



Annual Report and Accounts 2024/25

We are **caring** **one team** **listening to understand** **open and honest** **always improving** **inclusive**

1 April 2024 - 31 March 2025

University Hospitals Dorset NHS Foundation Trust

Annual Report and Accounts 2024/25

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Contents

Foreword from our Interim Chair and Chief Executive.....	6
A year in pictures.....	10
Performance Report	13
Performance overview	13
Statement from our Chief Executive	13
About us	15
Our structure	15
Our vision, values and strategic objectives	16
Going concern	19
Performance analysis	20
How we measure performance	20
Performance in 2024/25.....	20
Our risk profile	34
Equality of service delivery	37
Sustainability	43
Accountability Report	49
Directors' Report	49
Key activities of the Board	49
Our Board of Directors 1 April 2024 to 31 March 2025	50
Appointments and Remunerations Committee	58
Audit Committee	60
Charitable Funds Committee	61
Finance and Performance Committee	61
People and Culture Committee	62
Population Health and System Committee	62
Quality Committee	62
Transforming Care Together Group.....	62
Council of Governors.....	63
CQC and NHS England Well-led Framework.....	65
Patient experience.....	67
Stakeholder relations	72
Patient engagement.....	74
Staff engagement.....	75
Remuneration Report	78
Annual statement on remuneration from the Chair	78
Annual Report on Remuneration.....	78
Board's responsibility for the Annual Report and Accounts.....	88
Staff Report	89
Disclosures set out in the code of governance for NHS provider trusts	115
NHS Oversight Framework	116
Statement of Accounting Officer's responsibilities	116
Annual Governance Statement (1 April 2024 to 31 March 2025)	118
Review of economy, efficiency and effectiveness of the use of resources	130
Auditors' Report	
Foreword to the accounts	
Consolidated financial statements for the year ended 31 March 2025	

Foreword from our Interim Chair and Chief Executive

Welcome to our Annual Report for 2024-25. As we continue the transformation of our emergency and planned care services, maintaining the focus on patient safety and looking after each other continue to be the golden thread alongside our delivery of continuous improvement. This last year has been one of great change across University Hospitals Dorset (UHD), with lots of progress and improvement at a time of ongoing developments for our staff, who we would like to thank for the incredible work they do to care for our patients.



They were an incredibly valuable resource and brilliant link with the public and we are very grateful for all the support our governors provide our Trust.

Leading up to the service moves and changes, a range of stakeholders were invited to tour the new BEACH Building at the Royal Bournemouth Hospital, enabling us to showcase the many benefits of the new facility and provide the opportunity for stakeholders to raise concerns and ask questions. These included different patient groups who provided invaluable insight.



Better for patients, better for staff

Transforming Care Together

Thank you to our community for your ongoing support. A series of public engagement events were held across UHD sites over the year, giving the public the opportunity to come along and find out about the changes and ask questions. Larger marketplace events, in collaboration with the Dorset Integrated Care System (ICS), took place in Swanage, Blandford and Poole allowing members of the public to speak to staff at UHD as well as other health and social care organisations. Updates were also given in-person at residents' association meetings and as part of the UHD Understanding Health talks that are delivered to the public.

UHD governors are instrumental in engaging with our community, hosting listening events and attending external events throughout Dorset. Armed with literature, surveys and key messages about the changes, our governors have visited (and continue to visit) shopping centres, libraries, charity groups, veteran groups and university and colleges.

Staff Survey

We are very proud of our Staff Survey results this year. Our substantive staff response rate of 58% was 10.4% higher than the national average. For our bank members the response rate was 27%. This shows that together, we are creating a more positive culture where colleagues feel empowered to share your experiences, thoughts and ideas on what matters most to them and where we can improve.

UHD also scored significantly higher than other acute trusts across all seven of the NHS People Promise themes. 76% of colleagues told us they feel care of patients

and service users is our top priority. This is one of the most important areas for us as our patients should always be at the heart of what we do, and it is precisely why we introduced Patient First. When we all feel able to make positive changes in our organisation, our patients receive better care.

We have achieved and sustained significantly improved results for the reporting of harassment, bullying or abuse at work. All our comparator organisations have seen a decline. Our health and safety climate has also improved for three years in a row. This shows that colleagues feel more empowered and safe to speak up and raise issues at work, despite the increase in demand on the NHS, the organisational changes at UHD and the wider national pressures that impact us. There is more to do.

Improvements this year

We are proud that the waiting times for services are improving. We are aiming to be more productive and have an even bigger impact in the year ahead. Our Maternity and Neonatal services have made great improvements this year, achieved the maternity incentive scheme and moved out of the national improvement programme.

On 3 June, our Treatment and Investigation Units (TIU) at the Royal Bournemouth and Poole hospitals successfully merged into a single unit located on the Poole site. The integration of TIU has not only improved the efficiency and effectiveness of patient care, but has also fostered a strong sense of teamwork and collaboration among the team. As the unit continues to evolve, it remains committed to providing exceptional care and preventing unnecessary hospital admissions.

To help our teams travelling between sites with our transformation of services, we have launched a free shuttle bus between Poole and the Royal Bournemouth hospitals. This has proved very popular with colleagues.



BEACH Building clinical opening

We rounded off our NHS year by opening the doors to the BEACH Building at the Royal Bournemouth Hospital and moved our Maternity Unit from St Mary's in Poole, with colleagues joining teams from Critical Care and Radiology as the first part of our major moves.

These were enormous milestones as we continue our ambition to make Poole Hospital the largest planned care hospital in the country and the Royal Bournemouth the major emergency hospital for east Dorset. These developments have been always clinically led and we believe they will make the best use of our resources to provide the best possible care for our communities.

The BEACH Building is also our new front door to the Royal Bournemouth Hospital and the new shops and a coffee shop have been appreciated by colleagues, patients and visitors.

Patient First

We continue to roll out Patient First training at UHD. We have reviewed the training method for clinical teams and have reduced the length of time to complete the training while still retaining all of the content. We will continue to be rolling out the training to the Trust Board and its Committees in addition to continuing the clinical team rollout.

Staff Awards

Our UHD Awards were held on 20 June 2024 at the Pavilion in Bournemouth. From over 800 nominations a shortlist for the 15 categories was agreed by a multidisciplinary panel. The awards continue to go from strength to strength. We are so pleased to see how staff engage with the process of nominating their colleagues in recognition of the work they do and the extra mile they give.

Launch of Learning and Improvement Networks

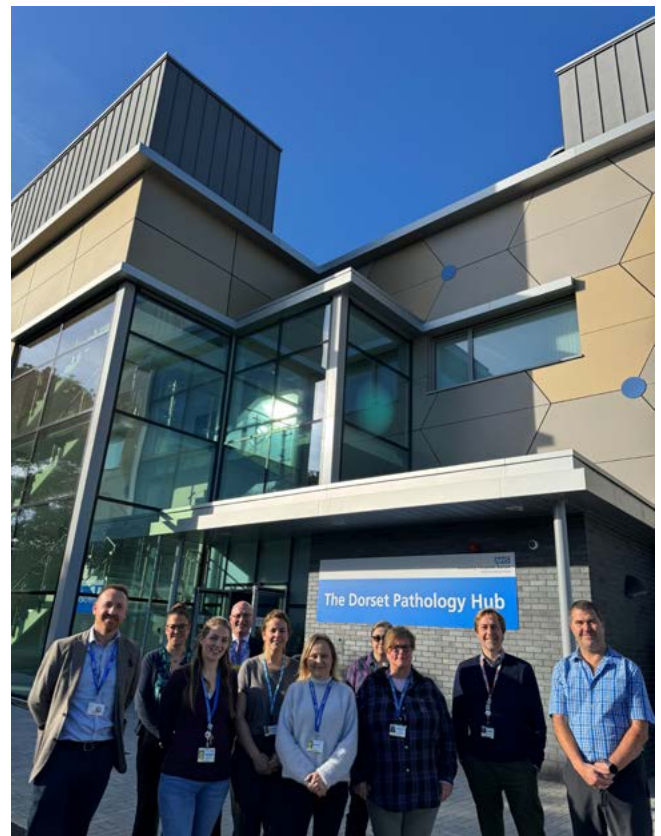
NHS England has selected 14 Trust Chief Executive Officers to lead a nationwide improvement drive on emergency and elective care. They will head up Learning and Improvement Networks (LINs) as part of NHS England's IMPACT programme. Each NHS England region has been given two improvement leads.

Siobhan was appointed as one of the two leads for the south west, alongside Peter Lewis from Somerset NHS Foundation Trust. Each LIN is to work up a limited number of proposals to deliver best practice ideas in elective and emergency with a view to these being tested at scale.

Pathology Hub opening

We held an official opening ceremony of the Dorset Pathology Hub at the Royal Bournemouth Hospital on 22 May 2024. The new innovative facility is part of the One Dorset Pathology Network - a collaborative partnership between Dorset County Hospital and University Hospitals Dorset.

The new laboratory is designed for rapid routine and advanced specialist testing and supports hospitals across the region to improve diagnostic tests for patients. At the event we were joined by well-known broadcaster and Chancellor of Bournemouth University, Kate Adie OBE.



Executive Team

Professor Paula Shobbrook, our Chief Nursing Officer, retired and left the Trust on 9 April 2024. Paula had been at UHD and before then at Royal Bournemouth and Christchurch hospitals for 13 years in total. She was also Acting Chief Executive of UHD from 1 April 2022 to 31 May 2022. Thank you to her for her many years of service and leading our Trust through the second part of the Covid pandemic.

Sarah Herbert was appointed Chief Nursing Officer on 13 May 2024. Sarah has held a number of clinical and senior nursing leadership roles, including supporting the University Hospital Southampton medical division through Covid before becoming the Deputy Chief Nurse there in 2021.

Fiona Hoskins, our Deputy Chief Nursing Officer was Interim Chief Nursing Officer between Paula's departure and Sarah's appointment. She left the Trust in July 2024 to become Chief Nursing Officer at Milton Keynes University Hospitals NHS Foundation Trust. We thank her for covering the gap.

Beverley Bryant joined UHD in October 2024 as Chief Digital Officer. She will be overseeing the provision of a new electronic health record in partnership with providers in Somerset. As part of the One Dorset Provider Collaborative (ODPC), University Hospitals Dorset, Dorset County Hospital and Dorset HealthCare are working together to strengthen the leadership of digital services to support patient care in Dorset. It has been agreed that she will take this role for all three trusts. Beverley will remain a Board member at UHD. Beverley joined us from Guy's and St. Thomas' and King's Hospitals in London.

Non-Executive Team

The year closed with Rob Whiteman leaving UHD as our Chair. Rob had been at UHD for almost three years and we are grateful for the drive and ambition he brought to us as Chair. He oversaw our Trust at a very exciting but challenging time as we continued to care for our patients in parallel with our £500m transformation programme. He helped to strengthen our Board of Directors and was instrumental in developing our system working with partners which will be vital in the future. We have greatly appreciated both his support and his passion for improvement. Judy will be Interim Chair until April 2026.

Pankaj Davé left his role as non-executive director in November 2024 having joined us in October 2020. Our thanks to him for his dedicated leadership of our People and Culture Committee.

We were delighted to welcome Tracie Langley and Femi Macaulay as non-executive directors this year, as well as Alison Honour and Andrew Doe as associate non-executives.

Our governors

This financial year began with the appointment of new Lead Governor, Michele Whitehurst, and Deputy Lead Governor, Carrie Stone. Michele took over in April 2024 from previous Lead Governor, Sharon Collett.

Our governors, as always, have been a great ally in this financial year, running a series of in-person public listening and information events. In addition, having identified hard to reach areas in the community, governors held talks within targeted locations to reduce health inequalities.

Staff governors have also been working to raise their profiles among colleagues, and we're grateful to all governors for their continued support.

Thank you to Team UHD

Thank you, Team UHD, for all that you have achieved this year and thank you to all our partners, governors, volunteers and patient groups for all that you have done to help support our hospitals through these exciting but very challenging times. We look forward to continuing our progress together to improve and transform services for our population.

J. m. Gillow

Judy Gillow
Interim Chair



Siobhan Harrington

Siobhan Harrington
Chief Executive

A year in pictures



▲ March was a big month for our transformational moves. From saying farewell to St Mary's Maternity Hospital and welcoming the opening of our new BEACH Building, to introducing our new staff shuttle bus and our Trust becoming smoke free. It was a rewarding and exciting month for #Team UHD.



▲ February was World Cancer Day and Year 3 pupils from Stourfield Junior School in Southbourne sent in a wonderful selection of artwork to the Jigsaw Ward at the Royal Bournemouth.



▲ We celebrated the new lunar year with colleagues across the Trust in January. From performances to activities, there was something for everyone, and we couldn't be more proud to help celebrate our colleagues' rich history and vibrant culture.



▲ We were featured on BBC Breakfast for our groundbreaking trial taking place at the Royal Bournemouth, looking at how a wearable device could be a game changer for people going through rehabilitation after having a stroke.



▲ Odette Rodda our Paediatric Dermatology Specialist Nurse made us very #TeamUHD Proud when she was given the prestigious title of 'Queen Nurse' by community nursing charity, The Queen's Nursing Institute.



◀ Our cover image

Colleagues celebrate the opening of services in our BEACH Building.



▲ We broke ground on our new Coast Building in November 2024, a £91m, state-of-the-art ward and catering block that will add 110 beds, expanded kitchen facilities and adaptable spaces.



▲ In October 2024, we marked Black History Month celebrations with talks from local groups which highlighted the rich Black history of Dorset.



▲ Our Annual Members' Meeting took place at St Saviours Church in Bournemouth in September 2024. Following the event, we held a talk on 'Understanding Diabetes' for attendees.



▲ Maternity Support Worker, Kerry Horley, was shortlisted for one of the highest awards in the country for the maternity profession from the Royal College of Midwives in August. Kerry went on to win the award in October 2024.



▲ Our vibrant #TeamUHD Cultural Celebration Day in July 2024 had a mix of inspiring talks, food and beautiful fashion as we celebrated everything that makes us so unique and special.



▲ We celebrated the inspirational care, compassion, and leadership of our colleagues at our second UHD Awards in June 2024. The awards scheme received more than 850 nominations put forward by staff and patients.



▲ It was a new era in medical diagnostics and patient care as we officially opened our state-of-the-art Dorset Pathology Hub in May 2024.



▲ We joined in on celebrations of 30 years of care at Forest Holme. A special installation of 1,000 handcrafted glass flowers were created to mark the occasion, symbolising the many years of dedication and support.



Thank you Team UHDS

Performance Report

Performance overview

In this overview, we provide you with:

A statement from our Chief Executive, providing a summary of how we have performed during 2024/25

An introduction to our organisation, covering what we do, the services we provide and our organisational structure

An overview of our strategy, our key priorities for the future and our values

A summary of key risks that we have identified and managed during 2024/25 and how these have affected the delivery of our objectives

Statement from our Chief Executive



We have had another challenging year, with high demand across our services and sustained operational pressures. I am so grateful to all our colleagues who have continued to work tirelessly to deliver safe, compassionate and high-quality care for our patients.

We saw increasing numbers of patients across our emergency departments, lengthy ambulance delays, continued issues with high numbers of patients with no criteria to reside and long waiting lists for elective procedures.

However, collectively we have made huge improvements in all areas through our Patient First roll out, including a combination of improved productivity, adopting new ways of working, collaboration with other partners and a real commitment from our staff to make a difference.

Urgent and emergency care

It has been a challenging year for our emergency departments and for urgent and emergency care nationally. Like other acute hospitals, UHD experienced an early onset and high prevalence of flu presentations; which in addition to losing bed capacity due to norovirus, resulted in delays in patient flow through our emergency departments.

We didn't meet our objective to treat 78% of patients with four hours through our emergency care pathway. Our position at the end of 2024/25 was 72.1%. While the organisation did not meet its objective, March 2025 performance was an improvement of 1.9% compared to March 2024. The failure to achieve the target was associated with high bed occupancy rate driven by higher than planned numbers of patients who no longer met the criteria to reside for inpatients care but were unable to be discharged due to lack of community or social care capacity.

Planned care

We have continued to deliver an increase in planned operations, procedures and appointments for patients compared to the 2019/20 baseline period. The Trust delivered 112.6% elective activity in 2024/25, exceeding our operational planning trajectory of 109.1%. Comparing our performance at the end of the year to March 2024, we have seen widespread improvements in elective care.

Alongside this we have seen some important improvement against the cancer standards - the Cancer 28 Day Faster

Diagnosis Standard (FDS) and 31-day standard were achieved by the end of the year, while the cancer 62-day time to first treatment standard also showed over 10% improvement over the year.

Finance

The Trust has reported a full year position of £93k surplus, slightly ahead of the breakeven plan position for the year. This performance was supported by Efficiency Improvement Programme (EIP) delivery of £42m, delivering the planned savings for the year, but recognising that £14.2m of these savings were non recurrent and therefore contribute to an increased EIP requirement for 2025/26 of £61m.

The capital programme has been fully delivered in line with the Capital Departmental Expenditure Limit set for the Trust of £156.8m.



Diagnostics

We have delivered more diagnostic activity than in previous years; 10,000 additional slots compared to the same period in 2023/24, and 19,000 more slots than the pre-Covid-19 period. This additional activity has ensured our performance has moved from 10.7% to 7.5% for patients waiting longer than six-weeks for their diagnostic test and the Trust has remained one of the top performing trusts in the south west in this respect. This position has been delivered alongside keeping up with increased demand for diagnostic tests across 2024/25, 4% more referrals in the year were received compared to 2023/24.

Quality performance

We have made a commitment to work in partnership with our patients and colleagues and hope to build on these strong foundations to further develop and embed safety systems and learning.

The Trust developed its Patient Safety Incident Response Plan, aligned to the Patient Safety Incident Response Framework (PSIRF), a fundamental cultural safety change focusing on learning and improving local priorities for patient safety. Our focus has included looking at improving patient safety by reducing in-hospital falls, pressure ulcers and venous thromboembolism. We also set and achieved some important safety and quality priorities for maternity care.

Our risk profile

The Trust identifies, prioritises and manages all aspects of risk through its integrated governance framework. We identified 10 major in-year risks which impact upon the achievement of our strategic priorities.

The most significant risks in 2024/25 facing the Trust (in-year and immediate future) are the demand, capacity and operational flow constraints in the wider health and social care system and national and local staff shortages in key specialties.

About us

We serve Bournemouth, Poole and Christchurch, East Dorset and Purbeck, and parts of the New Forest for most hospital services.

Our **specialist services** also serve the whole of Dorset, South Wiltshire and parts of Hampshire, for a population of up to one million. These services include oncology, neurology, vascular, cardiac and interventional radiology, along with specialist areas in services like surgery.

Our three main sites are Poole, Royal Bournemouth and Christchurch hospitals. We also have services in many community settings including Health Sciences University in Boscombe and in patients' homes. We also have many staff working offsite at Yeomans House, Discovery Court and Alderney Sterile Services.

Our Trust **employs around 10,000 staff** including via our staff bank. We are fortunate to have hundreds of volunteers and strong partners, as well as a thriving charity and allied independent charities. All this stands us in good stead for what are significant challenges to meet the health needs of our population which is ageing and growing by about 1% per year. In addition, the local area remains popular for 30,000+ students and over one million visitors a year.

Our services include the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services, delivering the following annual activity:

- 157,843 Type 1 Emergency Department (ED) attendances
- 79,193 non-elective admissions
- 111,863 elective admissions...
- ...of which 98,226 day case treatment
- 636,061 outpatient attendances (256,446 new and 379,615 follow ups)
- 3,683 live births
- diagnostics and other services.

