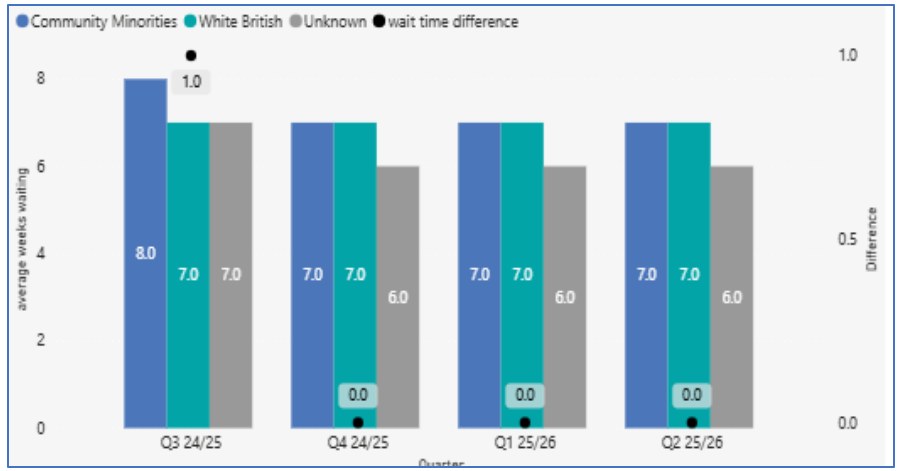
**Actions:**
- Planning to continue for FIT@80 roll out; which may increase demand by up to 40% across the system. Likely roll out April 2026. Programme manager in post for next 18 months to deliver this programme of work.
- Deliver plans with Dorset County to use additional insourcing capacity.
- Support 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 2 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 continues to shows no variation compared to people from IMD 3-10, demonstrating maintenance of 2024/25 performance. Children within the 20% most deprived groups, on average have 0.5 of a week less to wait compared to 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 compared with white British populations in Q2. Patients with unknown ethnicity are experiencing 1-week shorter waiting times.

Waiting times for children under 18 have shown mixed trends across different ethnic groups. Children from community minority groups are now waiting an average of 6 weeks. In contrast, waiting times for White British children are 10 weeks.

## Key Areas of Focus

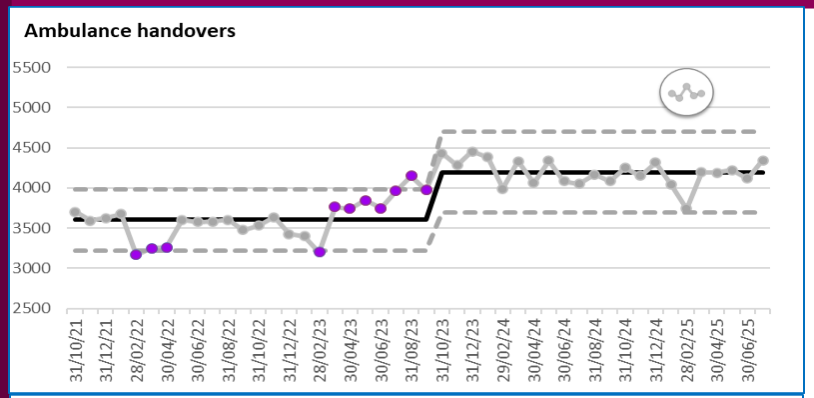
- The Trust's is continuing to deliver against the duties outlined within the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) to collect, analyse and publish information on health inequalities.
- Active engagement with Dorset 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.

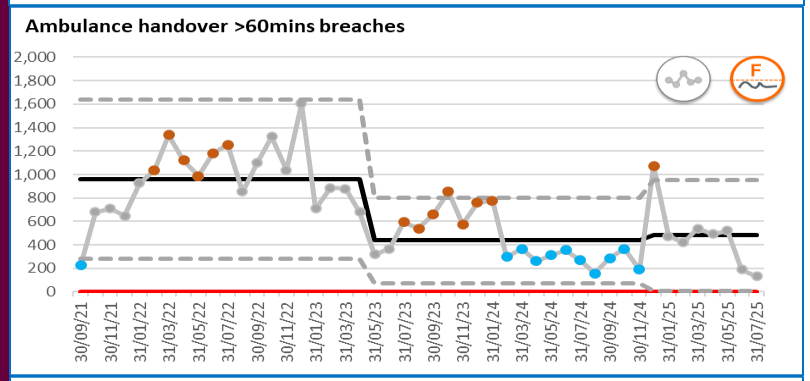
# Performance at-a-glance
# Responsive (Elective) - Key Performance Indicators Matrix

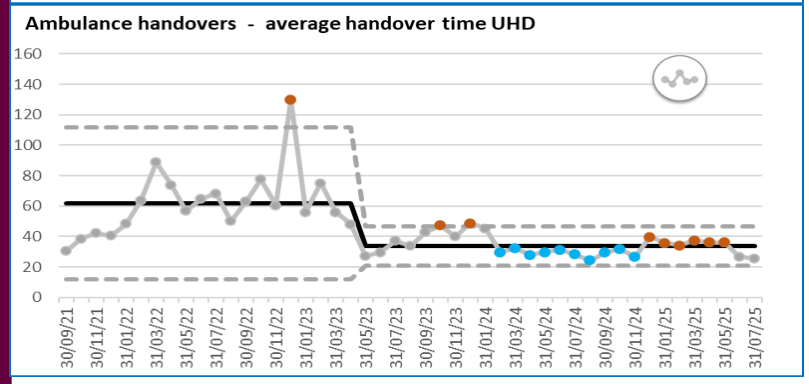

## UHD Elective Care

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| RTT Total Waiting List Size | Jul 25 | 62203 | 67615 | | | 62916 | 60121 | 65711 |
| RTT Performance against trajectory for 18 week standard (92%) | Jul 25 | 63.4% | 62.4% | | | 58.9% | 56.7% | 61.1% |
| Patients waiting >52 weeks | Jul 25 | 1959 | 1850 | | | 2124 | 1877 | 2372 |
| % Patients waiting >52 weeks (1% std) against trajectory | Jul 25 | 3.2% | 2.7% | | | 3.3% | 2.9% | 3.6% |
| Patients waiting >65 weeks | Jul 25 | 18 | 0 | | | 24 | -4 | 53 |
| % Patients waiting <18 weeks for 1st attendance | Jul 25 | 74.5% | 70.0% | | | 70.1% | 68.1% | 72.1% |
| UHD - Total Diagnostic Waiting List | Jul 25 | 11990 | - | | | 12759 | 11192 | 14326 |
| UHD - % waiting over 6 weeks | Jul 25 | 2.5% | 5.0% | | | 10.2% | 4.8% | 15.5% |
| UHD - % waiting over 13 weeks | Jul 25 | 0.2% | | | | 1.7% | 0.2% | 3.3% |
| Faster Diagnosis Standard (FDS) 28 days | Jun 25 | 77.9% | 75.0% | | | 72.6% | 62.0% | 83.2% |
| 31 day standard | Jun 25 | 96.9% | | | | 95.9% | 92.8% | 99.1% |
| 62 day standard | Jun 25 | 68.5% | 85.0% | | | 66.6% | 58.7% | 74.4% |
| Trauma Admissions | Jul 25 | 393 | - | | | 373 | 314 | 433 |
| % of NOF patients operated on within 36 hrs (admission from ED) | Jul 25 | 67.0% | 85.0% | | | 61.1% | 33.0% | 89.2% |
| % Outpatient appointments with procedures | Jul 25 | 21.7% | | | | 17.9% | 16.3% | 19.5% |
| UHD - Total Outpatient - Virtual (%) | Jul 25 | 17.0% | 25.0% | | | 17.4% | 16.5% | 18.2% |
| UHD Outpatient DNA rate | Jul 25 | 5.2% | 5.0% | | | 5.2% | 4.7% | 5.7% |
| Theatre utilisation (capped) | Jul 25 | 80.2% | 85.0% | | | 80.8% | 78.1% | 83.6% |
| UHD Theatre case opportunity | Jul 25 | 9.6% | 15.0% | | | 10.0% | 5.4% | 14.6% |