Our structure

As a Foundation Trust, we are accountable to the Department of Health and Social Care via NHS England. As the regulator for health services in England - working through and in partnership with the Dorset Integrated Care Board (NHS Dorset) - it oversees the performance of the organisation, providing support where required, and has oversight of the Trust operating in line with the conditions of its provider licence. We are also accountable to local people through our Council of Governors and members. In addition, there is a large range of inspection and other regulatory bodies which govern the activities of the Trust, including the Care Quality Commission (CQC).

The Council of Governors, which represents around 23,700 members, is made up of public, staff and appointed governors. The Council of Governors plays an important role in members' views being heard and fed back to our Board, as well as members of the public being kept up to date with developments within the hospitals.

Our Board is made up of full-time executives, who are responsible for the day-to-day running of the organisation, and part-time non-executive directors. The executive directors work closely with the clinical leaders and managers throughout the hospitals in running the services. The Board also works closely with the Council of Governors.

The Trust is organised under three clinical care groups - Medical Care Group, Surgical Care Group and the Women's, Children, Cancer and Support Services Care Group - and a number of departments providing support services.

We are an integral member of the Dorset Integrated Care System (ICS) working closely with a range of key health and social care partners to develop and deliver our services in partnership.

Our vision, values and strategic objectives

We are part of an integrated system of health and care, working towards making Dorset the healthiest place to live in England. That requires us to not just change but transform in many ways. All our enabling strategies have this vision and a transformative ambition.

Our values have been developed as a result of engaging with and listening to our staff to understand 'what is important to them?' This appreciative inquiry was carried out over many months with the support of our culture champions - a representative group and cross section of staff across our trust.

Our values underpin our vision and mission. They are the standards shared by all of our staff. They guide our day-to-day decisions and the way we behave. They describe what is important to us and 'the way we do things around here'.

What is striking about the values developed by staff is their duality. Each one consistently and equally speaks to the values for staff **and** for patients.

Patient First is the overarching strategy for University Hospitals Dorset. It is our guiding principle at the heart of everything that we do. It is also the long-term approach we take to transforming health services. It sets out that our True North is the 'patient first and foremost'. This is supported by the values of compassion, teamwork, communication, respect, continuous improvement, and inclusion.

We will remain flexible in how we go about achieving these objectives, as we learn and listen, try different approaches and develop our improvement skills. What is key though, is the True North and strategic objectives remain consistent, so as a team we are all pulling in the same direction.





Our strategic themes will support the delivery of our vision and shape our ‘breakthrough’ annual objectives and enabling programmes. The five strategic themes are [shown on the left](#).

Within the next 12-18 months we aim to achieve the following breakthrough objectives, [shown on the right](#).

Strategic Theme	Vision - LONG TERM	Breakthrough Objective - SHORT TERM: 1 YEAR
POPULATION AND SYSTEM <i>Mark Mould</i>	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.	<ul style="list-style-type: none"> To achieve 109% weighted value elective activity against the 2019/20 baseline, including specialist advice and guidance No more than 66.1% of patients on incomplete RTT pathways should have been waiting more than 18 weeks (18 week RTT) for treatment >78% of patients to be treated within 4 hours through the emergency care pathway
OUR PEOPLE <i>Tina Ricketts</i>	To be a great place to work, attracting and retaining the best talent.	<ul style="list-style-type: none"> To deliver improvements in the NHS Staff Survey Results for: “I would recommend my organisation as a place to work” > 65% Staff Engagement Score > 7.1 / 10
PATIENT EXPERIENCE <i>Sarah Herbert</i>	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	<ul style="list-style-type: none"> 100% of complaints to be closed within 35 days, with associated action plan Increase the number of Early Resolution of complaints by 20% Reduce the number of complaints received per 100 contacts for clinical services by 10% from baseline
QUALITY OUTCOMES AND SAFETY <i>Peter Wilson</i>	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios - HSMR) and patient safety (Patient Safety Incidents - PSIs).	<ul style="list-style-type: none"> To statistically reduce our rate of Falls per 1,000 bed days To ensure the % of patients given timely VTE prophylaxis is 95% or higher To statistically reduce the rate of pressure ulcers (hospital acquired) per 1,000 bed days Doctors to achieve 100% compliance in eMortality reviews
SUSTAINABLE SERVICES <i>Pete Papworth</i>	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	<ul style="list-style-type: none"> To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently To have reconfiguration efficiency plans in place

Progress has been made in 2024/2025 against the strategic themes, as set and measured through the breakthrough objectives. These are covered in the 2024/25 performance analysis section below.

This approach of being consistent with strategic themes over many years, and then reviewing the objectives to be delivered over the next 12-18 months is working well. The 2025/26 breakthrough objectives are broadly similar in areas, but with further stretch in some, e.g. even lower mortality. A few others have seen the metric change, especially as we listen and adapt around our patient experience measures.

Alongside the objectives, we also have our major change programmes. These help us improve in carefully selected, whole organisation wide, complex projects. They all need to deliver within one to two years to enable us to deliver our strategy. They are, each in their own right, a 'blockbuster' programme with their own governance and projects. All are overseen at least monthly, by the Trust Management Group (TMG), the most senior operational group in the Trust. These are summarised below in the hexagons, and they interlock, as they are mutually beneficial to delivering our overall strategy. Further detail is set out in our separate document: UHD Annual Plan 2025/6.

Corporate Projects 2025/26



While the colour coding links to the primary strategic theme, all projects support multiple areas. They are therefore reinforcing each other and our transformation efforts.

For 2024/25, 10 risks to achieving the strategic objectives were identified. Further detail on these risks is provided in the performance analysis section below and in our Annual Governance Statement, under the Board Assurance Framework section.

Going concern

Our accounts have been prepared on a going concern basis. The Financial Reporting Framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.



The directors have a reasonable expectation that this will continue to be the case.

International Accounting Standard 1 (IAS 1) requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the

dissolution of the Trust without the transfer of its services to another entity within the public sector. In preparing the financial statements, the Board has considered the Trust's overall financial position against the requirements of IAS1. The Trust has produced a financial plan for 2025/26 and has prepared a cashflow forecast to the end of March 2026. From the financial modelling undertaken the Trust is expecting to have sufficient cash to cover its requirements for this period.

Based on the factors outlined above, the Board has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver the full range of mandatory services for the 12 months from the date of approval of the financial statements and fulfil any liabilities as they fall due. The directors consider that this provides sufficient evidence the Trust will continue as a going concern for the 12 months from the date of approval of the financial statements. On this basis, the Trust has adopted the going concern basis for preparing the accounts.



Performance analysis

The NHS Oversight Framework sets out the key national standards which are applicable to University Hospitals Dorset NHS Foundation Trust as a service provider. Our performance delivery plans are highly aligned with this framework and the forward plans of the Dorset Integrated Care Board, regarding meeting nationally and locally set objectives. These are set out below. The capital plans of the Trust are also nested within the Integrated Care Board and partner organisations' plans. This includes the New Hospitals Programme.

How we measure performance

Our Strategic Plan is closely monitored for progress, effectiveness and continuous improvement. Supporting the Trust during this transition year towards full implementation of the **Patient First Improvement Programme** has been constantly improving governance. This includes Strategy Deployment Reviews (SDRs) that provide effective oversight and counter measures to ensure we are aligned and on track against our plan.

Care Group Strategy Deployment Review meetings are attended by members of the Executive Team, the Care Group triumvirate comprising the Group Director of Operations, Care Group Director of Nursing and Care Group Medical Director. The triumvirate is accountable for the delivery of their key performance indicators for quality, performance, finance and workforce, together with their strategic and Trust-wide programme responsibilities. Monthly performance reviews for corporate services follow a similar format.

The monthly Integrated Performance Report encapsulates the result of these processes and provides the Board with a rich source of information that has been reviewed and substantiated at all levels of the Trust.

The report contains details of all key aspects of performance, under the CQC domains of Safe, Effective, Caring, Responsive and Well-Led, as well as the Trust's strategic themes of Population and System, Our People, Patient Experience, Quality Outcomes and Safety, and Sustainable Services.

The Trust uses Statistical Process Control (SPC) methods to monitor and direct performance improvements. Additional performance information is provided on financial matters, informatics and clinical quality. These reports are available on the Trust's website, as part of the information provided for Board meetings. The content of the Integrated Performance Report is discussed at meetings of the Trust Management Group and Board (with specific strategic themes discussed at the relevant Trust Board Committees).

In addition to this, the Trust continues to use nationally published information (where available), to compare performance. This includes national staff and patient surveys and national clinical audits. The Trust also monitors its progress against the recommendations from its most recent CQC reports, through its Quality Committee.

Performance in 2024/25

A combination of reporting of performance against the Trust's strategic objectives and the wider performance framework is included in this section. The Trust's actual performance against each of its 2024/25 objectives is described below.

To achieve 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance.

This objective was exceeded, 112.1% weighted value activity compared to the

baseline year of 2019/20 was delivered to patients in 2024/25. This included around 2.6% specialist advice and guidance.

More than 78% of patients treated within four hours through the emergency care pathway

This objective was not met as the Trust's position at the end of 2024/25 was 72.1%. While the organisation did not meet its objective, March 2025 performance was an improvement of 1.9% compared to March 2024. The failure to achieve the target was associated with high bed occupancy rate driven by higher than planned numbers of patients who no longer met the criteria to reside for inpatients' care but were unable to be discharged due to lack of community or social care capacity.

To deliver improvements in the NHS Staff Survey results for:

- 'I would recommend my organisation as a great place to work' > 65%
- Staff Engagement Score > 7.1/10



Be a great place to work

We did not achieve this target in our 2024 NHS Staff Survey. Our score was 62.96% (0.54% lower compared to 2023), however our rating was above the NHS national average of 60.90% for comparator trusts. Our staff engagement score was 6.9, which is slightly above the NHS average but below the target we set ourselves.

To improve overall experience (rated 1-10) from the 'Have your Say' survey

This objective was partially met. There are six different Have Your Say survey types. Three showed improvement, one no change, and one showed a reduced rating (outpatients). The volume of responses however, remains too low to draw reliable conclusions from the ratings and ongoing work continues to promote the Have Your Say survey.



100% of total complaints closed within 35 days

We saw a sustained seven month improvement during 2024/25, although a reduction in performance in the latter part of the year. This objective has been carried forward to 2025/26.

HSMR <100

We met this target. The latest fully coded Hospital Standardised Mortality Ratio (HSMR) position is January 2025 at 96.9. This is below (better than) the national average of 100.

Improve Staff Survey safety culture questions by 5%

These improved by 1.7% since last year, against an average improvement of 0.6%.

Implement the UHD Patient Safety Assessment Framework (PSaF)

Measuring and improving safety culture within teams and across the Trust is a key component of our Patient First objectives. We have adapted some of the language used in the original 2006 Manchester Patient Safety Framework tool to create a bespoke UHD Patient Safety Assessment Culture Toolkit.

The UHD PSaF Tool links to our Trust values and Patient First objectives and will support staff to think about the strengths and weaknesses of the patient safety

culture in their teams and consider what a more mature safety culture might look like. Teams then use the Patient First improvement methodology to look at areas for improvement and to share good practice.

We initially piloted the tool with our early adopter wards for Patient First. We also asked our Board to complete the tool and used the results to support discussion at a Board development session on patient safety and risk management. We have now started a wider roll across our three Care Groups.

To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently

We partially met this objective, delivering 100% of our EIP, with 62.2% of this being recurrent. Achieving £42m of savings is a significant achievement and the largest annual saving since UHD was formed.

Beyond the Trust's strategic objectives, further details of our performance against key national metrics are outlined on the following table.



Performance Metric	National Target	31 March 2024	31 March 2025
4-hour care Emergency Department standard	78%	70.2%	72.1%
Diagnostic 6 week standard - % greater than 6 weeks	1%	10.7%	7.5%
Referral to Treatment - % patients within 18 weeks	92%	62.0%	60.9%
Referral to Treatment - number of patients waiting >52 weeks	-	2,767	2,184
Referral to Treatment - number of patients waiting >65 weeks	-	328	10
Referral to Treatment - number of patients waiting >78 weeks	-	29	0
Referral to Treatment - number of pathways	-	68,398	67,109
28 day Faster Diagnosis Standard (Target 75%)	75%	75.2%	79.8%
31 day Cancer Standard - % patients diagnosed being treated within 31 days (Target 96%)	96%	96.1%	96.6%
62 day Cancer Standard - % patients being seen 62 days from urgent GP referrals (Target 85%)	85%	68.9%	72.0%

Urgent and emergency care

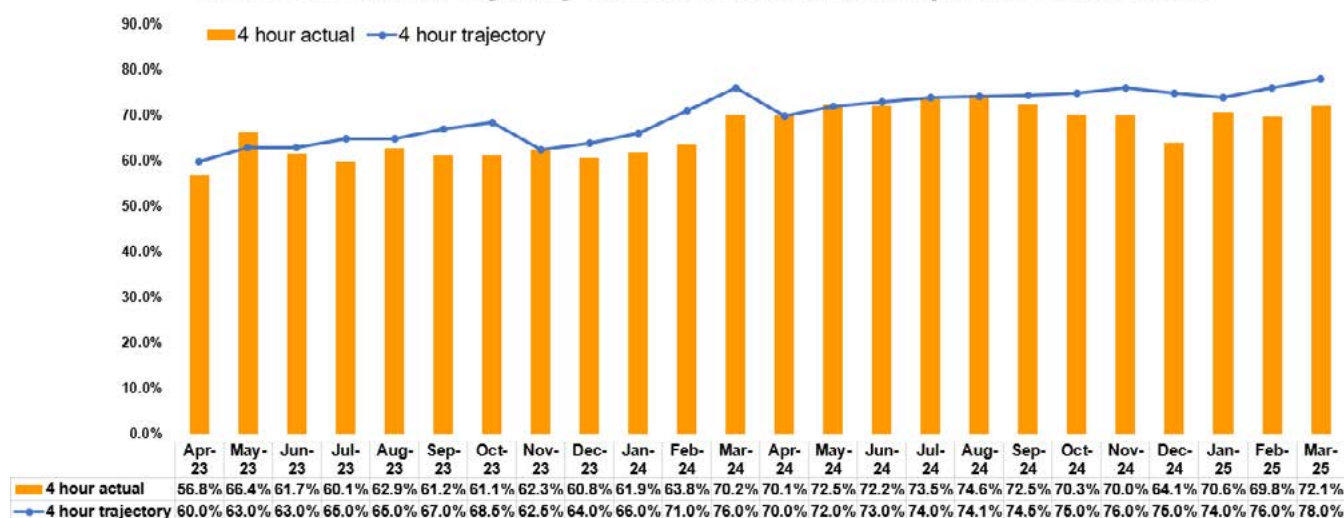
It has been a challenging year for our emergency departments and for urgent and emergency care nationally. Like other acute hospitals, we experienced an early onset and high prevalence of flu presentations; which in addition to losing bed capacity due to norovirus, resulted in delays in patient flow through our emergency departments.

The 4-hour access standard for emergency departments states '78% of emergency patients should be seen, treated if necessary, and either discharged or admitted, within four hours of arrival in an emergency department (ED)'. The Trust continues to work hard to identify areas and opportunities to improve and to ensure we continue to build on the progress made over the past 12 months.



Our Emergency Department Team re-framed the '4-hour access standard' as the '**4-hour safety standard**' in recognition of the patient centred approach that we would take to delivering improvements, and this has remained the term used throughout the organisation, including in reporting to our Board.

4 hour Performance Trajectory vs Actual Performance for April 2023 to March 2025



Co-locating the Urgent Treatment Centre has enabled around 60 patients each day to be 'streamed' to care settings more aligned to the patient need. This has enabled the Emergency Department to serve and **benefit those with the most urgent clinical needs**.

Over the past 12 months there has been a great deal of focus in ensuring the early and timely release of ambulance crews. The ongoing improvement plan has meant a sustained reduction in the time taken to handover care to the Emergency Department and other receiving areas.

In the last quarter of the year, performance was supported by the implementation of our Winter Preparedness and Resilience Plan for 2024/25. Actions were both designed to increase capacity and mitigate and balance risk across urgent and emergency care and elective care by reducing escalation beds open and retuning staff core bedded areas.

Despite the seasonal challenges that winter brings, the Trust made good progress against the Winter Plan for 2024/25. One of the principles that underpinned this year's plan was to focus on **creating alternatives to admission** through alternative and more appropriate care settings, which helped to

maintain patients within their usual place of residence. This approach was a key enabler in reducing the number of 'escalation' beds that were used compared to the previous winter. This significantly helps to ensure wards have the right skill-mix and clinical oversight in addition to helping to retain specialty teams on specialty wards.

One area of challenge the Trust faces is ongoing high occupancy driven by patients whose discharge is dependent on external services, including those administered by local authorities. Approximately 18% of our bed base is used to support patients who no longer need acute services.

We continue to work hard with partners in reducing the number of patients awaiting services outside the Trust, including strong partnership working and engagement with the charitable sector, who provide support with transport and where needed, settling patients back into their usual place of residence.

Over the past 12 months we have also made progress in moving towards a **seven-day discharge service** to help facilitate weekend discharges for patients who may have further needs from the wider social and healthcare community. A new discharge tool '**My Care**

Needs', has also been rolled out to help with early care plans, bringing together a wide range of information to help ensure plans are holistic and timely.



We have, alongside our system partners, embarked on a significant improvement programme to innovate our collective approach to finding alternative and more appropriate ways of meeting the care needs of the people of Dorset, including the use of a virtual ward model (Hospital at Home) and freeing up community and social capacity to support timely discharge. The programme aligns well with the transformational plans of the organisation and will bring different ways of working into the newly configured hospital as part of the Clinical Services Review.



**See our
patients sooner**

Referral to Treatment (RTT)

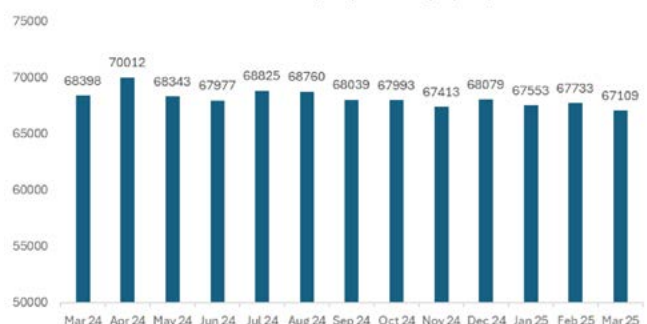
In 2024/25, we were able to successfully treat our most clinically urgent patients while making significant improvements to access to treatment for our longest-waiting patients. We were able to both lower the number of patients waiting on our elective waiting list following referral, and eliminate waits which exceed 78 weeks. Our elective (RTT) waiting list has reduced by almost 2% to just over 67,000 patients. We have had no patients waiting >78 weeks for treatment for capacity reasons since May 2024 and since the beginning of the year, we have significantly reduced the numbers of patients waiting >65 weeks to be seen or treated. This number is down from 328 patients waiting over 65 weeks in March 2024 to 10 in March 2025.

These 10 patients remain on the list due to waits for corneal graft material or due to capacity, often related to complexities of individual patient's planned treatment. We plan to eliminate waits over 65 weeks in quarter one of 2025/26.

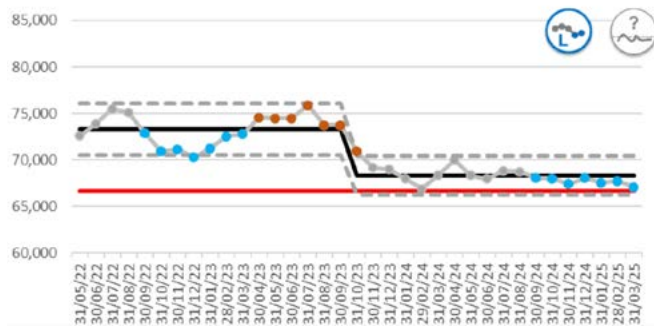
As a result of reducing the total waiting list and focusing on reducing long waits, a small reduction in the proportion of patients seen within the national RTT target of 18 weeks has been reported. We aim to deliver a significant improvement to RTT times in 2025/26.

Planned total elective activity targets were exceeded, achieving 112.1% (against a 2019/20 baseline), 3.1% above the Trust's operational plan target of 109% enabling more patients to be seen and treated.

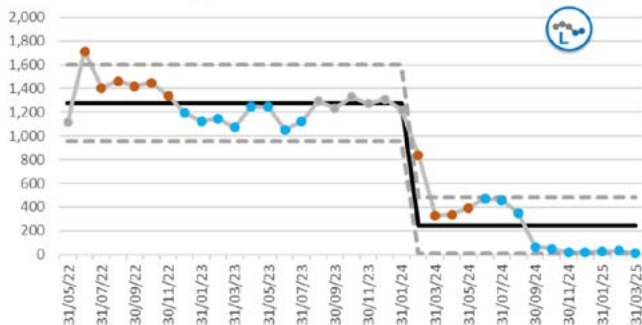
UHD RTT : Total open pathways (PTL)



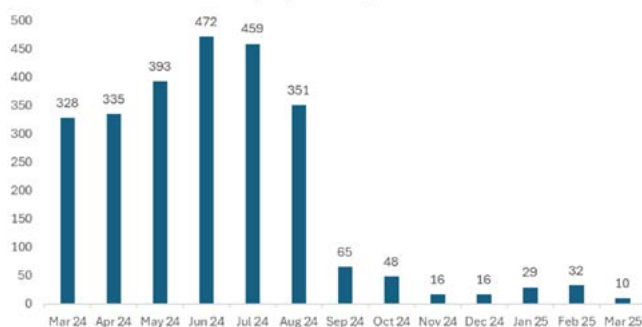
UHD - Total Waiting List Size



UHD - Patients waiting >65 weeks



UHD RTT : open pathways over 65 weeks



The Trust has delivered a number of improvement actions across the RTT pathway to improve patients' access. Some examples include:

Increasing the provision of High Volume Low Complexity (HVLC) outpatient clinics and routine theatre sessions

In 2024/25 we extended the use of HVLC routine sessions in areas such as cataracts and hernia repairs. These allow us to pool capacity and resources, improve theatre utilisation rates and help free up beds by increasing day case rates. Examples of advances in day case rates include children and young person's tonsillectomy (moving to 75% from 65%), mastectomies, and laparoscopic hysterectomies.

Reducing unwarranted variation in

clinical standards and outcomes through the adoption of best practice outlined in the Getting It Right First Time (GIRFT) programme. Through this programme an improvement in the length of stay for hip and knee replacements has been achieved.

Delivering outpatient transformation with initiatives to reduce missed appointments, including allowing more patients the opportunity to cancel their appointment digitally if they are no longer able to attend rather than calling the department, freeing up appointments for other patients. We have increased the rate of discharges to a Patient Initiated Follow Up (PIFU) pathway, enabling patients to take control over when and if they need a follow up appointment after their initial outpatient pathway ends.

Diagnostics

The Dorset CDC Programme has been responsible for rolling out additional diagnostic services across Dorset in line with the 2020 Richards' Review and Dorset's Strategy for Delivery. The national planning guidance requires trusts to maximise the roll out of community diagnostic capacity with new and expanding community diagnostic centres (CDCs).

Trusts were also asked to increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24. During 2024/25, trusts were mandated to increase this percentage again, by ensuring that further appointments were made possible across a range of tests.

Over the last 12 months the Trust made continued progress in the following areas as part of the CDC Programme: additional ultrasound, Dexa scanning, ophthalmology and phlebotomy services which all continued at the Outpatient Assessment Centre, Poole.

In October 2024, a new CT scanner and ultrasound unit became operational at Dorset Health Village, Health Science University in Boscombe, and works continue to build

a new Endoscopy facility on the Poole Hospital site, due to open in 2025/26. We have also further increased colposcopy services, delivered additional endoscopy and increased CT and MRI capacity in Poole Hospital.

Overall on the three UHD run CDC sites a total of 81,640 tests were completed in 2024/25.

We have delivered more diagnostic activity than in previous years; 10,000 additional slots compared to the same period in 2023/24, and 19,000 more slots than the pre-Covid-19 period. This additional activity has ensured our performance has moved from 10.7% to 7.5% for patients waiting longer than six-weeks for their diagnostic test and the Trust has remained one of the **top performing trusts in the south west** in this respect. This position has been delivered alongside keeping up with increased demand for diagnostic tests across 2024/25, 4% more referrals in the year were received compared to 2023/24.

Cancer

We understand how worrying it can be for people and their families when they are referred with a suspected cancer. Our teams have worked extremely hard to reduce the time between referral and the patient being told whether or not they have a cancer diagnosis. The Faster Diagnosis Standard states '75% of patients with suspected cancer who are referred for urgent cancer checks from a GP, screening programme or other route should be diagnosed or have cancer ruled out within 28 days', and the Trust **consistently achieved the standard** from October 2024. Further improvements throughout the year culminated in performance exceeding the improvement target of 77% by March 2025; performance improved to 79.8%.

The Trust performed well against the 31-day from decision to treat to treatment standard. This standard means patients who have

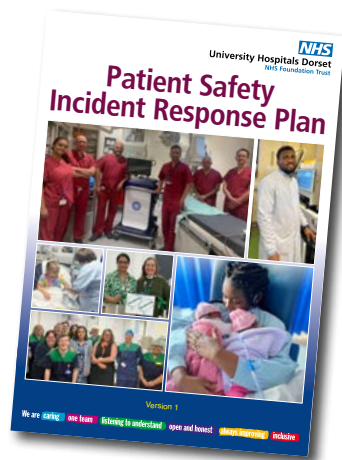
a cancer diagnosis and who have had a decision made on their first or subsequent treatment should then start that treatment within 31 days. The target is 96%, which was achieved in March 2025 at 96.1%. We are also starting to see an improvement in the time between receiving an urgent suspected cancer referral and the time a patient starts their first treatment. Against the national target of 85%; known as the 62-day standard, the Trust achieved its best performance in March 2025 at 72%. While the national standard was not met this represents a notable improvement of 3.1% compared to March 2024.

We have made important progress during 2024/25, including the following initiatives:

- Development of a cancer information hub, funded by third sector, scheduled to be installed in June 2025. This will support all patients with cancer who may attend the Royal Bournemouth for treatment or follow up. It will also provide families, carers and staff a means of accessing information.
- Established pre-habilitation and rehabilitation cancer pilots; the benefits of these pilots are to improve patient experience, to optimise health while on or before treatment, and to reduce length of stay post-operatively.
- In gynaecology the unscheduled bleeding on hormone replacement therapy pathway has been evaluated. It delivered an 18% reduction in post menopausal bleeding referral rates in 2024/25, contributing to service recovery, and provided a new pathway to better meet the need of patients in line with national British Menopause Society guidelines.
- A comprehensive pathway review and analysis of colorectal pathways was undertaken with a variety of actions taken forward, including a trial of same day outpatient appointment and triage.

Quality performance

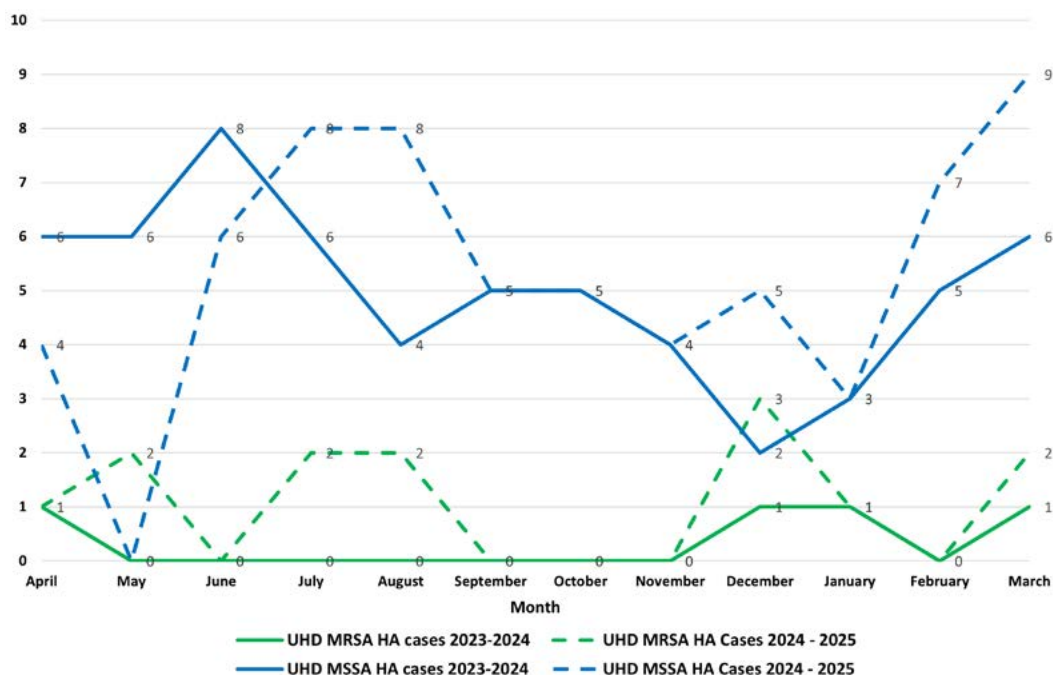
The Trust developed its Patient Safety Incident Response Plan, aligned to the Patient Safety Incident Response Framework (PSIRF), a fundamental cultural safety change **focusing on learning and improving** local priorities for patient safety. Our focus has included looking at improving patient safety by reducing in-hospital falls, pressure ulcers and venous thromboembolism. As part of work as a pilot site for implementing 'Martha's Rule', we have also looked at supporting the care and management of the deteriorating patient and listening to patients and their families in this process. We also set and achieved some important safety and quality priorities for maternity care.



There is a zero tolerance for MRSA bacteraemia. There are no thresholds set for MSSA by NHS England. All cases are reviewed by the Infection Prevention and Control Team (IPCT) and a post-infection review completed in conjunction with the ward and team where the bacteraemia was identified.

There has been an increase in number of MRSA cases reported in 2024/25 compared to 2023/24. All cases undergo a post-infection review process and any learning identified is discussed and shared. It has not been possible to identify the source of bacteraemia in seven of the 13 cases. Learning relating to assessing skin on admission and referring to services such as Tissue Viability and /or Dermatology in a timely manner has been identified and discussed at ward level.

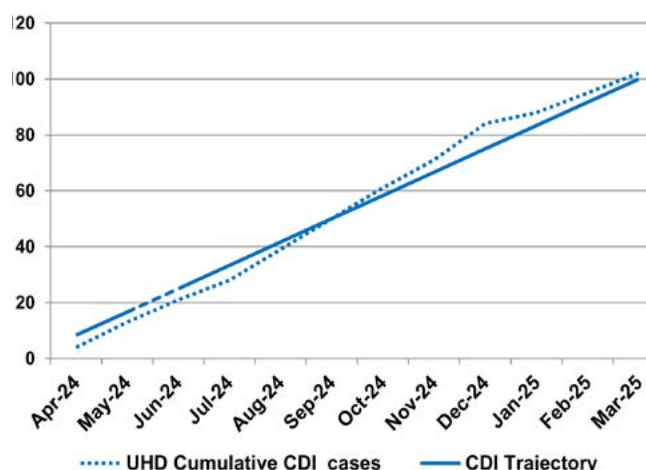
MRSA and MSSA Cases by Year



The NHS England threshold set for the Trust was 100 cases of C.difficile in the year 2024/25.

This data is Community Onset Healthcare Associated (COHA) and Hospital Onset Healthcare Associated cases (HOHA).

The Trust reported a total of 102 cases in the 2024/25 year. The graph (right) details cases identified over the 12-month period.



Key Performance Indicator	Target	2023/24	2024/25
Patient falls (per 1,000 bed days)	-	6.623	6.6289
Patient falls with harm (per 1,000 bed days)	-	0.129	0.206
Pressure ulcers (Category 3)	-	123	76
Pressure ulcers (Category 4)	-	3	3
Reported C-difficile	63 (2023/24) 100(2024/25)	104	102
MRSA bacteraemia cases (Hospital onset)	0		13

A PSIRF PSII Thematic review of hospital acquired pressure ulcers was undertaken between November 2024 and January 2025. The final report was agreed at the Trust PSIRF Oversight meeting in March 2025. A quality improvement project plan has been developed to action the report recommendations and a new 'Skin Integrity Group' has been formed to manage the actions. Oversight of this group will be via the Fundamentals of Care Group which in turn will report into the Clinical Governance Group and Quality Committee.



Improvements made over the year

- Implementation of a new pressure ulcer risk assessment tool - Purpose T - to simplify the assessment and care planning process.
- Education and training sessions for the ward teams.
- Implementation of a new total bed management contract that will enable patients to be cared for on a bed, mattress and chair cushion that suits their individual need.
- Local initiatives: including safety briefings, senior nurse weekly rounds and use of quality boards.
- Pan Dorset alignment for wound and skin care products.
- Weekly rapid review process for reported patient safety events involving pressure damage. The new process supports early decision making, improvement and shared learning.

A Patient Safety Incident Response Plan (PSIRF) Patient Safety Incident Investigation (PSII) Thematic Review of Falls across UHD has been undertaken. The commissioned report is likely to be completed in June 2025. The recommendations from the report will form the basis of the 'Fundamentals of Care - Safer Activity Improvement Plan for 2025/26'. The actions will be managed through the Fundamentals of Care Group with oversight by the Clinical Governance Group and Quality Committee.

Developing a culture where people feel safe to talk is central to all our safety work. We have made a commitment to work in partnership with our patients and colleagues and hope to build on these strong foundations to further develop and embed safety systems and learning. By doing this, we aim to reduce patient safety incidents and patient harm, and to support staff to report concerns. We are all part of the safety conversation.

Further quality and safety data is available in our Quality Account.

People			
			Trust score
Leadership and capability	Leadership	Aggregate score for NHS Staff Survey questions that measure perception of leadership culture	People Culture Sub Theme: <i>Compassionate Leadership 7.10</i> (More positive score compared to organisational comparator average score 6.98)
Leadership and capability	Leadership	CQC well-led rating	Awaiting well-led rating. No current score.
People	Looking after our people	Staff Survey engagement theme score	The 2024 Staff Engagement score is 6.90. While slightly lower than 2023 (6.95), it is better than the average result for our comparator group (6.84).
	Looking after our people	Staff Survey bullying and harassment score	*From patient and service user: 22.80% (More positive score than comparator organisation 24.68%) *From managers: 7.71% (More positive score than comparator organisation 10.00%) *From colleagues: 16.45% (More positive score than comparator organisation 18.49%)
	Looking after our people	Leaver rate	Rolling 12-month rate was 10.7%
	Looking after our people	Sickness absence rate	Rolling 12- month rate was 4.76%

Financial performance

This section summarises the Trust's financial results for the 2024/25 financial year. This provides a 12 month reflection of the Trust financial performance from 1 April 2024 to 31 March 2025.



Control Total

The Trust is regulated as part of a System Control Total agreed with NHS England. The Trust agreed a break-even Control Total position for the 2024/25 financial year. At 31 March 2025 the Trust **delivered a surplus of £93,000** against the break-even position.

2024/25 Control Total	2024/25 £'000
Deficit for the year	(81,978)
Add back impairment	81,517
Add donated capital/fixed asset disposal adjustment	440
Control total surplus/(deficit)	(21)
Add BHT surplus	114
Control total surplus	93
Agreed control total surplus	-
Performance against control total	93

Income

Trust income during the 12 months to 31 March 2025 was £906m. Of this, £842m related to income for patient care activities with £659m received from Integrated Care Boards. Dorset Integrated Care Board income received in 2024/25 was £611m representing 67% of total Trust income. Other Trust operating income was £64m for the period.

Operating income	12 months to 31 March 2025 £'000
Foundation Trusts and NHS Trusts	6,327
Integrated Care Board	659,172
NHS England	170,401
Non-NHS patient income	6,799
Total Income from patient related activities	842,699
Other operating income	63,565
Operating income from continuing operations	906,264

Expenditure

Operating expenses on continuing operations during 12 months to 31 March 2025 equated £982m. Of this, employee costs were £609m, representing 62% of total expenditure.

Cash

As at 31 March 2025 the Trust was holding a cash balance of £99m, which has been strategically generated over many years to support the reconfiguration programme.

Capital

The Trust set a very challenging capital programme for the year. This has required very careful management, and as at 31 March 2025 full year capital expenditure amounted to £157m against a plan of £157m. The Acute Reconfiguration Programme and associated works accounted for £115m of the 2024/25 capital programme spend.

Efficiency Improvement Plans

Regulators require all foundation trusts to identify and deliver annual efficiency savings as part of the annual planning process.

Efficiency savings of £42m were achieved for the financial year ending 31 March 2025.

Overseas operations

The Trust does not have any overseas operations.

Dorset System Financial Overview

Dorset NHS Integrated Care System (ICS) was issued a fixed financial envelope with a requirement to effectively plan and deliver services within this allocation for the population of Dorset. The NHS Dorset ICS comprises:

- NHS Dorset ICB
- Dorset County Hospital NHS Foundation Trust
- Dorset Healthcare NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- GPs

The Dorset ICB received an initial allocation of £1.9bn for 2024/25 and Dorset NHS partners were required to collectively plan within this envelope. NHS bodies in the Dorset ICS planned a break-even financial performance across the year, however revised this as part of the mid-year plan refresh to a forecast deficit of £25m. This reflected ongoing operational pressures experienced, as well as under delivery of planned recurrent savings within the system. The Dorset ICS ended the year with an aggregate deficit of £12m. In addition, NHS Dorset ICS partners have successfully planned and delivered capital investment projects totalling £240.6m, in line with allocations from NHS England.

This capital expenditure is aligned with the Dorset-wide infrastructure plan, and the wider system strategy. This includes the delivery of the Clinical Services Review (CSR) to create the planned and emergency hospitals at Poole and the Royal Bournemouth hospitals. This unlocks many benefits for patients and staff, including new facilities.

For 2024/25, key highlights include:

- fully opening of the One Dorset Pathology Hub
- handover and initial use of the BEACH Building for Radiology
- opening of the new main entrance at Royal Bournemouth Hospital
- completion of the link road for the Royal Bournemouth Hospital
- works started on the Endoscopy Hub at Poole
- new scanner opened in Boscombe, as part of community diagnostics
- energy efficiency projects for lighting and solar energy
- estates backlog reduction, improving the physical environment and resilience
- significant numbers of other enabling projects across the Trust



The Our Dorset Provider Collaborative (ODPC)

It was mandated (but not set in statute) when ICBs were formed in 2022 that all NHS Provider organisations should be part of at least one collaborative. The Our Dorset Provider Collaborative was first established in August 2022 and is formed of UHD, Dorset HealthCare University Foundation Trust, Dorset County Hospital NHS Foundation Trust and the General Practice Alliance (whose membership includes all GP practices in Dorset).