# 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.

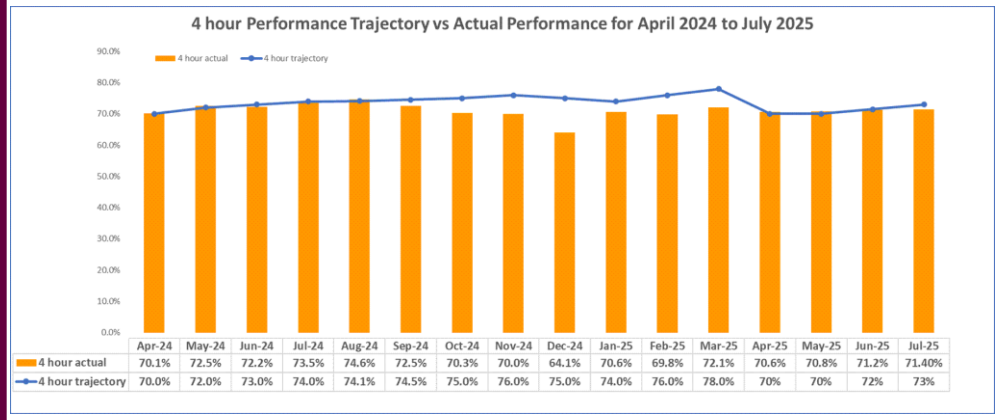
## Performance

- In July 25 there were 4305 conveyances – whilst this represents an additional 200 on the previous month this would be considered within the normal variation limits.
- In June 25 both UHD sites went live with the Timely Handover Proces (THP). Trust response to support this process and avoid longer delays to handover has been successful. This has been reflected in a reduction of care in non-clinical areas.
- Ambulance waits longer than 60 minutes have decreased from 496 in May, to 167 in June and subsequently 123 in July (93 were at RBH and 30 at PH).
- Average handover duration at Poole was 23.1 (5th in region) and 27.44 at RBH (10th). Both have improved since last month and are better than the regional average of 29.45 in July.

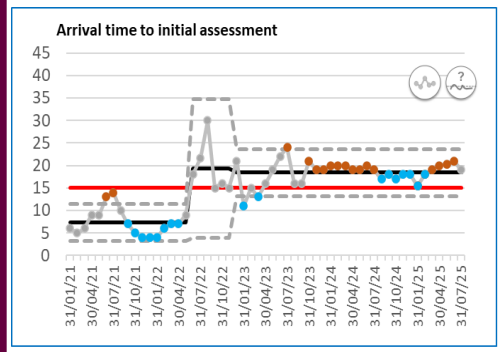
## Key Areas of Focus

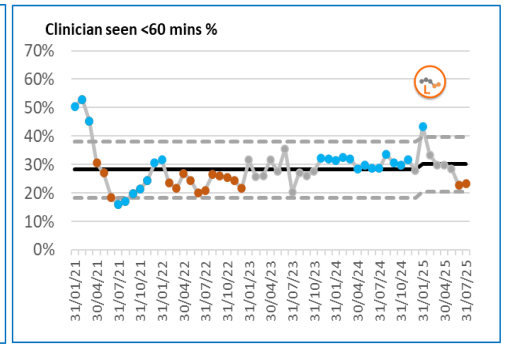
- Whilst acknowledging that THP launch has been positive, further work is required to embed routine practices to ensure timely and consistent enactment of policy. This will be pertinent moving into the winter months when delays will likely be compounded by flow-related occupancy pressures.
- The above will include, but not limited to, recirculation of SOP, randomised audit, awareness & engagement campaigns, a SWAST 'perfect week'.
- Further work is required across non-ED access points as a review of where >60 min handovers take place show areas such as cath lab, & acute medical SDEC. Also to note there are ocassions where for clinical reasons a handover may record beyond 60 mins i.e. stroke.
- Ambulance handover improvement is monitored through the Trusts internal enhanced support process to ensure accountability & support of viable action plans.
- There are a number of actions linked to 4-Hr performance and Trust-wide flow strategy which will lessen risks of delays at the pathway front end.

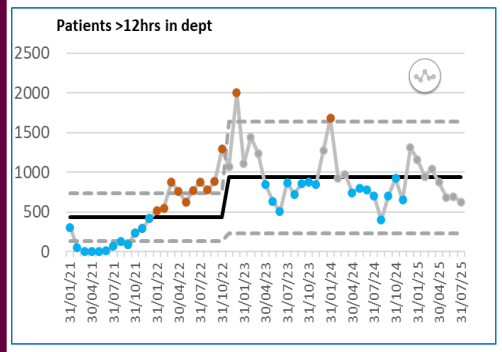
# Responsive (Emergency) Care Standards

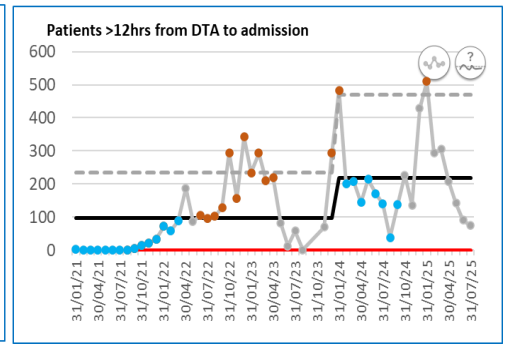



| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 hour actual | 70.1% | 72.5% | 72.2% | 73.5% | 74.6% | 72.5% | 70.3% | 70.0% | 64.1% | 70.6% | 69.8% | 72.1% | 70.6% | 70.8% | 71.2% | 71.40% |
| 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% | 72% | 73% |




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

July performance of 71.4% against a trajectory target of 73%.

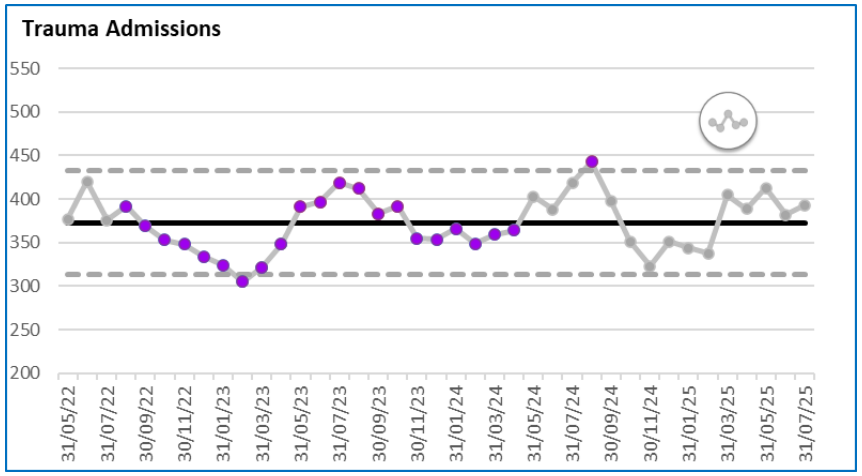
Key headlines:

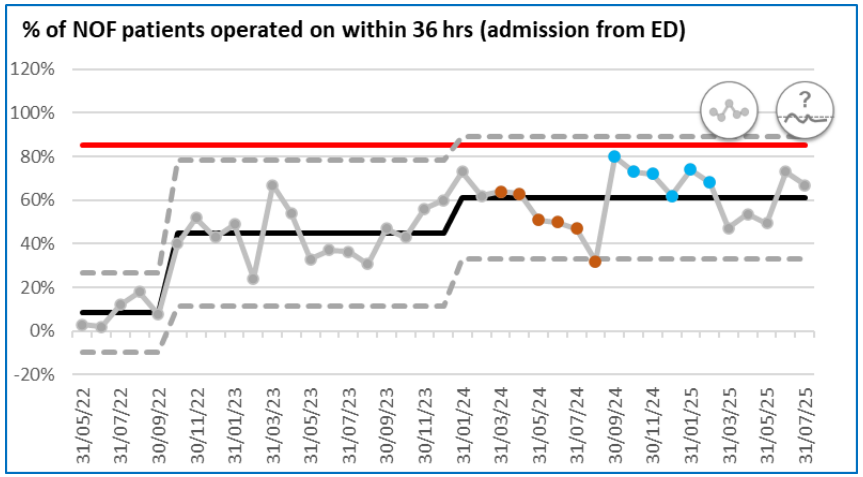
- Increase in 100 breaches from June to July (5821), against an increase in total patients.
- Total attendances June was 19,083. Increase to 20,374 in July. Ongoing increase noted over last 4 months.
- Improved non-referred performance of 73.53% against 71.85% in June. This still forms the majority of the overall breaches and accounts of 79% of the directorate activity.
- Admitted performance was 33.1% - this remains a challenging area.
- Average waits to be seen dropped by 3 mins in July (135 mins)
- Mean triage time went from 21.24 mins in June to 19.1 mins in July.
- Predicted mortality increased to 26.34%.
- Minors performance was in excess of 93.58%.

## Key Areas of Focus

- Executive led enhanced support process in place in accordance with Accountability Framework
- Improvement plan in place with a focus on timeline update against 25/26 trajectories and prioritised actions considered against impact, timeliness and viability.
- Organisational Development team deployed to support structured improvement and engagement plan across the UEC MDT through existing 'Patient First' mechanisms as well as focused and bespoke programmes of work to improve culture.
- Regionally led weekly performance calls in place to track progress against improvement plan and trajectory.
- Improvement in non-admitted performance is included within Future Care-supported Alternatives to Admission work.
- A focus on admitted performance continues with work aligned to Transfer of Care Hub and occupied bed day schemes. A Trust-wide 'coordinated care improvement workshop is scheduled in August.
- Expansion to SDEC services has a number of actions focussed on hours of delivery as well as widening opportunity and throughput.
- Further attention is required to ensure programmes of work falling under 'Future Care' are sufficiently reported, managed and overseen within UEC and care coordination/flow governance.
- Continue to instil internal professional standards across Care Groups

# 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 58%
**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

July performance for time to theatre for fractured neck of femur (#NoF) patients: 88.8% achieving surgery within 36 hours of being fit for surgery and 66.6% operated on within 36 hours from ED admission.

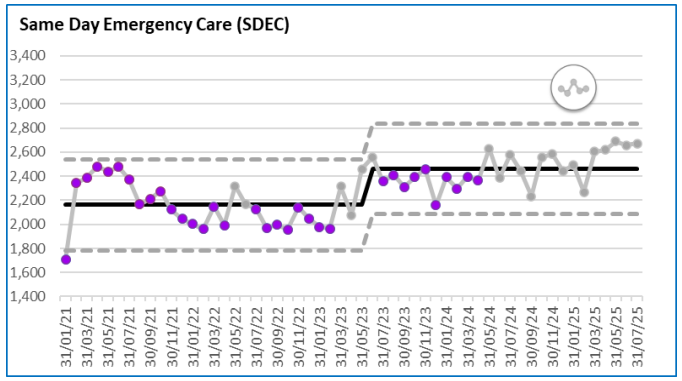
- July was a similar month to June. July saw a slight increase in numbers of Trauma admissions with 393 admissions compared to 382 in June. Accordingly, the Trust carried out 239 operations compared to 241 in June. 65 patients with a fractured neck of femur (NoF) were operated on in July which was the same for June.
- Our attainment to surgery within 36 hours of admission has decreased in July (66.6% in July vs 73.4% in June), as well as the number of patients with a fractured NoF attending surgery within 36 hours of being fit or surgery, which reduced from 89% to 88.8%.
- 21.5% of NoF's admitted in July were not fit for surgery on admission (increase from June @ 18%).
- 9 patients required additional operations resulting in an extra 14 operations, 2 of which were soft tissue cases.
- 16 patients were treated through the hand hub in July.
- The month started at stage 1 of escalation and remained there for the first week of the month, with the remainder of the month alternating between stages 2 and 1, peaking 41 patients outstanding on 17th July.
- Planned radiology support continued to be a constraint in July due to workforce capacity.
- Older fractures from clinic needing prioritising adding additional pressure to the capacity available

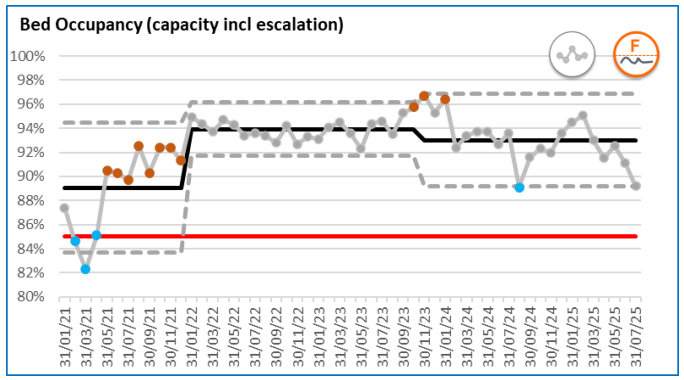
## Key Areas of Focus

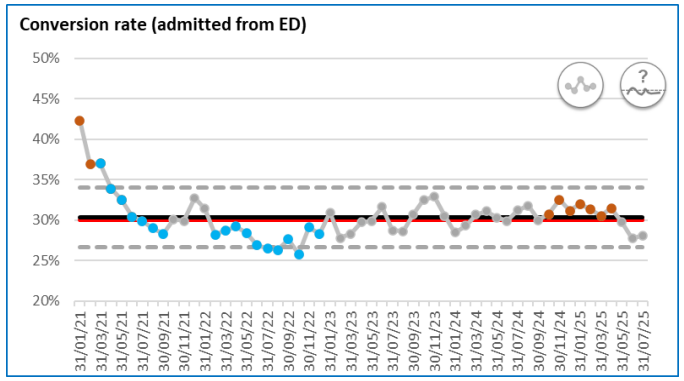
The key areas of focus to maintain this position are:

- Responsiveness from all the Care Groups to support the need to maintain urgent trauma capacity in theatres and clinics during the planned industrial action;
- Conclude workforce establishment review;
- Working to improve trauma theatre start times using data for procedure times and raising awareness of the Live On The Day Theatre Tool with the Trauma Wards
- Continued focus on maximising trauma theatre efficiency and mitigating periods of escalated service demand;
- Looking to embed protected 1st patient on the theatre list to improve start times
- SCG looking at capacity of pre-op assessment for non-inpatient trauma patients coming in for surgery

# 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 July, an average of 960 beds were occupied daily, average occupancy for July was 89.2% (June 90.2%.)..