There are monthly executive led Board meetings of the ODPC. The role of the Chair has been held by the UHD CEO, Siobhan Harrington, during 2024/25 and will continue to be for 2025/26. The Board currently has no delegated decision-making authority from any of the Trust Boards or the ICB.

The ODPC Board reports for information to the System Executive Group and reports progress to each of the Boards of the member organisations. The terms of reference are due for review in June 2025. It is not expected that there will be radical change, rather that some of the terms of reference are strengthened – such as the establishment of the Chairs and NEDs Oversight Group.

During 2024/25, the ODPC has overseen a number of programmes of work agreed and aligned to the national ask of provider collaboratives:



Reductions in unwarranted variation in outcomes for our patients



Reductions in health inequalities, greater resilience across systems



Better recruitment, retention and development of staff



Consolidation of low-volume or specialised services



Efficiencies and economies of scale

Achieved programmes of work for 2024/25

- Significant reduction in the reliance on bank and agency nursing staff across Dorset, reducing the cost of services and improving recruitment to substantive posts through the nursing bank workforce programme.
- Improvements in collaborative working and alignment of clinical policies and pathways in several services meeting across Dorset as a network (for example urology and orthopaedics).
- Move to providing two services county-wide due to fragility in the service model, which means Rheumatology and Orthodontics are now provided by a single leadership and clinical team across Dorset.
- Implementation and oversight of One Dorset Pathology services and the Clinical Diagnostic Centre programmes, giving patients faster access to diagnostic tests closer to home.
- Consideration of an approach to shared services which for 2025/26 has led to a business case proposal for single shared services in Dorset for Estates, Facilities and Procurement services (not yet approved). This will enable more of NHS funds to be spent on estates and facilities locally, supports retaining our staff, and reduces variation in clinical equipment making it easier for clinical teams to work across the county.



Our risk profile










Our Risk Management Strategy sets out the framework we use to identify, assess and manage risk. This includes operational and strategic risks where there is uncertainty about the delivery of key performance indicators and priorities.

The Trust's Risk Management Strategy, our approach to risk identification, assessment and control and the management and investigation of adverse events, is aligned with the Trust values and a culture of openness, accountability and transparency.

The Trust identifies, prioritises and manages all aspects of risk through its integrated governance framework. Risks to delivery of the Trust's strategic objectives are documented in the Board Assurance Framework, which is aligned through the UHD 'Patient First' methodology and has helped achieve greater alignment of our strategic themes, breakthrough objectives and enabling programmes.

Through the Board Assurance Framework, we identified 10 major in-year risks which impact upon the achievement of our strategic priorities. These are detailed overleaf.



BAF risk title	Risk scores				Population and System	Our People	Patient Experience	Quality Outcomes and Safety	Sustainable Services	Target risk score
	Jun-24	Sep-24	Dec-24	Mar-25						
BAF Risk 1 Risk of not achieving 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance	12	12	9	1						3
BAF Risk 2 Risk of not meeting the patient national constitutional standards for emergency care	12	12	16	16						6
BAF Risk 3 Risk of not significantly improving staff experience and retention over the next three years (and not being in the NHS Staff Survey results top 20% of comparator trusts)	12	12	8	8						8
BAF Risk 4 Risk that the Trust does not have adequate systems and processes in place to promote, gather, triangulate and utilise patient feedback consistently across UHD - it is therefore recognised that this may result in missed opportunities for learning and improvement in patient experience	6	6	6	6						6
BAF Risk 5 Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next three years	8	8	8	6						6
BAF Risk 6 If insufficient resources are in place for the implementation and continuation of PSIRF then there is a risk the Trust will not learn from patient safety events and will not reduce patient safety harm events	9	9	9	6						Achieved and closed at year end
BAF Risk 7 Risk of not returning to recurrent financial surplus from 2026/27	16	16	16	16						8
BAF Risk 8 Risk of not successfully and sustainably adopting the Patient First approach across UHD	12	12	8	8	Cross cutting to support the five strategic objectives.					6
BAF Risk 9 Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals	16	16	16	16						12
BAF Risk 10 Risk that Trust's electronic patient record (EPR) not fit for purpose for UHD	25	25	20	20						6

Note: BAF Risk 5: At the year end, it was noted that this BAF risk would be closed. Metrics would be fully embedded into the strategy deployment review process in 2025/26.

Of these, the following four areas are our top four risks, which are summarised from our Board Assurance Framework:

Meeting the National Constitutional Standards for Emergency Care

How we manage the risk

- Strategic breakthrough objective within Patient First Improvement Programme
- Timed admissions process evoked
- ED escalation plans/ SoPs
- Surge management criteria and plan
- 4 and 12 hour escalation process and ambulance divert policy

How we assess the outcome of actions

- Daily performance reporting against metrics to execs
- Daily operational meetings to support UEC flow and challenges seven days a week
- 4 hour performance metrics linked to ED escalation

Returning to financial surplus from 2026/27

How we manage the risk

- Budgets developed with directorate teams, accepted at Care Group level, devolved to named budget holders
- Dedicated financial support in place
- Scheme of delegation, Standing Financial Instructions, Financial Management Accountability Framework
- Enhanced vacancy and non-pay controls implemented to support financial recovery

How we assess the outcome of actions

- Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions
- Patient First 'driver' and 'watch' metrics agreed and monitored monthly

Integrating teams and services and then reconfiguring to create the planned and emergency hospitals

How we manage the risk

- Specialty level plans in place
- Service Reviews to assess readiness for moves with actions followed up by Care Groups
- Meeting structure, attendance, escalation and resolution from specialty steering groups into Care Group and then Service Ready Group
- Robust critical path timeline clearly articulating deliverables and interdependencies between specific deliverables
- Effective management of individual programmes

How we assess the outcome of actions

- Internal audit
- INHP scrutiny/ governance
- External gateway process
- Result of service review findings and progress on critical path actions
- Go/No Go checklist and criteria

Electronic Patient Record being fit for purpose for our Trust

How we manage the risk

- Strategic breakthrough objective within Patient First Improvement Programme
- Timed admissions process evoked
- ED escalation plans/SoPs
- Surge management criteria and plan
- 4 and 12 hour escalation process and ambulance divert policy

How we assess the outcome of actions

- Daily performance reporting against metrics to execs
- Daily operational meetings to support UEC flow and challenges seven days a week
- 4 hour performance metrics linked to ED escalation

The most significant risks in 2024/25 facing the Trust (in-year and immediate future) are the demand, capacity and operational flow constraints in the wider health and social care system and national and local staff shortages in key specialties.

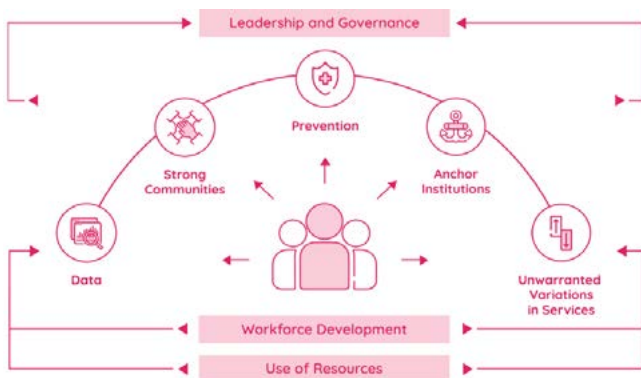


Equality of service delivery

This section provides a summary of how equality of service delivery to different groups of people has been promoted, in line with our public duties. This considers groups with protected characteristics and looks at measures of service delivery and access.

Deprivation is a major driver behind unwarranted variation and inequality. The section after this considers the wider health inequalities of the Dorset population, and actions being taken to address this. In this section we mainly consider service access.

It is important to say how our approach is based in system working, using the Dorset ICS health inequalities shared plan and governance:



In early 2024 partners across Dorset came together to review our logic model, and to identify the actions needed to deliver our shared ambitions. The five cross-cutting workstreams and three enablers were identified.

In 2024/25 we have focused our work under three major partnership workstreams:

- prevention
- data, using population health management (incorporating DiiS data)
- unwarranted variation in services

The resulting Dorset-wide Health Inequalities Framework and Plan will deliver against our Joint Forward Plan ambitions, Planning Guidance and NHS Long Term Plan priorities, and action required to deliver

against the 24 indicators, through a single co-ordinated work plan.

Delivery at system level is overseen through our system Health Inequalities Group and the ICB's Prevention, Equity and Outcomes Committee. Within UHD the Population Health and System Committee of the Board provides oversight of the work.

Reviewing the data on equality of service delivery

The following areas were reviewed as part of the Dorset ICS Health inequalities analysis. This 140+ page report provides the deep dive analysis, which is summarised here, to focus on the most pertinent points.

The main data analysis is for differences in access to healthcare services between population groups, with a focus on differences by age, deprivation, ethnicity and gender. Because need for health care services tends to increase with age, where possible the data for each population group has been adjusted to account for the influence in age (because some areas or groups might have more older people so we would expect to see higher utilisation by those areas/groups). We have also used statistical tests known as 'confidence intervals' to help identify where differences could be caused by chance for:

- elective admissions
- emergency admissions
- outpatients, including virtual outpatients
- emergency attendances

The most common theme is that deprivation has the strongest correlation with requiring emergency attendance, and then admission. Much of the variation by other factors is within the expected range (confidence intervals). There appears to be some variation by ethnic group, particularly for the Gypsy, Roma and Traveller population, with potentially higher rates of emergency admissions and virtual outpatient attendance. However, numbers are very small in this population group and more work is required

to understand the data and any action that might be required.

Looking at overall rates of **elective admission**, there is a big increase with increasing age up to 70-79. Women appear more likely to be admitted than men, but once age is considered this apparent difference is no longer there. There is some variation, but no clear pattern, in the rate of elective admission between ethnic groups. Unadjusted rates suggest that those from the most deprived areas are less likely to have an elective admission; after age is accounted for there is no clear pattern of variation for most population quintiles, other than the least deprived who appear to have a higher rate of elective admission.

Looking at overall rates of **emergency admission**, rates are moderate in 0-9 year olds, drop in 10-19 year olds and then increase with age. Those aged 80+ are more than twice as likely to be admitted as those aged 70-79. Women appear more likely to be admitted than men, but once age is considered this apparent difference is no longer there. Those of Gypsy, Irish Traveller ethnicity appear to have higher rates of emergency admission (this data needs more exploration because population numbers in this group are small). Other than this there are no clear differences based on ethnicity, even when age is accounted for. Those from the most deprived areas are more likely to have an emergency admission, and this is more marked when age is considered.

Face-to-face outpatient appointments vary by age with people aged 70 and over more likely to have a face to face attendance. Women are more likely to have a face-to-face outpatient appointment than men, even when age is taken into account. People whose ethnicity is unknown are less likely to have had a face-to-face appointment at UHD, with other groups broadly similar (this may reflect that where people have had a face to face appointment there has been more opportunity to collect information on ethnicity). People from the most and least deprived areas are the most likely to have had a face-to-face appointment, with those in median deprivation areas the least likely.

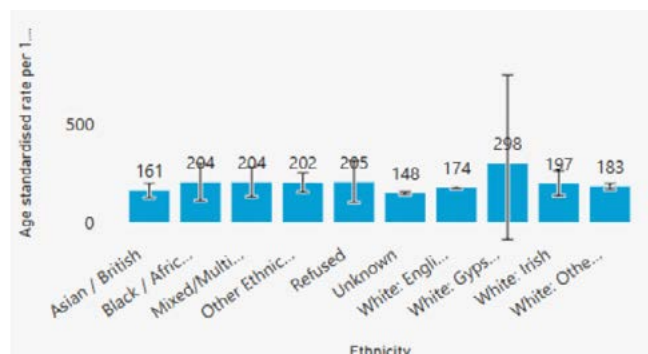
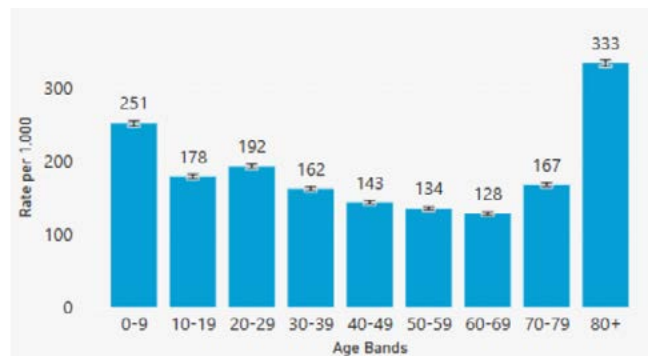
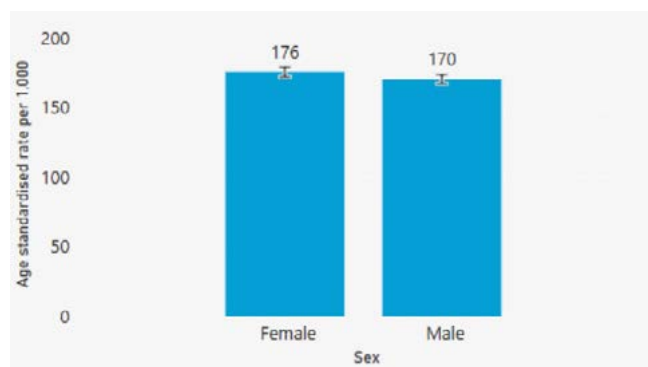
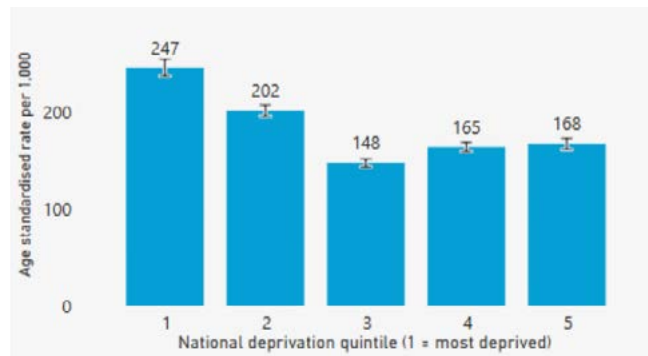
Rates for **virtual appointments** increase with age up to 70-79. Rates are higher in women than men. Those of Gypsy, Irish Traveller ethnicity appear to have notably higher rates of virtual outpatient attendance, followed by White Irish, and Black/Black British. People from White other, unknown and Asian/British Asian the lowest. Higher rates in the most deprived area can be seen once the age of the population is considered.

For **attendance at our Emergency Department**, rates are highest in the over 80s, followed by 0-9 year olds. Rates for women are the same as men, once age is considered. There is no difference between ethnic groups once age is considered. Rates are higher for this living in more deprived areas, and this is more marked once age is considered.



The following charts provide more detail on emergency admission variation. This highlights how more deprived areas, and those over 80, are more likely to have an emergency admission. When these two factors are combined this becomes a significant area requiring attention.

Age standardised and crude rates of emergency attendances per 1,000 population for UHD



Actions taken on improving service equity

In 2024/25, there has been good progress in several areas, for example:

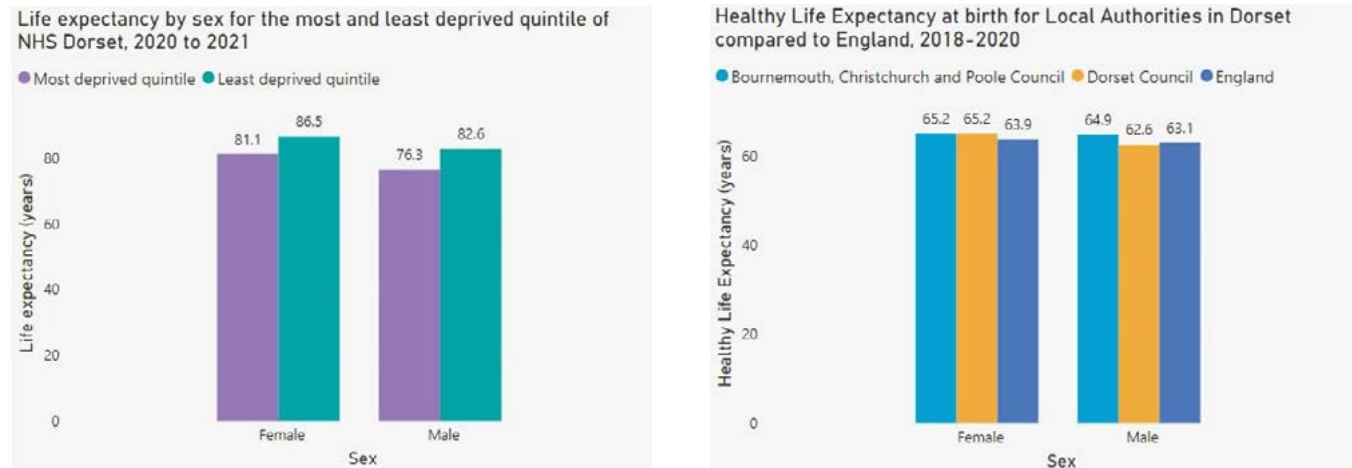
- ✓ reducing the elective wait times for children and young people
- ✓ supporting workforce development, including awareness raising across staff groups
- ✓ providing access to population health and health inequalities training or coaching
- ✓ participating in the Equality Delivery System (EDS) annual assessment which helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010
- ✓ continuing to deliver interventions to reduce health inequalities through our elective programmes, with a particular focus on reducing 'did not attends' or missed outpatients, which includes analysis by characteristics
- ✓ progressing our urgent and emergency access, by a focus on high intensity users of emergency care, and developing our wider programme, called 'Future Care' with a focus on admission avoidance, and reducing delayed transfers of care. This help all patients by especially the older cohort who, as the data shows, are more likely to be admitted.

Other initiatives and progress are also covered in the next section, on health inequalities.

Health inequalities national indicators

The outcome of health inequalities is that some people die much earlier than others from preventable or treatable conditions and live more of their lives in poor health.

Dorset ICB is a relatively healthy area compared with some parts of the country. However, in common with most health systems, the conditions in which people work, grow and live are different across the county, and for some groups compared with others.

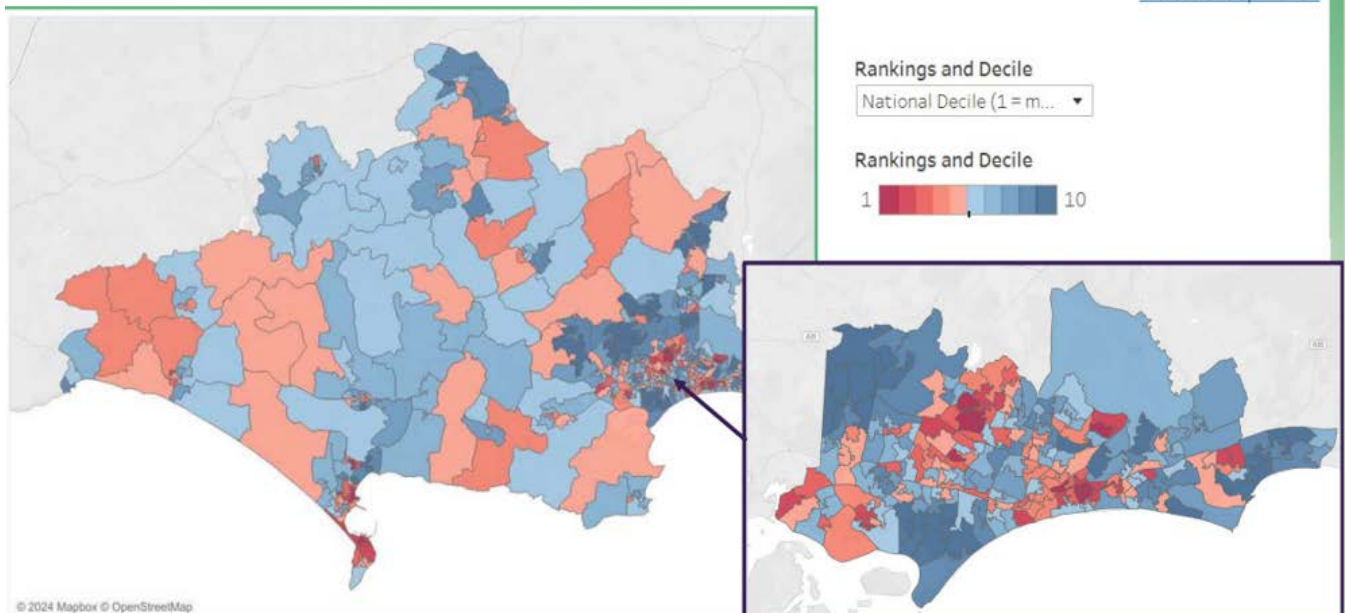


Looking at deprivation in Dorset, by geography, there are marked contrasts.

Thriving Communities - Deprivation

Whilst Dorset is generally an affluent there are areas falling within the 10% most deprived nationally across the area. **Deprivation is strongly linked with many health outcomes.**

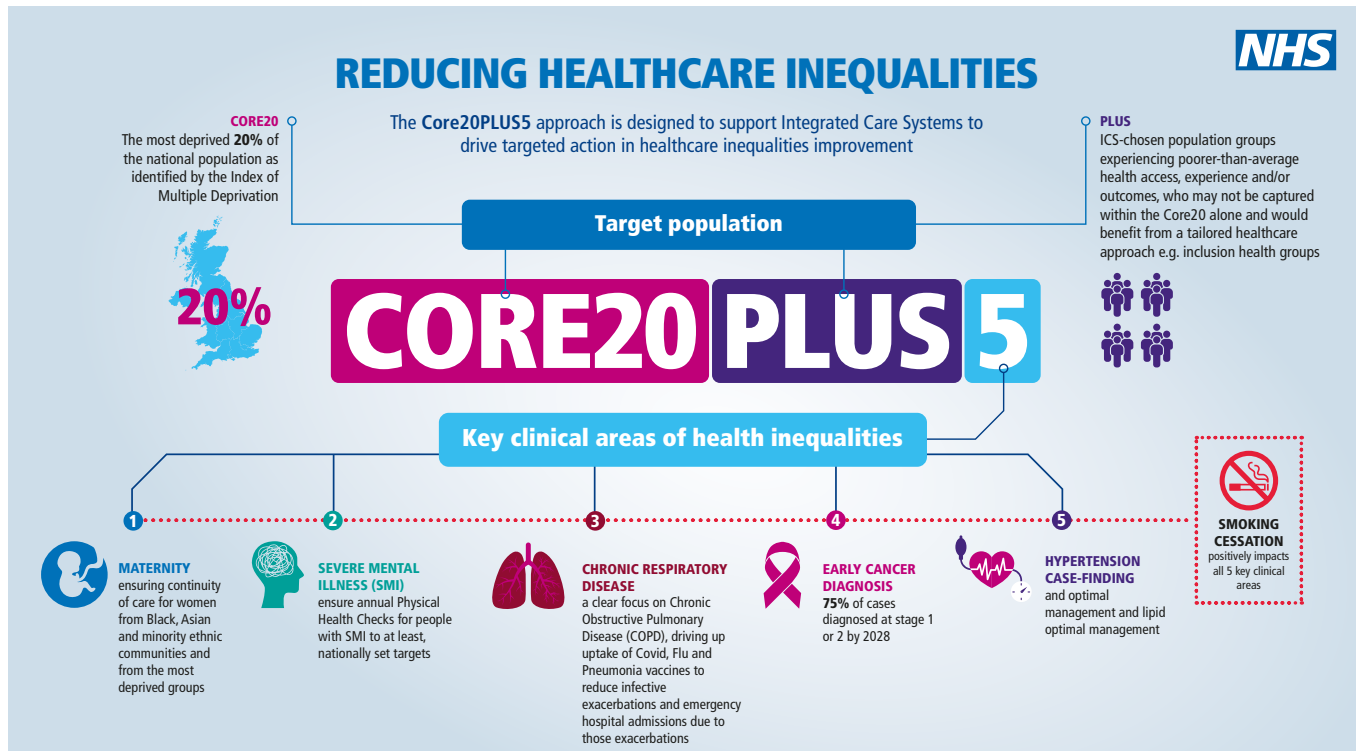
[Indices of deprivation](#)



The most deprived populations are concentrated in Primary Care Networks (PCNs) in the coastal and urban areas of Dorset ICB. A higher proportion of people living in the most deprived areas are from community minorities (compared with other areas of Dorset).

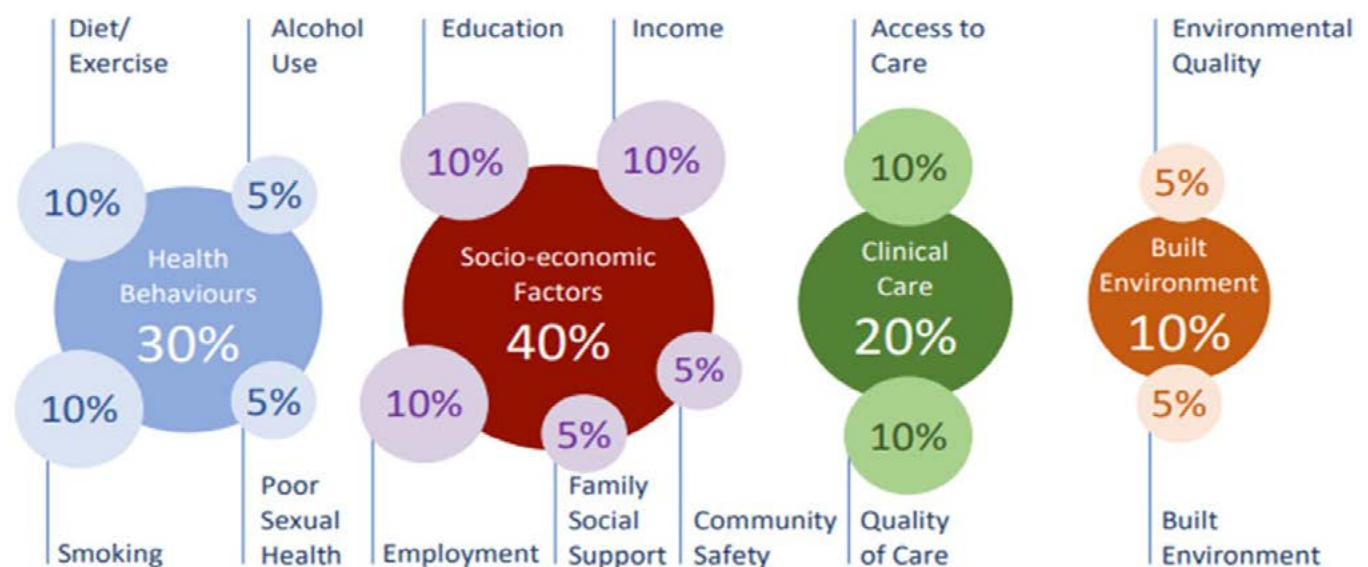
Around 9% of the Dorset population fall into the 20% most deprived areas in the country - the national 'Core20' population.

The 'Plus 5' factors are: maternity, mental illness, respiratory, cancer and hypertension.



The 'Plus 5' are part of the national and local focus on conditions where there are strong, evidence-based interventions by health systems in reducing inequality and improving outcomes. The Dorset system Annual Report explores these in detail. This UHD Annual Report will highlight areas of pertinence to the work of the Trust.

In considering these interventions, it is worth noting that clinical care represents just one fifth (20%) of the estimated impacts on population health. This is why Dorset's ambition to be the healthiest place to live in the UK requires a whole community approach.



Ensuring access to good quality healthcare is an important aspect of addressing health inequalities. However, the NHS on its own cannot tackle all the causes of health inequalities.

Considering the overlay of deprivation and old age (especially 80+), has a particularly strong relationship with requiring more emergency care, the following analysis by DiiS has been used to inform targeted work around fuel poverty and social support in Dorset.

There are higher concentrations of financially vulnerable pensioners in urban areas in the east of Dorset.

However, there are clusters of vulnerable populations across the ICB footprint, with similar numbers of financially vulnerable people in the BCP Council area and the Dorset Council area.

The Trust has exercised its functions consistent with NHS England's statement under section 135A(1) of the National Health Service Act 2006.



Sustainability

The revised edition of our UHD Green Plan sets out the Trust's over-arching sustainability objectives, including to have a net zero core carbon footprint by 2040. This year we have made good progress on this multi-year plan.

Our UHD Green Plan sets out a broad and deep scope of work with a clear governance structure that ensures the whole organisation is embedding sustainability into day-to-day practices, decision making and strategies.



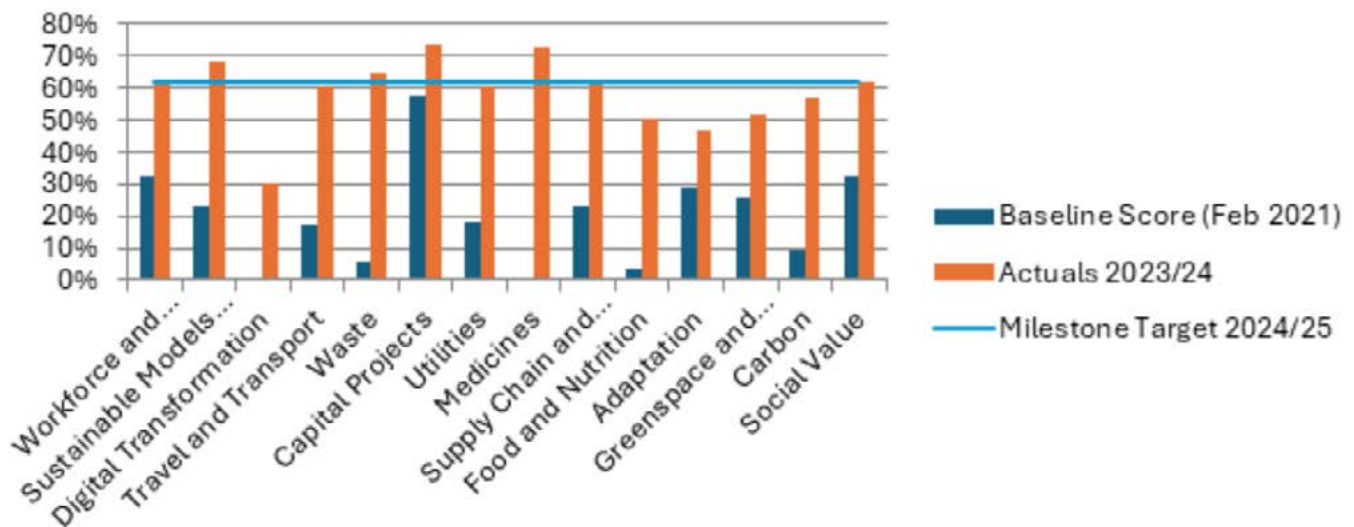
UHD Green Plan

The table below sets out our progress against the UHD Green Plan Cornerstone targets:

Cornerstone Area	Target	Outcome	Comment
Carbon	1000 tonnes core emissions reduction	TBC	Final data pending for year-end however draft data suggests approx. 500 tCO ₂ e total reduction over previous year. This is set against continued site expansion. UHD carbon reduction measures have made a positive contribution as has UK grid decarbonisation and a mild winter leading to lower heating demand. Refrigerant gas emissions were unusually high (497 tCO ₂ e) and being investigated.
Our People	All executives and senior leaders have actions from Green Plan within their annual objectives	Achieved	Executives and senior leaders are appraised on their delivery of the Trust annual objectives.
Our People	All sustainability leaders and QI staff to have Sustainable QI Training	On Hold	Patient First quality improvement model being rolled out to Trust. Sus QI principles to be incorporated when initial phase is complete.
Air Quality	Achieve Rating of Excellent on Clean Air Hospital Framework by 2026	Alert	Progress hampered by capacity constraints, new Travel Manager now recruited and will prioritise however target date will require review.
SDAT	62% score for each area of activity	Mixed 7 of 14	UHD has now achieved 62% for 7 out of 14 activity areas and averages 59%.
Use of resources	Zero waste to landfill by 2021	Achieved	Achieved
Use of resources	Grid sourced power 100% renewable	N/A*	NHS Standard Contract now requires Trust to utilise the CCS NHS - E Central Energy Purchasing Agreement which is not backed by REGOs.
Use of resources	Reduce single use plastic, adopt the plastic pledge	Embedding	Most plastics removed from catering services. The consumption of single use plastics in clinical services is an ongoing process featuring many small initiatives, further embedding will now take place through patient first and improvements projects.
Use of resources	Sustainability Impact Assessment for all business cases over 250k	Work in progress	Sustainable Impact Assessment tool has been created and shared with various departments. Adoption ongoing.

Much progress has been made against targets, with more work to be done to achieve them all.

The Sustainable Development Tool (SDAT) is an important management tool for UHD's Green Plan and tracks progress against over 450 sustainability criteria. The chart below illustrates the significant progress which has been achieved since our baseline exercise in 2021.



The Trust had an achievement target of 62% for 2024-25 and achieved or exceeded this for seven of 14 activity areas, resulting in an average of 59%. This has been against a backdrop of considerable workload for departments as the organisation continues to go through major transformation.

The Trust updated the UHD Green Plan and plans to review again during 2025 to create a One Dorset Green Plan, reflecting closer working arrangements with other Dorset NHS trusts and the desire to further standardise ways of working and maximise opportunities.

Net zero progress

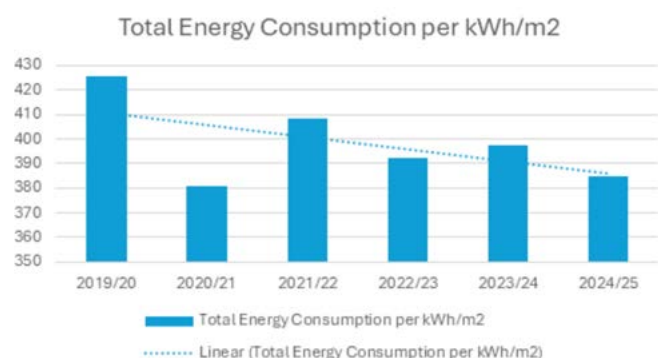
NHS England now reports carbon emissions for the entire NHS via the NHS Annual Report and Accounts. UHD also publishes carbon emission data on the Trust's website - www.uhd.nhs.uk - using a methodology aligned to the national approach, including a 2019/20 baseline.

UHD developed a Trust-wide decarbonisation strategy which was published in 2023. The report describes options for estates decarbonisation which are subject to further analysis and feasibility studies. The Trust has been progressing these, as detailed here.

Energy:

UHD is mid-way through a number of major changes to our estate which have a material effect on energy consumption. This reporting year provides the first full year of use of our new theatre block in Poole Hospital and the Trust's **first net zero building** - the One Dorset Pathology Hub, as well as occupation of our new BEACH Building. During the construction phase these required additional energy. As a result of these projects, we have recognised 2500m² growth in our estate footprint over 2024/25.

Measures taken to ensure all our new buildings are constructed to high efficiency standards, together with other energy efficiency projects during the year, resulted in reduced Trust carbon emissions by floor area.



NHS trusts benchmark energy consumption and UHD is performing well against our peers.

In-year energy projects:

- £1.3m was invested in Solar PV arrays for Poole Hospital and the Royal Bournemouth Hospital. These projects will save approximately £170k in energy and 200 tonnes of CO₂e each year.
- A further £1.7m was invested in the final phase of LED lighting upgrades for our main sites which will save approximately £340k in energy and 260 tonnes of CO₂e each year.
- The Trust has continued to progress with a large building management system upgrade project, investing £450k this financial year. The project, when complete, is projected to save 3-5% of our total energy consumption.

Waste:

The Trust has continued its programme to minimise waste and handle the waste we generate in the most responsible way.

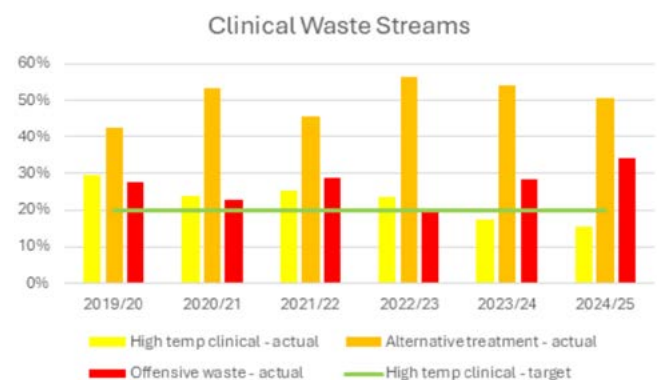
We saw the acquisition and implementation of several new waste compactors which provide a more efficient way of processing and transporting our waste.

The Trust now **segregates all food waste** and carefully monitors plate waste from each ward. Plate waste is an important indicator of patient satisfaction, portion sizing and patient nutrition. We trial changes and use plate waste data, among other factors, to gauge success.

Due to the biohazards associated with certain clinical waste, high temperature treatment processing is required to render this safe. This processing comes with higher levels of carbon emissions compared to other less-hazardous waste streams. Responsible carbon management requires the Trust to take steps to ensure only the waste that requires high temperature treatment enters this waste stream.

The chart below shows the progress in **reducing the proportion of clinical waste** (shown in yellow) entering the high temperature waste stream. NHS England

has set a national target of 20% which has been met and exceeded by the Trust. The offensive waste stream (shown in red) is associated with the lowest carbon emissions. We are aiming to **meet or exceed the national target of 60%**. The Covid pandemic led to a higher proportion of our waste needing higher temperature treatment but we have managed to re-establish our previous waste segregation norms and extend the rollout of offensive waste streams across our sites. Year on year improvements can be seen in the graph and we expect 2025/26 to take us further toward the 60% target.