Virtual Ward capacity is at 100 beds. The occupancy rate in July was 62.71% which shows opportunity to further develop virtual ward pathways. There has been some variation in metrics due to uncertainty of funding leading to operational challenges. Some of the occupancy variation will be related to seasonality.

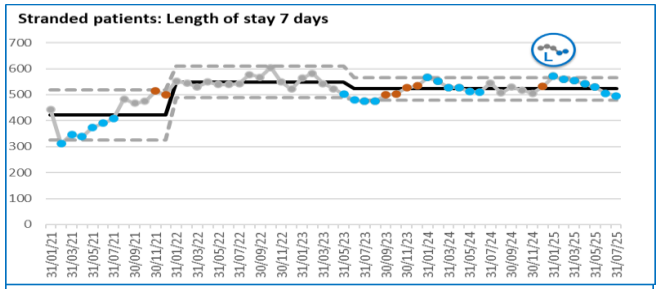
The average number of NCTR (patients with No Criteria to Reside) during July has increased slightly to 187 from 185, however July started around 180 creeping up over the course of the month to peak >200.

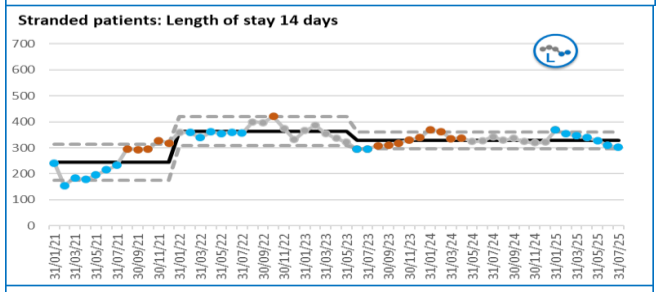
Despite the NCTR position, the occupied bed days continue to track favourably compared to the previous year showing special cause variation (improvement) following occupied bed day reductions plans and more recently the FutureCare programme.

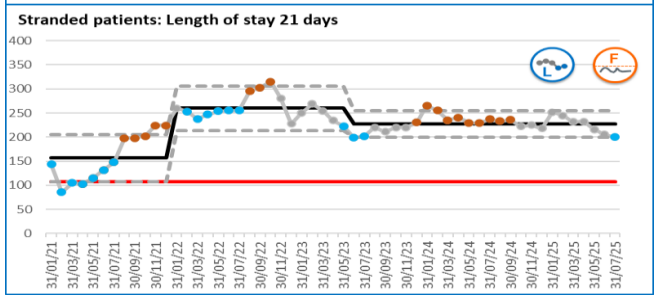
## Key Areas of Focus

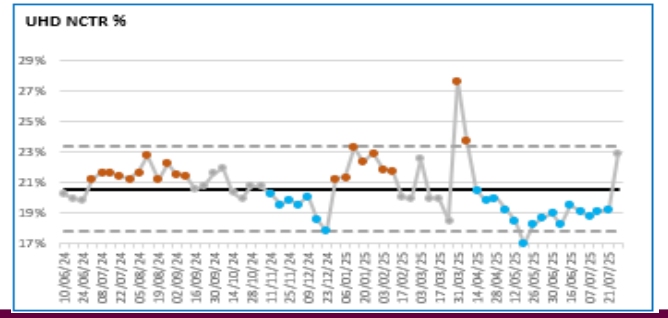
- A refreshed flow strategy has been launched to pull together the multiple areas of work that contribute to flow including a significant piece of work to improve Health of the ward and people's engagement with the system. This forms part of a wider piece of work building the Care Coordination Hub and 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 particular focus on ward 22 before being rolled out trust-wide, this has had a positive impact.

# 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 July 25,

- In July average monthly count of +21-day post DRD (become NcTR) was 96.58. This is a downward trend since August 24. National Target is 12%, on 28th July this stood at 20.7% for 21+ LOS patients
- Future Care Programme in place to progress the reduction through the use of the Transfer of Care (TOC) hub. This functional change essentially creates a 'round table,' for all system partners to plan, action and communicate more effectively to facilitate improvement across pathway 1 and 2 workstreams, recognising commissioned services currently do not always meet complex need leading to elongated LOS.
- Weekend discharges continue to show improvement particularly on a Saturday where P0 discharges have consistently been above 100 for the month of June 25.

## 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 are 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.
- Plans to improve traction include a robust internal and escalation process for patients triggering 14/21 days + and critically review progress and plans, leveraging resources and clear lines of escalation internally and externally with TOC/system leads.

# 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 | Jul 25 | 19 | 15 | | | 18 | 13 | 24 |
| Clinician seen <60 mins % | Jul 25 | 23% | - | | | 30% | 21% | 40% |
| Patients >12hrs from DTA to admission | Jul 25 | 75 | 0 | | | 219 | -33 | 470 |
| Patients >12hrs in dept | Jul 25 | 626 | - | | | 938 | 233 | 1643 |
| 4 hour safety standard | Jul 25 | 71.4% | 73.0% | | | 67.5% | 62.1% | 72.9% |
| Ambulance handovers - average handover time UHD | Jul 25 | 25.8 | - | | | 34.0 | 21.2 | 46.8 |
| Ambulance handovers - average handover time RBH | Jul 25 | 27.7 | - | | | 36.5 | 22.0 | 51.0 |
| Ambulance handovers - average handover time Poole | Jul 25 | 23.7 | - | | | 31.4 | 19.0 | 43.9 |
| Ambulance handover >60mins breaches | Jul 25 | 131 | | | | 481 | 10 | 952 |
| Ambulance handovers | Jul 25 | 4346 | - | | | 4193 | 3690 | 4696 |
| Bed Occupancy (capacity incl escalation) | Jul 25 | 89% | 85% | | | 93% | 89% | 97% |
| Stranded patients: Length of stay 7 days | Jul 25 | 495 | - | | | 522 | 478 | 566 |
| Stranded patients: Length of stay 14 days | Jul 25 | 302 | - | | | 330 | 298 | 362 |
| Stranded patients: Length of stay 21 days | Jul 25 | 200 | 108 | | | 227 | 200 | 255 |
| | | | | | | | | |
| Non-elective admissions | Jul 25 | 6805 | - | | | 6176 | 5308 | 7044 |
| > 1 day non-elective admissions | Jul 25 | 4131 | - | | | 3849 | 3295 | 4403 |
| Same Day Emergency Care (SDEC) | Jul 25 | 2673 | - | | | 2460 | 2083 | 2836 |
| Conversion rate (admitted from ED) | Jul 25 | 28.1% | 30.0% | | | 30.4% | 26.7% | 34.0% |

# Sustainable Services

**Pete Papworth**
Chief Finance Officer

**Operational Lead:**
Adrian Tron, Deputy Chief Finance Officer

**Committees:**
Finance and Performance Committee

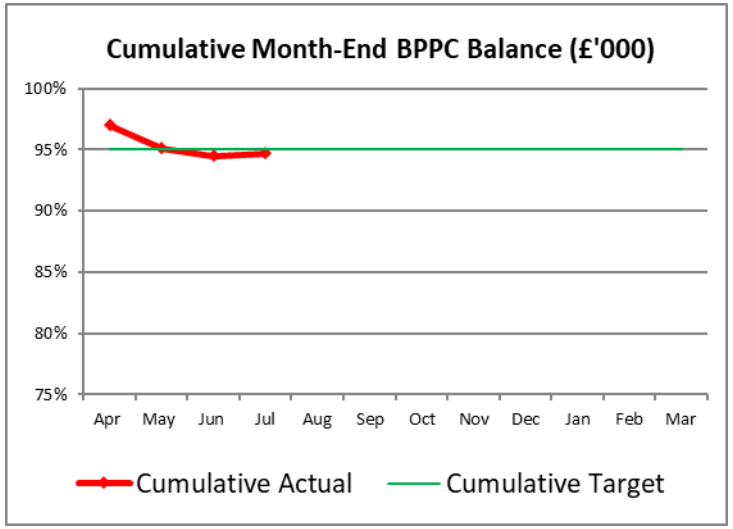
NHS
University Hospitals Dorset
NHS Foundation Trust