Travel:

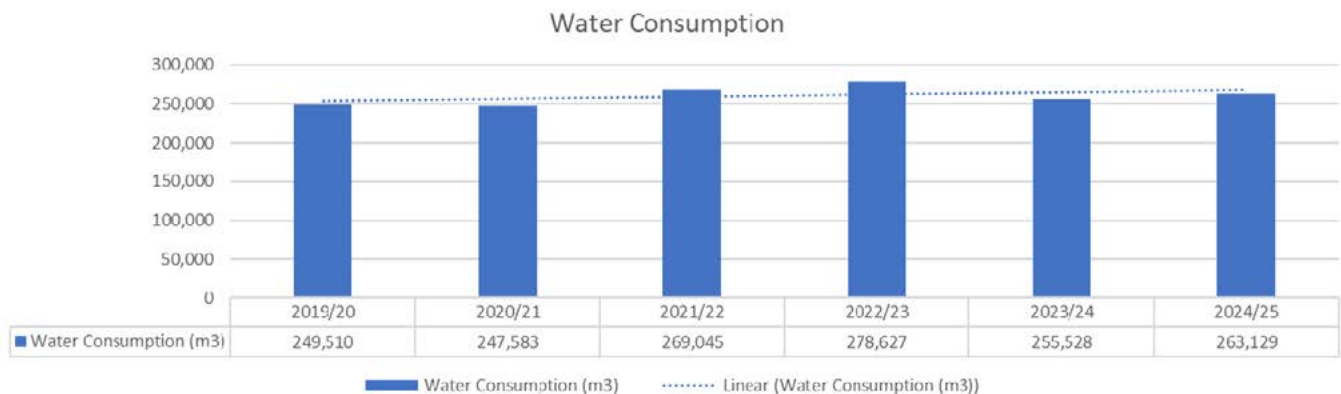
The Trust is working hard to encourage sustainable travel, continuing to provide all staff access to a cycle to work scheme, free staff bicycle maintenance, modern secure bike storage, showering and changing facilities, discounted bus tickets and personalised travel plans. We also only support the purchase and lease of zero or ultra-low emissions vehicles (under 3.5 tonnes). The Trust participates in Dorset NHS Liftshare - a platform to assist staff to find matches for shared car commutes thereby reducing costs, emissions, and congestion.

At the end of March 2025, the Trust **launched a dedicated inter-site bus** to provide staff with fast, free transport between the Poole and Royal Bournemouth hospital sites.



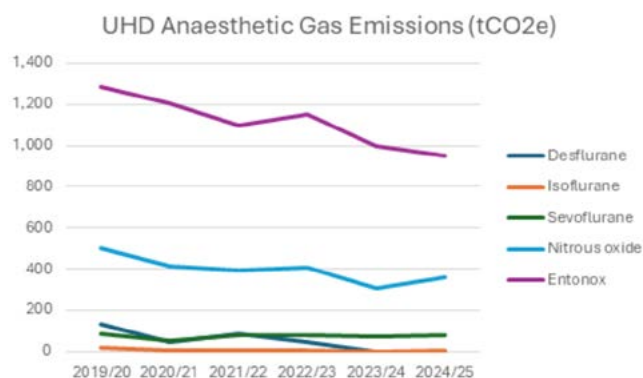
Water:

Our estate expansion and growth in clinical activity drives higher water demand. To mitigate this additional demand, we monitor for leaks, take remedial action quickly and our sustainable procurement policy enforces the selection of water efficient equipment.



Medicines:

Medicines and chemicals account for approximate 20% of the NHS total carbon footprint. Anaesthetics in particular are a significant contributor. At UHD we have **eradicated the use of the most potent global warming anaesthetic gas, desflurane**. We also decommissioned all nitrous oxide manifolds across the Trust this year in favour of more efficient delivery systems. A summary of progress can be seen in the graph below. (Note, the in-year uptick in nitrous oxide related emissions is due to the requirement to return full / partially full cylinders to the supplier upon decommissioning the manifolds and is a onetime hit to release ongoing future reductions).



The Trust is also working hard to optimise medicines use to avoid waste and associated carbon emissions and we have supported several campaigns that have been implemented Dorset wide.

Partnership work

The Trust recognises the scale of the challenges we face require deep organisation change and partnership work. Sustainability managers for all Dorset NHS trusts meet regularly to further develop strategy and progress joint initiatives.

Dorset NHS partners have also worked together to successfully bid for a Dorset based 'nature ranger'. The nature ranger will start work in the summer of 2025 to support efforts to develop sustainable healthcare through nature projects in the region.

Partnership work also extends to regular meetings and coordination efforts with BCP Council, Dorset County Council, Bournemouth University and local MPs, focusing on decarbonisation, climate adaptation and ecological resilience.

Task force on Climate-related Financial Disclosures (TCFD)

NHS England's NHS Foundation Trust Annual Reporting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the Annual Report and Accounts and in other external publications. Some disclosure requirements have been deferred while significant service transformation takes place through 2024-2026.

Governance pillar

The UHD Green Plan progress is monitored by the Sustainability Steering Group which reports to the Finance Performance Committee (FPC) quarterly. Through 2024-25, the FPC has been chaired by the Board lead for sustainability. The FPC reports to

the Board providing an escalation path and opportunity to keep the Board appraised. In addition, 'deep dive' sessions are prepared for the Board. Recent sustainability deep dives were conducted in March 2023 (public board - Green Plan revision), March 2025 (topic - estates decarbonisation) and the next one is scheduled for June 2025 (topic - climate adaptation).

The Trust Sustainable Development Assessment Tool (SDAT) has a dedicated section for climate adaptation, tracking Trust progress against 28 actions. Each quarter, an update is provided to FPC on SDAT progress along with a descriptive summary of work undertaken and any barriers to progress.

The Trust's Head of Emergency Preparedness, Resilience and Response and the Trust's Sustainability and Carbon Manager have worked with other Dorset public sector partners to create a 'Dorset Climate Risk Assessment Tool'. This tool incorporates the impact statements from the respected 'Adapt to Survive' framework, developed by Sustainability West Midlands in collaboration with the Environment Agency. The Dorset Climate Risk Assessment Tool has been reviewed by senior Trust



officers. Completion of the assessment is a sizeable undertaking and requires significant clinical and non-clinical team input. This aspect of the project is scheduled for 2026 after the clinical team moves across our sites, and the potential shared services for Estates, Facilities and Procurement staff. Both projects are significant undertakings absorbing all spare capacity, but once complete will allow better assessment and management of climate-based risks.

Risk Management pillar

The Trust has co-developed the Dorset Climate Change Risk Assessment which captures over 100 climate related risks and identifies whether they are relevant impacts to the following departments: Clinical, Estates, Facilities, Finance and Commercial Services, IT and Telecommunications, HR, Occupational Health and Education.

For each risk the assessment tool is ready to capture the likelihood score for 2030, 2050 and 2080, and a consequence score for unmitigated risk. It will also capture mitigation measures such as emergency preparedness plans, the activity owner, and links to other risk registers.

Metrics and target pillar

As set out at the beginning of this section, the five cornerstone targets ensure a comprehensive set of SMART, multi-year metrics. Progress has been tracked for these over 2024/25. Stretching targets are set, and while not achieving all of these, there has still been significant progress on carbon reduction, use of resources and SDAT measures. The conscious decision to defer some of the people metrics reflects the significant service reconfiguration occurring during 2024-2026. The SDAT baseline year is 2020/21, the first year the Trust undertook an assessment using the tool. The Trust Carbon Targets employ a 2019/20 baseline year, in line with NHS England methodology.

For more information about the UHD Green Plan, carbon footprint and recent developments, please see:
www.uhd.nhs.uk/about-us/sustainability.



Siobhan Harrington
Chief Executive
18 June 2025



Accountability Report

In this section of our Annual Report, you will find our:

- Directors' Report
- Remuneration Report
- Staff Report
- Statement of accounting officer's responsibilities
- Governance information, including our Annual Governance Statement

Directors' Report

Key activities of the Board

The Board has a collective responsibility for:

- Ensuring high quality and effective care for all patients and service users
- Setting strategic direction, ensuring the Executive Team has appropriate capacity and capability to monitor and manage quality of care and operational delivery
- Adding value to the success of the organisation and its system
- Using prudent and effective controls to lead the organisation
- Promoting and adhering to the organisation's values
- Ensuring the organisation's obligations and duties are met.

Much of the day-to-day work is done by the executive directors, who work closely with the medical, nursing and operational leads of each of the three clinical Care Groups as well as the clinical directors, senior nurses, clinical leads and other leaders throughout the organisation.

The Board clearly sets out the financial, quality and operating objectives in the Trust's strategic objectives and quality priorities.

The Board generally meets 10 times each year. Its business cycle provides oversight of adequate systems and processes being in place to measure and monitor the Trust's performance and effectiveness, efficiency, economy and quality of healthcare delivery. Relevant metrics have been developed to assess progress and delivery of performance.

All of the non-executive directors are considered to be independent by the Board.

The balance, completeness and appropriateness of our Board is kept under review and a statement reflecting this is available on our website: [Board governance](#).



Our Board of Directors 1 April 2024 to 31 March 2025

Non-executive directors - as at 31 March 2025



Rob Whiteman CBE

Trust Chair and Chair
of the Appointments
and Remuneration
Committee

[Date of appointment:](#)

1 July 2022

[End of term:](#)

31 March 2025

Rob has been Chief Executive of the Chartered Institute of Public Finance and Accountancy and has held many other executive and non-executive roles including Chief Executive of the London Borough of Barking and Dagenham and Chief Executive of the UK Border Agency. Rob has significant experience of working with the NHS from his time as chair of North East London Sustainability and Transformation Programme (STP) and as a non-executive director and Chair of Audit at Whittington Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust.



Professor

Cliff Shearman OBE

Vice Chair and Chair of
the Quality Committee

[Date of appointment:](#)

1 October 2020

[End of term:](#)

30 September 2025

Cliff was a Professor of Vascular Surgery/ Consultant Vascular Surgeon at University Hospital Southampton NHS Foundation Trust until 2016, where he was also Associate Medical Director. He was head of the Wessex Postgraduate School of Surgery from 2007-2012. Cliff is now Emeritus Professor of Vascular Surgery at the University of Southampton.

Cliff has been heavily engaged in quality improvement work relating to people with diabetes to improve the quality of care and reduce vascular complications which can result in foot and leg amputations. He has also maintained an active research programme throughout his career, leading various studies and publishing national and international guidelines, books, papers and articles. Cliff has represented the Vascular Society on the Royal College of Surgeons of England Council since 2015, and in April 2018 was elected as its Vice-President. Cliff is a non-executive director on the Board of Spire Health Care.



Judy Gillow MBE
Senior Independent
Director and Chair of
the Audit Committee
Date of appointment:
3 April 2023
End of term:
1 May 2025¹

Judy is a nurse by background and completed her training at Great Ormond Street Hospital in London. She has had a varied career across the NHS following this and has worked in a range of clinical settings in acute, community, primary care and education. Roles have included Director of Nursing and Organisational Development at University Hospitals Southampton and she has also been a non-executive director at Dorset County Hospital.

Judy has been a specialist professional advisor for the Care Quality Commission (CQC), supporting hospital inspections and is involved with helping to oversee the Trust meets the needs of its patients by providing high quality clinical care.



Tracie Langley
Date of appointment:
6 January 2025
End of term:
5 January 2028

Tracie has had a career as a senior strategic executive across both public and private sectors. She is a qualified accountant and has held a number of director roles across a variety of organisations and industries, most latterly as Chief Operating Officer and Finance Director of Cornwall Council.

Tracie has a deep understanding of how the public sector functions and how to overcome the challenge of the provision of quality services in a financially constrained environment. She has an ability to connect and grow strong collaborative relationships between health and social care organisations to best support patients' needs.

Tracie lives in Dorset with her husband and is committed to ensuring that Dorset offers the best healthcare in the country.

¹ Judy Gillow became Interim Chair with effect from 1 May 2025, with her tenure as Senior Independent Director and Non-Executive Director terminating as at that date.



John Lelliott OBE
Chair of the Finance
and Performance
Committee
Date of appointment:
1 October 2023
End of term:
30 September 2025

John has had a long career in public service, retiring from The Crown Estate in September 2016 where he held the position of Finance Director. He also held positions of non-executive director and Chair of the Audit Committees of the Environment Agency and the Covent Garden Market Authority until September 2024 and Chair of the Natural Capital Coalition from July 2016 to July 2019.

He was Chair of the ACCA Global Sustainability Forum and was a member of The Capitals Coalition Board. He is a trustee of JTL Training and The Royal Agriculture Benevolent Institution.

Prior to becoming a non-executive at UHD, he was on the Board of The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust since 2016.

He is a qualified chartered certified accountant and a fellow of the Chartered Association of Certified Accountants.



Femi Macaulay
Date of appointment:
16 December 2024
End of term:
15 December 2027

Femi has over 35 years' experience at senior levels in banking, insurance, health, education, and management consulting. He was an Executive Director at JP Morgan Private Bank in London and New York, and Chief Marketing Officer of GE Capital in Switzerland. Other roles included Global Head of Marketing Operations at Zurich Insurance Company and Director of Brand and Marketing at HSBC in the US and the UK. He started his career with PwC in London in 1985.

Currently, Femi is Chair of Linacre College, University of Oxford. He has previously been Associate Non-Executive Director of University Hospital Southampton NHS Foundation Trust where he chaired the Charitable Funds Committee, served on the Audit and Risk Committee, and the People and Organisation Development Committee.

Femi is also a trustee and co-founder of Stuckton Adventure Centre, a charitable incorporated organisation based in the New Forest that helps young people reach their potential using practical outdoor experiential learning and adventure.

Femi graduated from the University of Oxford with a Master of Philosophy (MPhil) in Management Studies. He also holds a Bachelor of Arts (BA) first class honours degree in Economics.



Helena McKeown
Chair of the Population
Health and System
Committee
Date of appointment:
1 October 2023
End of term:
30 September 2026

Helena is currently Medical Director (professional development and quality) at the Royal College of GPs. Her background includes being Chief Officer and Board member at the British Medical Association (BMA), a council member of the World Medical Association and member of the NHS Equality Diversity Council.

She has served on numerous partnership groups, including the standing commission on carers and a period as an elected councillor in Wiltshire.



Sharath Ranjan
Chair of the People and
Culture Committee
Date of appointment:
3 April 2023
End of term:
2 April 2026

Sharath was born in Bangalore, India, completed a degree in hospitality from the University of Mysore and moved to the United Kingdom in 2004.

After several stints with Holiday Inn, British Gas, Centrica and Expleo (formerly SQS), he joined Hampshire Constabulary as a police constable in 2013.

Sharath graduated from the Fast Track to Inspector scheme run by the College of Policing in December 2020. He is currently a Chief Inspector with responsibility for Test Valley as the District Commander in Hampshire and the Isle of Wight.

Sharath is committed to adopting an 'institutionally inclusive' approach to promote equality, diversity and inclusion and in particular tackling race discrimination and disproportionality in policing. He was the previous chair of the Black, Asian and Minority Ethnic support group - BEAM. Under his leadership, BEAM was shortlisted for 'Outstanding Diversity Network - 2022' award by Inclusive Companies - UK.

Sharath has been an independent governor on the Board of Governors for Solent University, Southampton since 2020 and is a member of the Governance Committee and Chair of the People and Culture Committee. He mentors students at the university and is passionate about making a difference to people at pace.



Claire Whitaker CBE
Chair of the Charitable
Funds Committee
[Date of appointment:](#)
1 October 2023
[End of term:](#)
30 September 2026

Claire is CEO of Southampton Forward, an independent charity with a remit across culture, including culture-led regeneration, festivals, events and tourism for the city, having previously led its shortlisted bid to be UK City of Culture.

Claire was an owner/director of international live music producers, Serious, for nearly 25 years. She has combined her executive roles with a career as a non-executive director on a range of educational, philanthropic, housing, health and charitable organisations, as well as being a member of several high-profile advisory groups. She is currently a main Board member of Aster Group Ltd and Chair of Aster's Customer and Community Network Committee.

Claire's expertise ranges from the creation and delivery of ambitious cultural events and programmes, advising companies and organisations on equality, diversity and inclusion and the development of strategic partnerships with a broad range of stakeholders and communities. She is actively involved in policy development across culture, civil society and placemaking.

Our other non-executive directors who served during the period 1 April 2024 to 31 March 2025



Pankaj Davé
Chair of the People and
Culture Committee
[Date of appointment:](#)
1 October 2020
[Date of expiry:](#)
30 November 2024

Executive directors - as at 31 March 2025



Siobhan Harrington
Chief Executive
[Date of appointment:](#)
1 June 2022

Siobhan began her career in nursing posts in London, working at St Thomas's and Royal Free Hospitals.

After programme management roles including at regional level, in 2004 Siobhan was appointed Director of Primary Care Commissioning and Lead Nurse at Haringey PCT. She joined Whittington Hospital NHS Trust in 2006 moving through roles including Director of Primary Care, Acting Director of Nursing, Director of Strategy, and Deputy Chief Executive. She spent two years as Programme Director for the Barnet Enfield Haringey clinical strategy, and in 2017 was appointed Chief Executive of Whittington Health NHS Trust.



Beverley Bryant
Chief Digital Officer
[Date of appointment:](#)
28 October 2024

Beverley leads our digital strategy. She joined University Hospitals Dorset from Guy's and St Thomas's NHS Trust and Kings College Hospitals NHS Trust where she was joint Chief Digital Information Officer. Beverley led the major transformation of all clinical applications and workflows to bring IT systems together across the trusts. As part of her role at the Trust, she takes our executive lead for the creation of the new electronic health record (EHR) in partnership with trusts and both Integrated Care Boards across Dorset and Somerset.

Beverley's previous roles have included Director of Digital Technology for NHS England and Chief Information Officer for the Department of Health.



Sarah Herbert
Chief Nursing Officer
[Date of appointment:](#)
13 May 2024

Sarah Herbert graduated as a registered nurse in 1999 and began her career in London. She has a clinical background in surgery, critical care and theatres, with a keen interest in applied research, clinical education and leadership development. Sarah has held a number of clinical and senior nursing leadership roles, including supporting the University Hospital Southampton medical division through Covid before becoming the Deputy Chief Nurse there in 2021.

Sarah holds an MSc in Nursing and is a Florence Nightingale Foundation Scholar, where she remains an active alumnus of the foundation. She is passionate about ensuring patients receive high quality, personalised care, through working in partnership with patients, staff and local partners to create positive practice environments.



Mark Mould
Chief Operating Officer
[Date of appointment:](#)
1 October 2020

Mark is the first Chief Operating Officer for University Hospitals Dorset. He was previously the Chief Operating Officer for Poole Hospital NHS Foundation Trust where he served for six years.

Mark has extensive operational management experience across a number of other acute trusts across the country.



Pete Papworth
Chief Finance Officer
[Date of appointment:](#)
1 October 2020

Pete was appointed Director of Finance for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2017 and was subsequently appointed Director of Finance for Poole Hospital NHS Foundation Trust in 2019 in a joint role across both organisations. He led the financial aspects of the merger of the two organisations and was appointed as the first Chief Finance Officer for University Hospitals Dorset on 1 October 2020. Pete is a chartered accountant with experience working across all aspects of the public sector locally, since joining the Audit Commission's graduate scheme in 2003.



Richard Renaut
Chief Strategy and
Transformation Officer
[Date of appointment:](#)
1 October 2020

Richard joined the NHS through the NHS management training scheme. He has worked in both primary care and tertiary hospital settings. Prior to his appointment as Chief Strategy and Transformation Officer on 1 October 2020, Richard was Chief Operating Officer at the Royal Bournemouth and Christchurch Hospitals and has been a Board executive since 2006.



Tina Ricketts
Chief People Officer
Date of appointment:
26 February 2024
End of term:
30 April 2025

Tina has been an executive director in the NHS since July 2011. She previously worked at Worcestershire Acute Hospitals NHS Trust where she was Director of People and Culture for over six years. Prior to this Tina worked in the NHS in Gloucestershire for 14 years. Her career includes senior leadership roles at Integrated Care System level, in a large complex acute trust and in a community health and care trust. Tina is a Fellow of the Chartered Institute of Personnel and Development.



Dr Peter Wilson
Chief Medical Officer
Date of appointment:
1 April 2023

Peter joined the Trust from his role as Medical Director for direct commissioning for the south west region of NHS England. Peter's background is as a consultant in paediatric intensive care. He developed his clinical and leadership career at University Hospitals Southampton NHS Foundation Trust, where he held the role of Divisional Clinical Director for women's and children's services and Clinical Director for the Southampton Children's Hospital. Nationally, he has also been Clinical Chair of NHS England's programme board for women and children.

Our other executive directors who served during the period 1 April 2024 to 31 March 2025



Paula Shobbrook
Chief Nursing Officer,
Deputy Chief Executive
Date of appointment:
1 October 2020
End of term:
9 April 2024



Fiona Hoskins
Acting Chief Nursing
Officer
Date of appointment:
10 April 2024
End of term:
10 May 2024

In addition, **Professor Alison Honour**, Vice Chancellor of Bournemouth University, and **Andrew Doe** hold the position of Associate Non-Executive Directors of the Trust. **Dr David Broadley** held the position of Medical Director - Integrated Care (GP).

Declarations of interest

The Trust holds a register of directors' interests which is made publicly available on our website. The register can be found on the Board Governance page.
(www.uhd.nhs.uk)

Cost allocation and charging guidance issued by HM Treasury

University Hospitals Dorset NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Better Payment Practice Code

The Better Payment Practice Code (BPPC) requires the Trust to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. To facilitate this, the Trust processes daily payments of all invoices that are approved.

During 2024/25 we delivered performance of 95.5% against the national standard of 95%.

Better Payment Practice Code Non-NHS Invoices	Year to Date	
	No.	£'000
Total bills paid	112,588	487,417
Total bills paid within target	107,501	466,180
Percentage of bills paid within target	95.5%	95.6%
NHS Invoices		
Total bills paid	3,609	69,740
Total bills paid within target	3,341	65,699
Percentage of bills paid within target	92.6%	94.2%
Total		
Total bills paid	116,197	557,157
Total bills paid within target	110,842	531,879
Percentage of bills paid within target	95.4%	95.5%

Private patient income

The Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Board committees

The Board delegates areas of its powers to its Committees (not including executive powers unless expressly authorised). There is a schedule of matters reserved for the Board: Scheme of Delegation (www.uhd.nhs.uk/uploads/about/docs/bod/scheme_of_delegation_v2_-_approved_28_june_2023.pdf)

The Board currently has eight committees: the Appointment and Remuneration Committee, Audit Committee, Charitable Funds Committee, Finance and Performance Committee, Quality Committee, People and Culture Committee, Population Health and System Committee and Transforming Care Together Group. Each committee has terms of reference and a governance cycle. The members of each committee are also members of the Board. An annual review of its effectiveness is conducted by the Board and by its committees.

Appointments and Remunerations Committee

A summary of the work of our Appointments and Remuneration Committee during the year is set out below.

Attendance at Board and Committee meetings by directors is shown in the following table:

Name	Board of Directors - Part 1 meetings	Board of Directors - Part 2 meetings	Appointments and Remuneration Committee meetings	Audit Committee meetings	Charitable Funds Committee meetings	Finance and Performance Committee meetings	Joint Audit and Finance and Performance Committee meeting	People and Culture Committee meetings	Population Health and System Committee meetings	Quality Committee meetings	Transforming Care Together Group
Beverley Bryant	3(3)	6(7)				2(2)					
Pankaj Davé	4(4)	8(8)	2(2)		3(3)	8(8)	1(1)	3(3)			4(4)
Judy Gillow	5(6)	13(14)	3(3)	5(5)			1(1)	4(5)	3(4)	11(12)	5(6)
Siobhan Harrington	6(6)	13(14)									4(6)
Sarah Herbert	5(5)	12(12)								10(11)	
Fiona Hoskins	1(1)	1(1)						1(1)		1(1)	
Tracie Langley	1(1)	4(4)	1(1)			3(3)					
John Lelliott	6(6)	13(14)	3(3)	5(5)		12(12)	1(1)				6(6)
Femi Macaulay	2(2)	5(5)	1(1)					1(1)		1(1)	
Helena McKeown	5(6)	13(14)	3(3)		4(4)				5(5)	9(12)	4(6)
Mark Mould	6(6)	12(14)				10(12)	1(1)	3(5)		8(12)	6(6)
Pete Papworth	6(6)	14(14)			4(4)	11(12)	1(1)				4(6)
Sharath Ranjan	6(6)	14(14)	1(3)			11(12)	1(1)	5(5)	5(5)		1(2)
Richard Renaut	6(6)	14(14)				12(12)	1(1)		4(5)		6(6)
Tina Ricketts	5(6)	13(14)			3(4)			5(5)		1(1)	
Cliff Shearman	6(6)	14(14)	2(3)	5(5)			1(1)			12(12)	5(6)
Paula Shobbrook		0(1)									
Claire Whitaker	6(6)	13(14)	2(3)	4(5)	4(4)	12(12)	1(1)				
Rob Whiteman	6(6)	14(14)	3(3)								5(6)
Peter Wilson	6(6)	14(14)						1(1)		10(12)	
Quorate	Y	Y	Y	Y	Y	Y	Y	Y	Y*	Y	Y

N.B. Table shows committee attendance of directors in their capacity as members; it does not reflect where a delegate may have been sent in place of a member nor where apologies may have been sent by a director

Audit Committee

The Audit Committee meets at least four times in each financial year and representatives from internal audit, and the Counter Fraud Service attend these meetings. The Chief Finance Officer, Chief Nursing Officer, Chief Digital Officer, and representatives from the Risk Management and Clinical Audit teams also attend meetings at the request of the Committee Chair. The committee members are all independent non-executive directors. The Chair is not a member of the committee.

At least one member of the committee has recent and relevant financial experience. The Audit Committee's responsibilities include the following areas:

- reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of our objectives
- ensuring there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the committee, Chief Executive and Board
- reviewing and approving the annual internal audit plan and the more detailed programme of work; considering the major findings of internal audit work; considering the appointment of external auditors, including providing information and recommendations to the Council of Governors; reviewing the nature and scope of the audit as set out in the annual external audit plan and reviewing the reports of the external auditors
- reviewing the counter fraud programme and considering major findings from investigations
- considering management's responses to internal audit, external audit and counter fraud reports and the appropriateness of implementation of management responses to internal audit work
- ensuring co-ordination between internal and external auditors
- reviewing the Annual Report, Annual Governance Statement and Annual Financial Statements before their presentation to the Board
- reviewing the effectiveness of the arrangements in place for allowing staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, fraud, bribery and corruption, clinical quality, patient safety or other matters.

The terms of reference can be found at: [Board governance \(www.uhd.nhs.uk\)](http://www.uhd.nhs.uk)

During the year, the Audit Committee paid particular attention to the following areas: right to work checks, IT asset management, staff networks, ward identity checks, data quality, Care Group financial governance, complaints follow up, cash office controls follow up, system workforce controls, maternity incentive scheme year 6, private practice and job planning.

Internal audit

Internal auditors assist the Audit Committee by providing a clear statement of assurance regarding the design and effectiveness of internal controls. The Chief Finance Officer is professionally responsible for implementing systems of internal financial control and is able to advise the Audit Committee on such matters. The internal audit function is provided by BDO and has reported:

*"The role of internal audit is to provide an opinion to the Board, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. Overall, we provide **Moderate Assurance** that there is a sound system of internal controls, designed to meet the Trust's objectives, that controls are being applied consistently across various services."*

External auditors

The Trust's external auditors to 31 March 2025 were and continue to be KPMG. Following a compliant tender process a contract for the provision of external audit services was awarded to KPMG for a three year term commencing 1 April 2023, with an option to extend by two further 12 month periods. This followed on from a Dorset-wide procurement process undertaken in 2022.

The role of external auditors is to provide an independent audit opinion on the annual report and accounts.

The key elements for the framework of assessment of effectiveness of the external audit process include a review of performance in relation to the contracted service specification, the standard of audits conducted, the timeliness of reporting, the availability of the auditor for discussion and value for money being received from the audit service provided. Using this framework, the Audit Committee and the Council of Governors was satisfied with the effectiveness of the external audit process.

The significant audit risks which were identified as part of the overall audit were:

- valuation of land and buildings
- fraud risk from expenditure recognition - completeness
- management override of controls

These were discussed with the Audit Committee as part of the audit planning process and KPMG reported on these areas as part of their year end report. No significant issues were identified.

The Board has approved a policy for the provision of any non-audit service that might be provided by the Trust's external auditor. This policy removes any unnecessary restrictions on the purchase of services from the external auditor but ensures that any non-audit service provided by them cannot impair or cannot be seen to impair the objectivity of their opinion on the financial statements.

The Trust considers and annually assesses the effectiveness of its external auditors.

Counter fraud

The Audit Committee is responsible for appointing the Counter Fraud Service and ensuring it has appropriate support within the Trust to carry out its work. It reviews the annual counter fraud programme and the results of its proactive monitoring and awareness activities as well as considering major findings of investigations work including management's response to recommendations, highlighting any issues to the Board if necessary. The Counter Fraud Service is accredited by the NHS Counter Fraud Authority (CFA) and works with the Trust to ensure compliance with the Government Functional Standard 013 Counter Fraud and the requirements set out by the NHS CFA, reflecting the NHS CFA Strategy 2023-2026.

Charitable Funds Committee

The Charitable Funds Committee is formally established as a committee of the Trust as corporate trustee of the University Hospitals Dorset NHS Foundation Trust Charity. The Board of the Trust acts as the Board of the trustee. The Committee provides the Trust Board with a means of assurance regarding the administration of the charity in accordance with applicable legislation. The charity produces a separate Annual Report on its activities.



**University Hospitals Dorset
NHS Charity**

Registered Charity No. 1057366

Finance and Performance Committee

The Finance and Performance Committee's focus includes providing input and recommendations to the Board for the development of the Annual Operating Plan, Productivity and Efficiency Plan, Estates Strategy, Sustainability Strategy and Digital Strategy.

Its responsibilities include reviewing and making comment to the Board on the substance of the annual revenue and capital budgets of the Trust and in relation to operational performance monitoring against key national performance standards, such as access times.

People and Culture Committee

The People and Culture Committee's focus includes providing input and recommendations to the Board for the development of the People Strategy and the Equality, Diversity and Inclusion Strategy and obtaining assurance on the implementation of such strategies.

The People and Culture Committee seeks assurance on the Trust's culture, with a Chair's report being presented to the Board. This includes reviewing reports from the guardians of safe working hours and our Freedom to Speak Up Guardian. It also obtains assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged by supporting the speaking up agenda.



Standing items as part of the Board's programme include the gender pay gap, Freedom to Speak Up, equality and diversity, WRES and WDES.

Population Health and System Committee

The Population Health and System Committee's Responsibilities include obtaining assurance that the Trust's delivery plan aligns with the Dorset Integrated Care Board strategy and/or relevant aspects of the 'Core20 plus 5' approach. The committees role is also to obtain assurance that significant strategic change programmes

deliver a positive impact, where possible, on reducing variation in outcomes between groups with protected characteristics and other vulnerable groups and services are adapted to meet the needs of those groups appropriately.

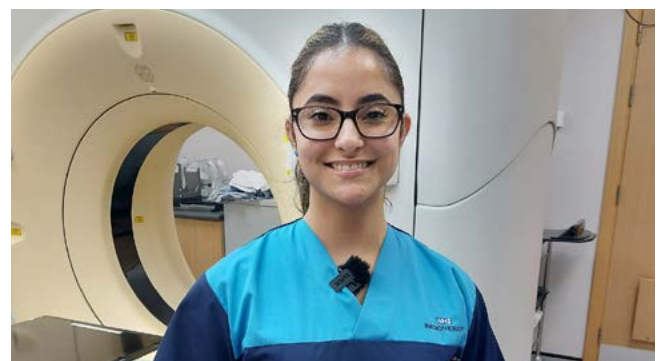
Quality Committee

The Quality Committee's responsibilities include overseeing that there are robust management systems and processes in place for ensuring high standards for quality of care. It serves to provide assurance that the Trust has an effective framework within which it can provide an effective, safe, patient experience by working to improve and assure the quality and safety of services it provides in a range of areas. It acts as a means of internal assurance for compliance against the CQC regulating and inspection compliance framework. The extensive work of the committee, and the processes that it oversees are set out in this Annual Report and the Quality Accounts.

Transforming Care Together Group

The Transforming Care Together Group is a time limited group which will provide input and recommendations to the Board and relevant committees for the delivery of the Trust's service ready, build ready and people ready programmes. Together these deliver the Clinical Services Review to create the planned and emergency hospitals for Dorset.

For a number of our committees, representatives of the Integrated Care Board are periodically invited to attend as part of our system working.



Council of Governors

The role and responsibilities of the Council of Governors are set out in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and Health and Care Act 2022). These have been incorporated into the Trust's Constitution, Code of Conduct for governors and in the Schedule of Matters reserved for the Board.

The Board works closely with the Council of Governors to support the interests of patients and ensuring the local community is represented. Governors hold listening events and other events at which feedback from members and the public is canvassed. The Board hears this feedback in a number of ways, including through questions raised by our governors at our Board meetings held in public; our Lead Governor presenting a bi-annual update on behalf of the Council of Governors to the Board highlighting themes from engagement activity; and through feedback provided at Council of Governors' meetings. We asked for views and comments feedback on our Annual Plan from a cross-section of the Trust's members. This together with feedback from governors, staff and commissioners helped develop the plan.

In addition to the formal Nominations, Remuneration and Evaluation Committee, our Council of Governors currently has three engaged and active informal groups: Effectiveness Group, Membership Engagement Group and the Quality Group. During the year, some of our governors and non-executive directors also participated in our Constitution Review Group, with our Constitution having been subsequently updated.

Council of Governors' development sessions held during 2024/25 covered a number of topics, including: an overview of the Annual Accounts; Clinical Strategy; Council of Governors' pledges and team building; communication and engagement capabilities; Workshop in a Box - NHS 10 year plan; and statutory duties.

We also held our first three-way Council of Governors' event alongside governors from Dorset County Hospital and Dorset HealthCare. This focused on the role of governors in public engagement, learning from each other about what has worked well, and how governors could enhance collective public engagement across the Dorset system.



The members of our Council of Governors as at 31 March 2025 were:

Name	Constituency/organisation represented	Attendance at meetings of the Council of Governors	
		Part 1	Part 2
Colin Blebta	Bournemouth	5(5)	6(6)
Robert Bufton	Poole and Rest of Dorset	5(5)	6(6)
Deniz Cetinkaya	Bournemouth	3(3)	3(4)*
Sharon Collett	Bournemouth	5(5)	6(6)
Sue Comrie	Appointed Governor: Volunteers	5(5)	4(6)*
Steve Dickens	Christchurch, East Dorset and Rest of England	3(5)	3(6)*
Beryl Ezzard	Dorset County Council	5(5)	5(6)*
Richard Ferns	Poole and Rest of Dorset	4(5)	2(6)*
Rob Flux	Staff: Non-Clinical	5(5)	3(6)*
Colin Hamilton	Staff: Non-Clinical	3(5)*	3(6)*
Paul Hilliard	Appointed: Bournemouth, Christchurch and Poole Council	5(5)	6(6)
Elizabeth McDermott	Bournemouth	4(5)	5(6)
Andrew McLeod	Poole and Rest of Dorset	3(5)*	3(6)*
Keith Mitchell	Bournemouth	5(5)	6(6)
Jerry Scrivens	Christchurch, East Dorset and Rest of England	5(5)	6(6)
Diane Smelt	Bournemouth	5(5)	5(6)*
Carrie Stone	Poole and Rest of Dorset	5(5)	6(6)
Kani Trehorn	Staff: Clinical	4(5)	5(6)
Shelley Thompson	Appointed Governor: Bournemouth University	3(3)	4(4)
Michele Whitehurst	Poole and Rest of Dorset	5(5)	6(6)
Sandy Wilson	Christchurch, East Dorset and Rest of England	4(5)	5(6)

* One of the meeting(s) not attended was an extraordinary meeting
(All elected, save where stated above as appointed).

The terms for which each were elected or appointed was three years. We would like to thank Mark Haslam for his contribution and whose tenure came to an end during 2024/25.

The register of governors' interests is available on the Trust's website.

Our directors and governors can be contacted by emailing

ftmembers@uhd.nhs.uk

The Trust has various routes for resolving disagreements between the Board and the Council of Governors were these to arise. These include the interventions of the Senior Independent Director and the Lead Governor. There is also a formal policy for resolving any disagreements which can be found at: [UHD Board policy for Engagement with Council of Governors](#)

CQC and NHS England Well-led Framework

Our approach to ensuring that our services are well-led is also discussed in our Performance Report and our Annual Governance Statement.

The Board has approved an Accountability Framework that supports the delivery of our vision and strategic objectives as a well led organisation that delivers safe, high-quality patient care that is clinically and financially sustainable. Through the framework the Board will oversee the creation of the leadership capabilities and leadership culture the organisation needs to possess in order to achieve its vision. The leadership model for culture change is one of collective leadership that is clinically led. The Board promotes the development of an inclusive leadership and management style. The Accountability Framework also outlines the performance management framework.

Leadership capacity and capability is supported by management structures within the Trust. A Care Group model has been established to strengthen the clinical

leadership model and embedding the triumvirate/quadrumvirate approach through care groups. By triumvirate we mean the three-way partnership between the manager, the lead nurse or allied health professional and the lead doctor. Within the Women's, Children, Cancer and Support Services Care Group, the role of Director of Maternity is an integral part of a quadrumvirate at Care Group level. The team take a collective responsibility for the delivery of services in their area, and this is replicated at all leadership levels in the Trust.

The Trust has established a series of management and leadership development programmes. These support the delivery of the Trust's mission and strategic objectives and an inclusive and well-led organisation that delivers safe, high-quality patient care in a way that is clinically and financially sustainable. Please see also the Staff Report.

In addition to executive directors visiting services, the Trust has a programme of visits for non-executive directors. As well as having a Maternity Board Safety Champion, Wellbeing Guardian, Freedom to Speak Up Champion and Security Management non-executive director champion, the Trust has a non-executive director Engagement Lead.

The Council of Governors play a key role in engaging with the Trust's members and the wider community, supporting the Trust's communication strategy. In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice and should look to identify the areas of the Trust's leadership and governance that would benefit from further targeted development work to secure and sustain future performance. NHS England requires all trusts to carry out externally facilitated, developmental reviews of their leadership and governance using the Well-led Framework. The Trust intends to commission an externally facilitated review during 2025/26. The Board participates in a Board development programme.

During the year, Board development sessions have included well-led related subjects.

The Trust is required to register with the CQC and its current registration status is unconditional. This means that the Trust does not have any current restrictions on its practice or services. University Hospitals Dorset NHS Foundation Trust is yet to receive a rating by the CQC for its services or hospital sites.

The Trust received an unannounced inspection of surgical services at Poole Hospital and Royal Bournemouth Hospital on 28 and 29 January 2025. A post inspection feedback letter was sent by the CQC in February, however the full report is not expected to be published until June 2025.

The feedback letter highlighted a few areas for improvement, including the availability of clinical equipment, low level environmental infection prevention and control concerns at the Royal Bournemouth Hospital, and general oversight of the environment. Actions have already been taken to respond to the concerns raised. The feedback letter also noted improvements with the timeliness of the fractured neck of femur pathway at Poole Hospital and reported that generally the environment was clean and free from clutter.

Across surgical services they highlighted that internationally trained staff gave positive feedback about working in the Trust, patients gave positive feedback about the care they received and overall staff were caring and responsive to their patients.