# Finance – Key Financial Indicators

| Summary I&E | Year to date | | | Unmitigated Forecast | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Forecast | Variance |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Total Income** | **295,365** | **296,311** | **945** | **884,480** | **887,274** | **2,794** |
| Employee expenses | (199,510) | (198,905) | 605 | (586,967) | (600,442) | (13,475) |
| Clinical supplies expenses | (23,764) | (24,679) | (915) | (71,279) | (72,071) | (792) |
| Drugs expenses | (29,390) | (29,406) | (16) | (91,675) | (91,669) | 6 |
| Purchase of healthcare and social care | (5,039) | (6,530) | (1,491) | (13,219) | (18,294) | (5,075) |
| Depreciation and amortisation expense | (11,863) | (11,863) | 0 | (36,005) | (36,005) | (0) |
| Clinical negligence expense | (6,299) | (6,251) | 48 | (18,898) | (18,161) | 737 |
| Premises & fixed plant | (11,328) | (11,385) | (57) | (35,142) | (34,088) | 1,054 |
| Other operating expenses | (11,023) | (14,328) | (3,305) | (103,399) | (124,623) | (21,224) |
| **Operating Expenses** | **(298,216)** | **(303,347)** | **(5,131)** | **(956,584)** | **(995,353)** | **(38,769)** |
| Net finance costs | (4,868) | (4,658) | 209 | (14,603) | (11,055) | 3,548 |
| Other adj to control total basis | 492 | 6,702 | 6,209 | 86,707 | 93,710 | 7,003 |
| **Control Total Surplus/ (Deficit)** | **(7,227)** | **(4,993)** | **2,233** | **0** | **(25,424)** | **(25,424)** |

| Capital | Year to date | | | Forecast | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Estate Schemes | 6,310 | 5,922 | 388 | 19,189 | 19,189 | 0 |
| IT Schemes | 4,387 | 4,256 | 131 | 10,838 | 10,838 | 0 |
| Medical Equipment | 1,668 | 331 | 1,337 | 6,053 | 6,053 | 0 |
| **Total Operational CDEL** | **12,365** | **10,508** | **1,857** | **36,080** | **36,080** | **0** |
| **Total Donated Assets** | **574** | **904** | **(330)** | **1,401** | **1,401** | **0** |
| CDC - Endoscopy Hub Build | 2,145 | 2,077 | 68 | 6,000 | 6,000 | 0 |
| CDC - Outpatient Assessment Centre | 1,500 | 443 | 1,057 | 8,465 | 8,465 | 0 |
| CIR - Critical Infrastructure Funding | 473 | 70 | 403 | 2,780 | 2,780 | 0 |
| DDP - Digital Pathology | 64 | 64 | 0 | 203 | 203 | 0 |
| ELR - Elective Recovery | 78 | 63 | 15 | 78 | 78 | 0 |
| EPR - Front Line Digitisation | 576 | 339 | 237 | 2,784 | 2,784 | 0 |
| NHP - FBCa / Enabling / FBCB | 4,512 | 4,362 | 150 | 31,687 | 31,687 | 0 |
| SOL - Renewables - Solar Partnership Schem | 4,130 | 4,653 | (523) | 21,141 | 21,141 | 0 |
| STPW1 - Beach & PH Theatres (ESL & C2) | 0 | 0 | 0 | 1,000 | 1,000 | 0 |
| UEC - Urgent Emergency Care | 0 | 0 | 0 | 1,000 | 1,000 | 0 |
| **Total Central PDC** | **33,457** | **32,045** | **1,412** | **147,374** | **147,374** | **0** |
| **UHD Capital Total** | **46,396** | **43,457** | **2,939** | **184,855** | **184,855** | **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** | **635,917** | **698,258** |
| Inventories | 9,934 | 10,441 | 9,000 |
| Receivables | 17,654 | 25,359 | 19,250 |
| Cash and cash equivalents | 102,496 | 80,016 | 74,976 |
| **Total current assets** | **130,084** | **115,816** | **103,226** |
| Trade and other payables | (100,571) | (121,066) | (85,000) |
| Other current liabilities | (6,039) | (14,481) | (6,975) |
| **Total current liabilities** | **(106,610)** | **(135,547)** | **(91,975)** |
| Borrowings | (39,507) | (38,917) | (37,020) |
| Other non-current liabilities | (2,997) | (2,914) | (2,568) |
| **Total non-current liabilities** | **(42,504)** | **(41,831)** | **(39,588)** |
| **Total net assets employed** | **591,352** | **574,355** | **669,921** |
| Public dividend capital | 585,114 | 590,498 | 732,488 |
| Revaluation reserve | 60,076 | 51,887 | 51,887 |
| Other reserves | 2,819 | 0 | 0 |
| Income & expenditure reserve | (56,657) | (68,030) | (114,454) |
| **Total taxpayers' and others' equity** | **591,352** | **574,355** | **669,921** |




At the end of July the Trust reported a deficit of £4.993 million, being £2.233 million better than plan. The Trust is **£2.233 million ahead of plan** due to the revaluation of an investment property in M3 which was planned for but phased differently. However, there remains a significant shortfall in the value of efficiency savings identified against the target. A full, detailed financial forecast has been prepared based on the Month 3 outturn and is reported against the M4 outputs. This will be updated monthly to inform any necessary corrective action.

The **unmitigated forecast as at July is £25.4 million deficit, largely due to the risk adjusted EIP gap desribed below, and with work underway to mitigate.**

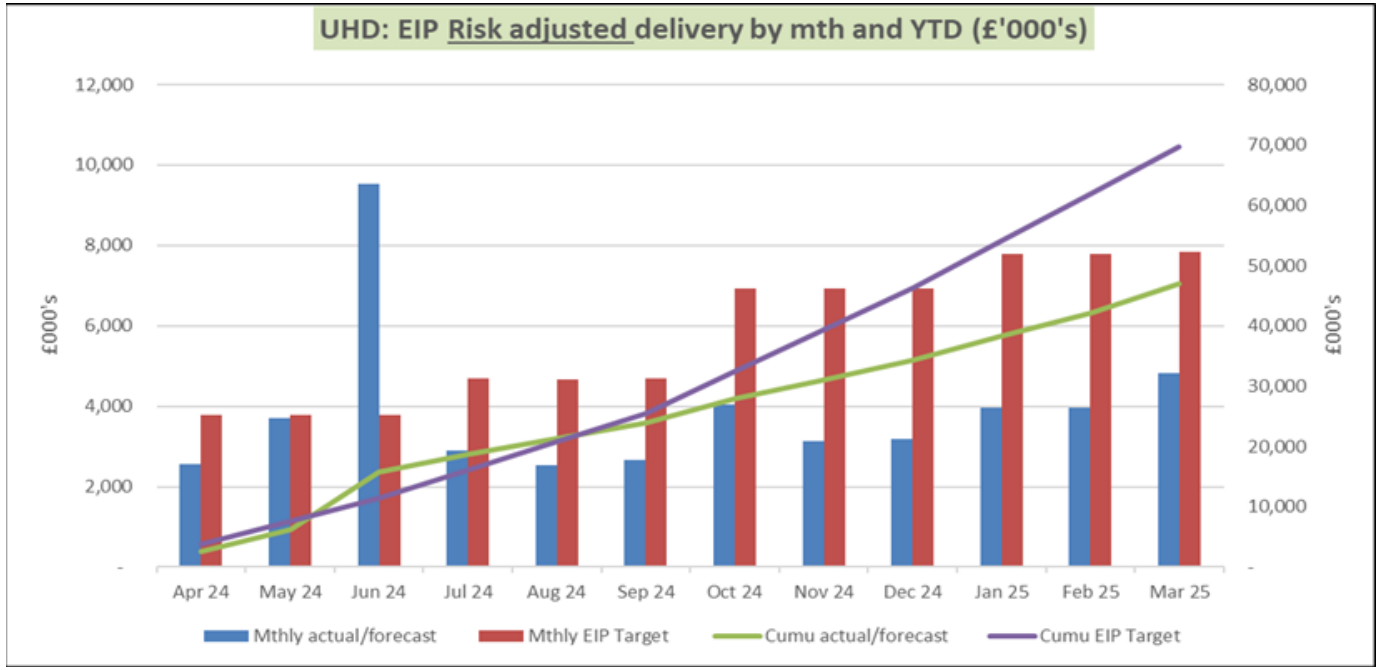
In relation to the **timely payment of supplier invoices, the Trust is currently delivering performance of 94.7%**, slightly below the national standard of 95%.

The Trust has reported **capital expenditure of £43.5 million YTD, £2.9 million below plan**, and is **forecasting full achievement of the full year capital programme**.

As at July 2025 the Trust is holding a consolidated cash balance of £80.0 million which is fully committed against the Medium-Term Capital Programme. This current balance represents 30 days of operating expenditure.

# 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 | Actual | Variation | Target | Forecast | Variation | % of target | Forecast | % of target | Forecast | FY Impact | Variation | % of target |
| Surgical | (2,699) | 1,437 | (1,262) | (8,551) | 3,783 | (4,768) | 44% | 4,647 | 54% | 2,157 | 1,337 | (5,057) | 41% |
| Medical | (3,604) | 2,860 | (744) | (12,524) | 7,494 | (5,029) | 60% | 8,421 | 67% | 4,963 | 1,264 | (6,297) | 50% |
| WCCSS | (3,696) | 2,317 | (1,379) | (11,318) | 7,638 | (3,679) | 67% | 8,440 | 75% | 4,568 | 456 | (6,294) | 44% |
| Operations | (649) | 793 | 144 | (1,875) | 1,906 | 31 | 102% | 2,101 | 112% | 1,083 | 106 | (686) | 63% |
| Corporate | (1,303) | 1,932 | 629 | (3,875) | 4,516 | 641 | 117% | 4,823 | 124% | 2,701 | 155 | (1,019) | 74% |
| Trust Wide | (4,104) | 9,375 | 5,271 | (23,497) | 21,071 | (2,425) | 90% | 21,622 | 92% | 11,951 | 7,030 | (4,516) | 81% |
| Dorset wide schemes | 0 | 0 | 0 | (7,986) | 604 | (7,382) | 8% | 7,986 | 100% | 0 | 0 | (7,986) | 0% |
| **UHD** | **(16,056)** | **18,713** | **2,657** | **(69,625)** | **47,013** | **(22,612)** | **68%** | **58,040** | **83%** | **27,422** | **10,348** | **(31,855)** | **54%** |




**Efficiency Improvement delivery at M4 is £2.657 million above planned levels.**

The trust has **identified savings opportunities of £58 million**, however when **adjusted to reflect the risk of delivery, this is reduced to £47 million**, representing an improvement of £3.3 million from the M3 reported value. However, this **risk adjusted forecast is £22.6 million short of the full year savings requirement**. This remains a priority area of focus, with numerous workstreams in place to mitigate this risk.

Focus has been on reviewing non recurrent schemes for potential opportunities to make them recurrent & validating full year impacts of recurrent schemes. Further work around pay schemes, including non recurrent vacancy factor, will be undertaken along side workforce plans and targets.

# 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 |
| Service Desk | 1,543 | 656 | 2,199 |
| Clinical Application | 1,349 | 808 | 2,157 |
| Password | 0 | 1,660 | 1,660 |
| Non-Clinical Software | 817 | 92 | 909 |
| Email | 559 | 102 | 661 |
| Hardware | 216 | 253 | 469 |
| Telecoms | 77 | 90 | 167 |
| Printing | 0 | 111 | 111 |
| Network | 25 | 54 | 79 |
| Mobile Device | 5 | 36 | 41 |
| IT / Cyber Security | 2 | 7 | 9 |

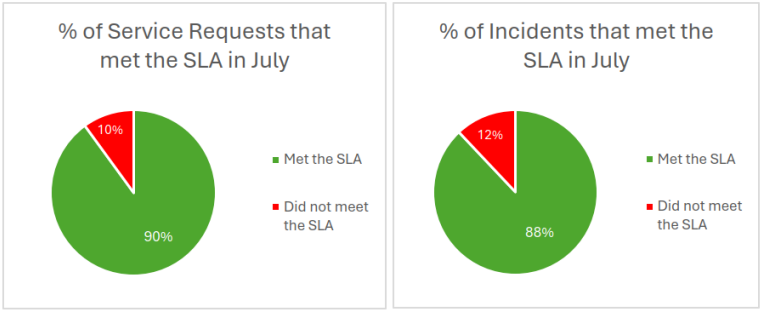
## Monthly P1 Position

| Priority 1 Incidents | | | | | |
|---|---|---|---|---|---|
| Incident Description | Ref Number | Fixed within current SLA? | Actual Fix Time (Hours) | Cause Resolution | 3rd Party assistance |
| | | | | | |

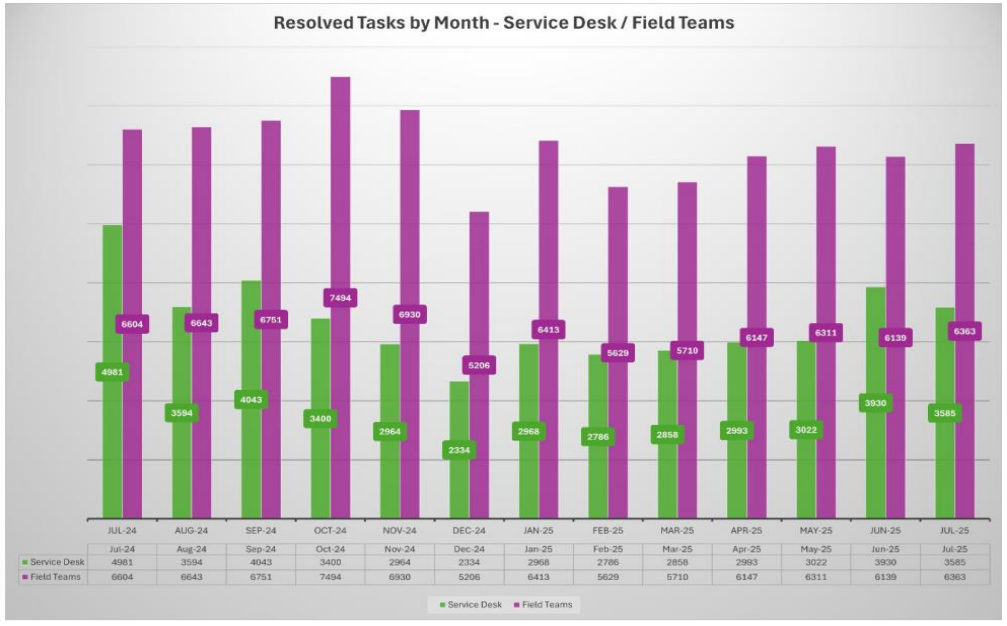
No P1's logged in July 2025

*Priority 1 SLA (Service Level Agreement) is 4 Hours

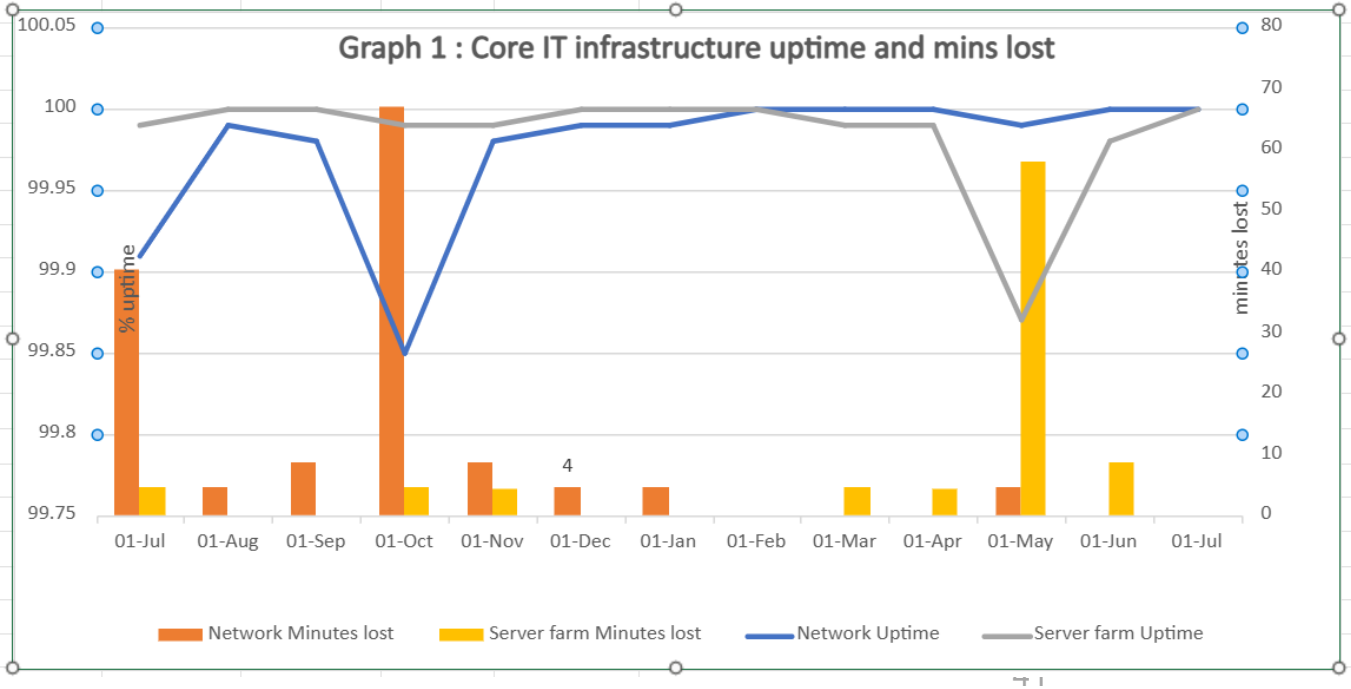
## Service Call SLA Position




## Resolved IT Tasks




## Core Infrastructure Uptime



# Information Governance & Cyber

**Table 4: Freedom of Information compliance**

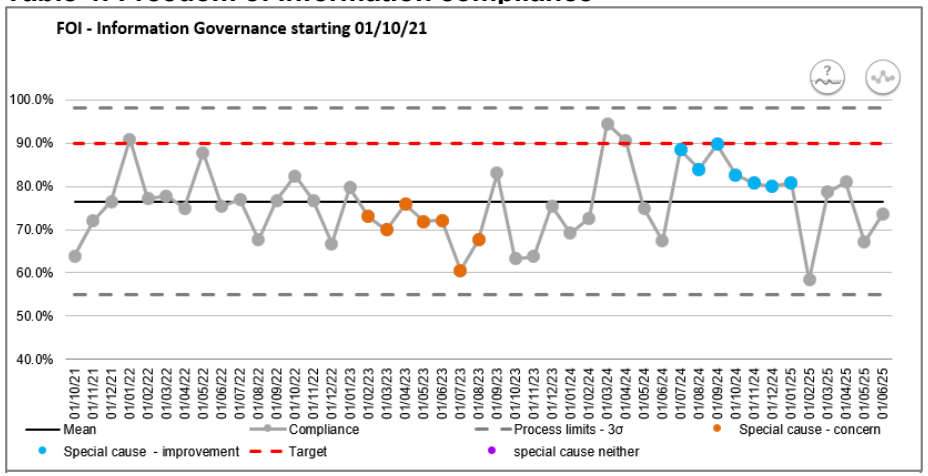
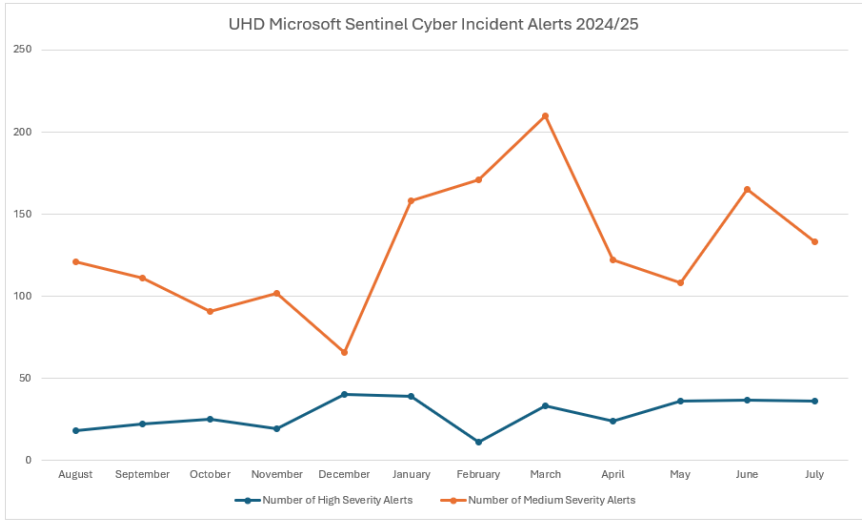



**Table 5: SIEM Incident Alerts**

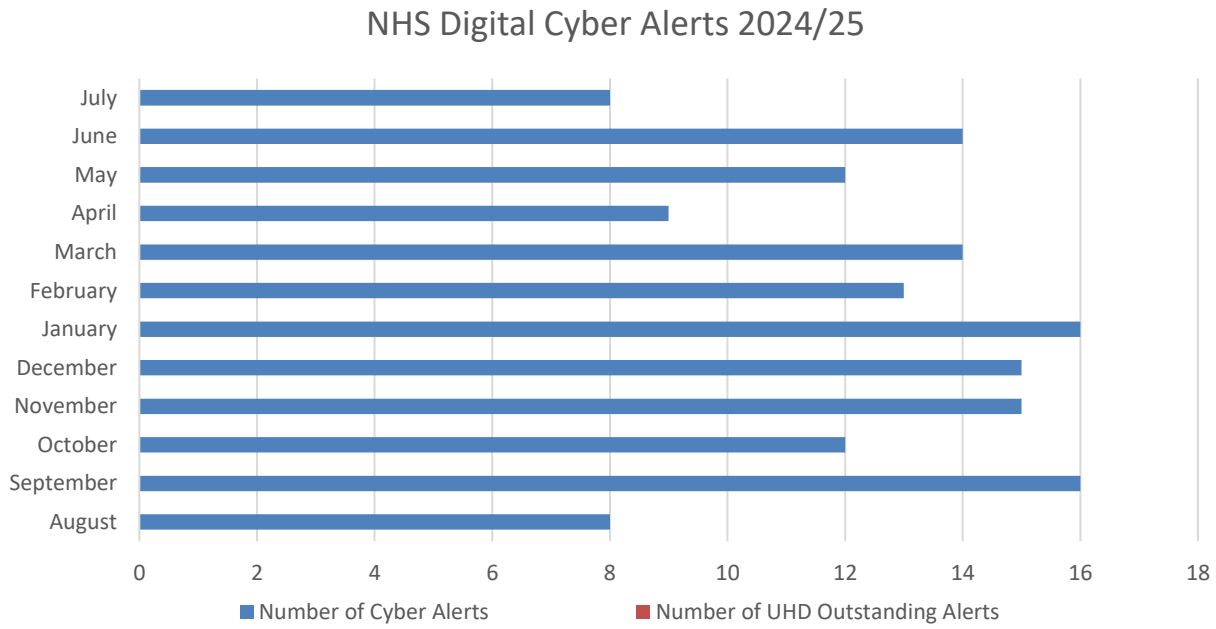



Microsoft Sentinel is a cloud-native security information and event management (SIEM) platform that uses built-in AI to help analyse large volumes of data across an enterprise. The alerts are based on potential suspicious activities.

**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**

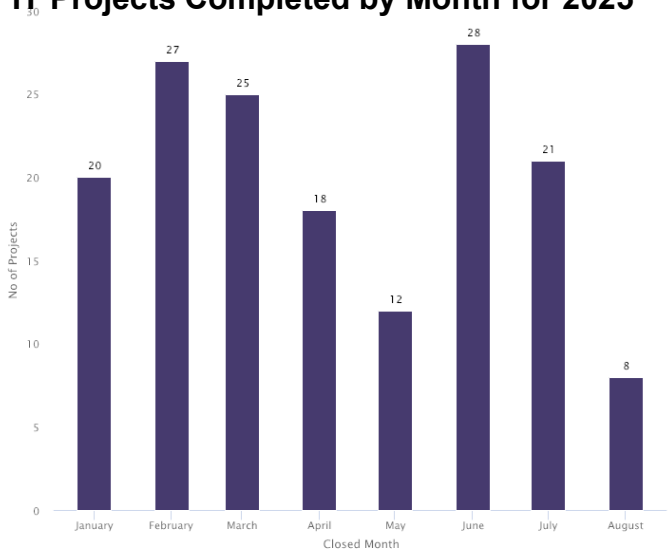


# Development & Medical Records

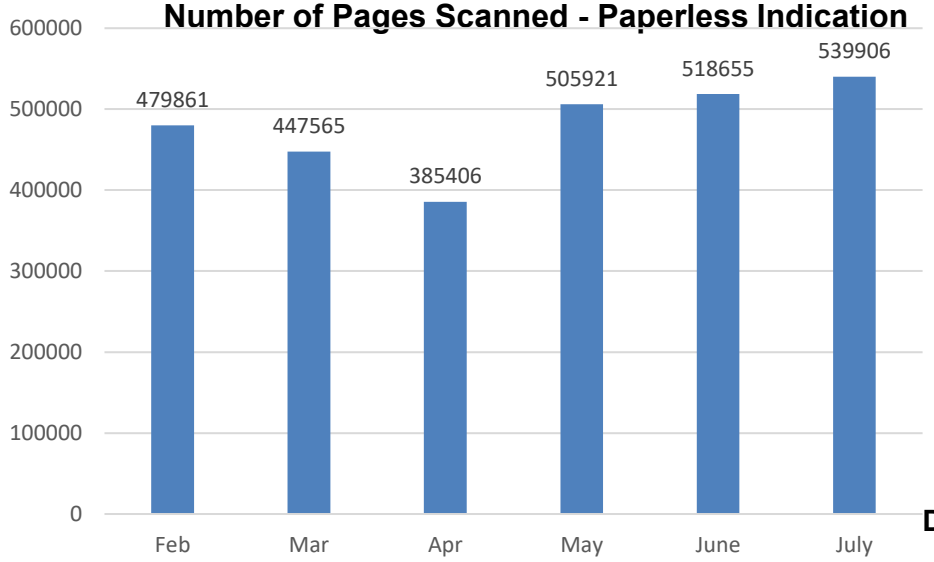
## EHR Programme Timeline

| Current Go live | March 2028 |
|---|---|
| Previous Go Live | Feb 2028<br>October 2027<br>June 2027 |
| Reason for Change | • Invitation to Tender released |

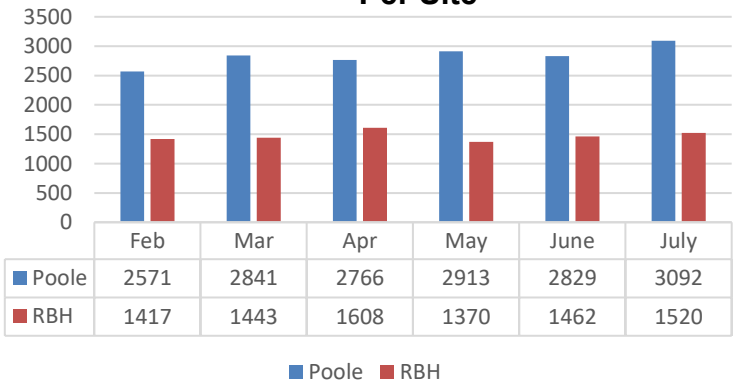
## IT Projects Completed by Month for 2025




## Number of Pages Scanned - Paperless Indication




## Number of Blank Case-notes Returned from Clinic Per Site



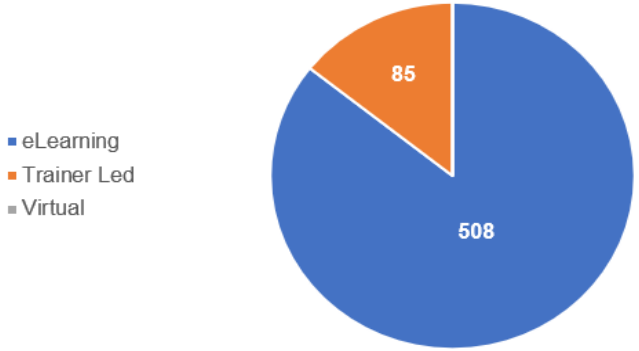

| | Feb | Mar | Apr | May | June | July |
|---|---|---|---|---|---|---|
| Poole | 2571 | 2841 | 2766 | 2913 | 2829 | 3092 |
| RBH | 1417 | 1443 | 1608 | 1370 | 1462 | 1520 |

## Training Statistics
## Face to Face or eLearning Delivered

**Total Trained - July 2025**

**593**

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**