The CQC has also undertaken a visit to our new BEACH Building at the Royal Bournemouth Hospital as part of routine registration assessment under the New Hospital Programme framework. On 5 and 6 March 2025, the CQC visited the BEACH Building to assess the Emergency Department, Critical Care, Maternity and Radiology, and focused on the following areas:

- suitability of premises and equipment
- safe care and treatment
- staffing
- good governance

The Trust received a post visit letter on 7 May 2025 with positive feedback across all areas visited. The CQC letter noted in summary that *“the opening of the BEACH will have a positive and beneficial effect on life for patients attending it and staff working in it”*. The CQC also extended thanks for the arrangements that were made at short notice to help organise the assessment and for the cooperation that they experienced from all staff who were involved in the visit.



Patient experience

Measuring patient experience for improvement is essential for the provision of a high-quality service.

It is important to ensure that patients and the public are given an opportunity to comment on the quality of the services they receive.



Improve patient experience, listen and act

Patient experience work at the Trust over the last year has included:

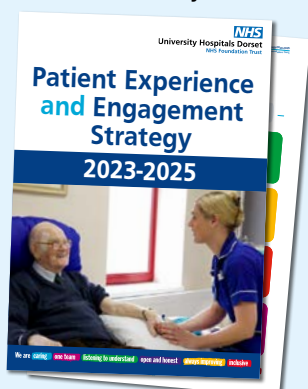
- national annual inpatient surveys, national cancer patient surveys, national Friends and Family Test monitoring
- internal feedback via the use of real time patient feedback, patient surveys and focus groups
- monitoring for any emerging issues via formal and informal complaints, issues raised by letters and compliments from patients, carers, relatives and the public
- launching a new Patient Experience Strategy:

Launching our Patient Experience Strategy

Our UHD Patient Experience and Engagement Strategy sets out the vision to improve our patients' experience over the next two years.

The CARE priorities describe how we will achieve the patient experience and Patient First objectives, and details the actions we will need to take.

We CARE



The UHD Patient Experience and Engagement Strategy 2023-2025 sets out how the Trust will deliver the Patient First objectives and guide how we will continue to meaningfully engage with patients during the continued transformation of our services.

As part of the Patient First journey, our patient experience **CARE** priorities further expand on the Trust priority of 'improving patient experience' by acting on feedback.

The **CARE** priorities for the organisation are:

Continuous Feedback - increasing the opportunity for patients to give their views on their care and increase accessibility by using different methods to enable patients to tell us about their experiences.

Areas for Improvement - teams use this feedback to recognise and drive changes, ensuring any improvements that are made deliver the intended improvement.

Recognising People - ensuring all patients who use our services are heard, by actively seeking out their opinion through engagement with the community.

Excellent Partnerships - working with health, social and voluntary partners to understand the views of the public and work together to solve problems.

The **CARE** priorities link to our Trust values. The strategy describes what activities and measures will be taken to achieve these priorities. During 2025-2026 it is expected that the **CARE** priorities, set out in the strategy will be realised in full, with the outcome being outstanding care for our patients.

Clear and transparent communication with the public about the transformation of our services has been vital and will continue into 2025/26, where plans for the further moving of services across the Trust will be realised. The public and patients of the hospitals have been extensively involved in decision making through the Clinical Services Review engagement, but this was several years ago. Therefore, this next phase will include continuing to be informed of the changes and provided with educational materials and workshops to understand what the transformation will mean to them.

Involvement includes co-designed workshops for the transformation of services e.g. stroke services. Similar involvement of our patients is planned into future transformation, which will include larger scale workshops and smaller group work for specific changes.

Learning from complaints and concerns

Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the Trust must prepare an Annual Report each year. This must specify the number of complaints received, the number of complaints which the Trust decided were well-founded and to summarise the subject matter of complaints, any matters of general importance arising from those complaints, or the way in which they have been managed and any actions that have been or are to be taken to improve services as a consequence of those complaints.

Complaints made to the Trust are managed within the terms of the Trust's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion. It is important to note that the two historical trusts had different approaches to managing and investigating complaints prior to the merger in 2020. The number of formal complaints received and investigated can be seen below.

Formal complaints received	2024/25	2023/24	2022/23	2021/22
	UHD	UHD	UHD	UHD
	803	800	984	491

The Trust has implemented an early resolution of complaints process, the data for these types of complaints was not included in the complaints figures previously however this is now part of the formal complaint process and reported as such. Early resolution is intended to provide a quicker response usually within 10 working days.

The focus of the Patient Advice and Liaison Service (PALS) is to resolve concerns informally with frontline staff. The table below shows that there has been a further increase in the number of concerns being raised informally over the past year.

PALS concerns	2024/25	2023/24	2022/23	2021/22
	UHD	UHD	UHD	UHD
	6624	5982	5530	5200



Subjects of complaints

Every complaint is assessed at the outset and the key themes extracted. The themes based on the DOH submission dataset can be seen in the table below; recorded by number and % of total.

Complaint themes	2024/25	2023/24	2022/23
Clinical treatment	131 (15.9%)	505 (33.7%)	664 (35%)
Access to treatment	6 (0.7%)	64 (4.3%)	94 (4.9%)
Admission, discharge, transfers	90 (10.9%)	101 (6.7%)	97 (5.1%)
Delays and cancelled appointments	36 (4.3%)	38 (2.5%)	153 (8%)
Communication	208 (25.3%)	272 (18.1%)	435 (22.9%)
Consent	9 (1.1%)	7 (0.5%)	27 (1.4%)
End of life care	0 (0.0%)	14 (0.9%)	21 (1.1%)
Facilities	8 (0.9%)	6 (0.4%)	0 (0%)
Integrated care	0 (0.0%)	3 (0.2%)	0 (0%)
Patient care	0 (0.0%)	72 (4.8%)	90 (4.7%)
Mortuary	0 (0.0%)	2 (0.1%)	0 (0%)
Prescribing	0 (0.0%)	37 (2.5%)	43 (2.2%)
Privacy, dignity and wellbeing	154 (18.7%)	41 (2.7%)	22 (1.1%)
Staffing numbers	1 (0.1%)	1 (0.1%)	9 (0.5%)
Administration	82 (9.9%)	48 (3.2%)	0 (0%)
Values and behaviours	46 (5.6%)	264 (17.6%)	146 (7.7%)
Waiting times	51 (6.2%)	24 (1.6%)	95 (5%)

Any emerging themes or hotspots are identified and escalated to the Directorate or Care Group triumvirate or to the relevant director, depending on the seriousness, complexity and/or frequency of complaint theme monitored. Complaints can have more than one theme assigned to them, for example the complaint could be about the clinical treatment and communication and administration.

You said, we did: Changes resulting from complaints

One of the main purposes in investigating complaints is to identify opportunities for learning and change in practice to improve services for patients. Examples of changes brought about through complaints are:

You said

Concerns raised that patient was not wearing an ID band when family member visited them on the ward.

We did

Ward have changed practice to ensure patients are wearing two ID bands at all times. They are conducting a twice monthly audit to ensure compliance with this and are regularly raising the issue at the daily safety briefings.

You said

It was highlighted that the appropriately sized blood pressure cuff was not available when a patient came for their surgery, leading to a delay while this was sourced.

We did

Stock in theatres has been reviewed and redistributed to ensure there is a range of cuff sizes available in each theatre.

You said

Feedback received from patient that it was difficult to find information about maternity appointments and what to expect once they complete a referral to our Maternity Team.

We did

This information is available on the Maternity Matters Dorset website and has now been added to the front page of the website so it is more accessible for patients.

You said

A patient's family raised concerns regarding the end of life ward setting, stating that the environment was too noisy for their loved one receiving end of life care.

We did

Staff on the ward now place three battery operated candles at the entry of the ward with a sign informing staff and visitors that family members are spending time with their loved ones. This is also being introduced across other wards.

You said

Concerns raised by family of a patient regarding a lack of support from staff when their relative was nearing the end of their life.

We did

Staff on the ward have received advanced end of life training from the practice educator and there are now six end of life care champions on the ward who can in turn share learning with their colleagues to improve care in this area.

You said

Concerns raised regarding accessing support following dermatology procedures.

We did

The dermatology post-operative information leaflet is under review. This will include one telephone number for patients to use to enable them to access support quicker and easier.

You said

Patient reported that their endoscopy procedure was cancelled on the day as the correct blood tests had not been carried out.

We did

It was highlighted this occurred as a result of lack of knowledge on a staff member's part. A training afternoon was therefore organised for the whole team to increase staff knowledge and prevent future similar occurrences.

You said

Concerns raised by a patient that there was a delay in them being referred to the menopause clinic following radiotherapy.

We did

The clinical team recognise that this is an opportunity to improve processes and are working to have a streamlined referral process in place to ensure patients who have received pelvic radiotherapy are referred to the menopause clinic as standard.

You said

It was highlighted that women in our Maternity Unit were not always aware that there is a senior staff member available 24/7 to escalate concerns to.

We did

Posters to be added at bedsides and in bathrooms to make this information widely available to service users.

You said

Patient experienced a delay in referral for treatment for osteoporosis.

We did

Database introduced to keep track of all patients referred and to ensure appointments booked within reasonable timeframes.

You said

Concerns raised regarding poor communication from department and delays in care.

We did

Changes to process in department made and additional administrative staff has resulted in improved communication.

Action plan for 2025/26

A further internal audit of the Trust complaints procedures was undertaken in year and the results presented to the Audit Committee. The audit highlighted a number of areas for further improvement, including:

- continue to improve and reduce response times
- improve communications with complainants to explain about potential delays
- the Complaints Team user survey continues to be shared and responses shared via quarterly reports

The improvement work around response times and communication will continue to progress.

Stakeholder relations

This financial year has seen a marked increase in communications with all key stakeholder groups in the lead up to the major transformational milestones that have taken place at both the Royal Bournemouth Hospital and Poole Hospital.



A significant moment occurred in March at the Royal Bournemouth, when we saw the first departments move into the BEACH Building. Radiology and Critical Care moved first, followed by Maternity and Neonatal on 31 March 2025. There was considerable media coverage around the opening of the new Maternity and Neonatal Unit in particular. Leading up to these moves, major stakeholders were offered the chance to tour the new BEACH Building, enabling us to showcase the many benefits of the new facility and provide the opportunity for attendees to raise concerns and ask questions.



On the same day maternity moved into the Royal Bournemouth, after 64 years of delivering an estimated 250,000 babies,

St Mary's Maternity Unit in Poole closed. The public and stakeholders were invited to attend a 'Farewell to St Mary's' event on Saturday 5 April 2025. This event was very well attended and received much media coverage.



In November 2024, stakeholders and partners gathered to witness our Chief Executive Siobhan Harrington and local MP Tom Hayes, break ground on the construction of our new Coast Building. This purpose-built £91m state-of-the-art ward and catering block, will expand patient capacity and elevate University Hospital Dorset's services as part of the national New Hospital Programme.



In advance of all these developments, communication with various key stakeholder groups was increased to ensure they were kept informed of the transformational changes. This included the creation of several new newsletters to target specific stakeholders.

The newsletter 'UHD Update' was created to directly communicate important changes with major stakeholders, such as MPs, the Health

Overview Scrutiny Committee (HOSC), councillors, other nearby hospitals and South West Ambulance Service, to name a few.

A GP newsletter was also developed over the year to provide operational-specific information to GP surgeries.

In addition to newsletters, our Executive Team met face to face with MPs following the change in government in order to gain support for the changes.

HOSCs in Dorset and BCP Council has also been kept informed throughout the changes via publications and UHD representatives presenting at Committee meetings.



Our governors, as always, have been a great ally over this time running a series of in-person public listening and information events throughout the year that gave the public the opportunity to hear about the transformation plans. These listening and engagement events took place across the area in libraries, community or church halls, shopping centres and educational facilities like Bournemouth University and Brockenhurst College. These events are an important communication and engagement channel for Trust members and the public and are also a fantastic way of keeping our ear to the ground on how different stakeholder groups are feeling about the Trust.

In addition, having identified hard to reach areas in the community, governors held talks within targeted locations to reduce health inequalities.



We ran a transformation focused event in Wareham, where the public were most unsettled about the upcoming changes.

A tour of the BEACH Building was hosted for members of Purbeck Primary Care Network, a concerned group. The outcome was very positive and the group was impressed with the facilities and the thought that had gone into the design, stating that the facilities will serve patients well.

These small group tours are planned to continue, especially for stakeholders in the west, to keep everyone informed about our future plans.



We held our Annual Members' Meeting (AMM) in person at St. Saviours Church, Bournemouth on Thursday 12 September. The event, which was also live streamed via Microsoft Teams, included presentations from our Chief Executive, Siobhan Harrington, and Chief Finance Officer, Pete Papworth, on the 2023/24 Annual Report and Accounts and forward planning for 2024/25. Michele Whitehurst, Lead Governor, also gave a presentation on the Council of Governors. Following the AMM, Dr Helen Partridge gave an informative health talk on understanding diabetes.

Our monthly member newsletter has continued throughout the year, providing our 12,000 members with updates of the transformations.

Three editions of *Together* magazine (a printed newsletter for members) were also published - this contained important updates including details of our future development plans and aimed to reach those members without internet access.



The established partnership with Bournemouth University continued to benefit staff from both organisations, students, patients and the public during 2024/2025.

Partnership working enabled successful public health, research and leadership events to take place, and joint research studies were launched and published. These joint studies brought together insights and experience from both organisations and continue to grow in number.

The research and leadership focused events were highpoints of the fourth year of the partnership and two public health talks on pathology and concussion in sport were well attended. UHD governors also attended the Freshers Fair.

The media remained one of our key stakeholder groups over the year. We have built strong relationships with both local and national media and worked closely with them throughout the year. One highlight was a three-part series with BBC South Today, shining a spotlight on our Prosthetics Team.

Patient engagement

Our patients were involved in numerous activities over the last year, informing our teams how their care should be delivered and giving their valuable insights into service redesign.

An example of some of the projects included:

Patient clothing

Patient and relatives were reporting that they were often unable to access their own clean clothes to go home in. In the winter months our transport teams reported that patients were returning to cold homes, which took a while to warm up on return. Our UHD Charity funded two clothing banks in Poole and the Royal Bournemouth hospitals containing new clothes, shoes and blankets to support comfortable and dignified discharges.



Redesigning the Spiritual Care Centre

Our Chaplaincy Team met with faith leaders across the local area and listened to what our community wanted from a spiritual centre in the new BEACH Building. Our community wanted space that could be used by all, they wished for improved facilities for foot washing and storage of shoes, and they wanted a space to be versatile to address peoples' needs of any faith or of no religion. The new centre has been designed with the community to meet their needs for inclusivity.



Peer support volunteers

Patients who have been recently diagnosed with certain conditions have appreciated the clinical staff providing them with information about their condition, but they reported that talking to someone with a similar experience would help them in their journey through illness. We have built on our already existing army of peer support volunteers by introducing the role into cancer care.

Partnership working with unpaid carers

We saw closer working with other acute trusts and voluntary partners across Dorset in a project to improve recognition and the support of unpaid carers. A training programme for our existing ward-based volunteers and wayfinding volunteers has been co-designed with carers and community partners to be delivered in 2025/2026. This builds on UHD's Carers Service which supports carers of patients who are in the care of the Trust.

Staff engagement

With a number of significant changes across our Trust, including our ambitious transformation plans and teams coming together in the years post merger, staff engagement remained a major priority this year.



With a number of significant changes across our Trust, including our ambitious transformation plans and teams coming together in the years post merger, staff engagement remained a major priority this year.

Our Chief Executive Siobhan Harrington, runs monthly face-to-face staff briefings across sites and in public areas to provide an update on operational pressures, our elective recovery, our redevelopment, staff success and any major campaigns.

Colleagues are encouraged to attend or to watch online - the event is broadcast via Microsoft Teams. A recording is also shared on YouTube afterwards with the key messages from the briefing sent to all users of our UHD staff app. Managers are encouraged to use the app and *The Brief* to share information with their teams.



Siobhan and her executive colleagues also host ad hoc informal meetings for staff, for example to mark dates in our awareness calendar or to address issues faced by colleagues. In the summer of 2024, Siobhan hosted a series of listening events for colleagues impacted by the racist riots, and in March 2025 ran a session to address questions following the government's decision to disband NHS England.

As part of her briefings, Siobhan includes an interactive 'slido' element - these allow us to take a 'temperature check' of the Trust and also hear what issues colleagues are facing with people feeding back via their mobile phones. These responses are worked through at our exec meetings and are often included as a 'you said we did' in our monthly publication, *The Brief*.

Alongside the monthly *The Brief*, we publish via email and the intranet an all-staff bulletin twice a week. This contains news, events and operational updates for staff. We also produce newsletters and updates for our three care groups which has enabled us to share more specific information to relatable audiences, and have developed a newsletter template for teams to use in their own departments.

We continue to run our successful monthly 'Ask Me' online meetings. These are led by our senior medical team and give an opportunity for colleagues to hear an update and then ask questions in a very informal setting. Topics range from major NHS changes to issues with parking. They have proved a very engaging way to work with colleagues and receive feedback.



We also host special versions of 'Ask Me' to cover questions around our transformation programme, and to mark key staff network events. A similar model has now been adopted by our UHD Safety Crew to engage staff in safety topics via a monthly 'Learn at Lunch' which have been successfully running now for over a year.

We host a number of face-to-face meetings and events for colleagues, including our popular Schwartz Rounds. This gives staff the opportunity to share their experiences with other colleagues in a safe and non-judgmental environment. Colleagues can also book stands in our main hospital entrances to promote awareness events, gather feedback, or to celebrate the work of their departments.

The transformation of our hospitals to create a major emergency care site at the Royal Bournemouth and a major planned care site at Poole has accelerated, with our BEACH Building at Bournemouth now open and the introduction of a shuttle bus linking Poole and the Royal Bournemouth. Many colleagues have now moved sites or to new facilities, so we have been running a series of tours in preparation for the moves, and to give all colleagues an opportunity to explore the new areas. A regular transformation newsletter is available to staff, with regular updates on the dedicated transformation intranet pages and on social media, and the team carry out walkarounds with the 'transformation trolley' - taking updates to teams in their own areas.

Siobhan continues to run her monthly Staff Excellence Awards, which are very popular for recognising the work of all our colleagues. In June 2024, we held our second UHD staff awards, with over 800 nominations made in a number of categories, culminating in a successful evening at the Pavilion in Bournemouth. The awards brought together teams from across our large organisation and were supported by our UHD Charity as well as external sponsors.



Our UHD staff app continues to thrive, giving all staff access to Trust news, updates, e-Roster, staff networks and our education platform on the go. The app also includes links to our staff wellbeing pages on our intranet that signpost colleagues to support. We also promote these pages across our communications.

Our social media platforms remain key channels of messaging to staff and the public, also working effectively for promotion of our recruitment events. Our 'People Pod' podcast for Trust colleagues, delves into the untold stories of the people at the heart of our hospitals, and is also available online via our intranet, UHD App and Spotify.

The People Pod

Delve into the untold and inspiring stories of the people at the heart of our hospitals...you!

Episode 2: Leadership and Legacy

Pabalelo Pule

Clarence Moore

Fardowsa Ahmed-Timms

Scan to listen on Spotify

Spotify

Remuneration Report

Annual statement on remuneration from the Chair

Major decisions on senior managers' remuneration and terms of service, including salary arrangements for newly appointed executive directors, changes to individual remuneration arrangements and amendments to salary ranges, are made by the Trust's Appointments and Remuneration Committee. For the financial year, a summary of these is set out below including the context in which the changes occurred and decisions taken.

Annual Report on Remuneration

Appointments and Remuneration Committee membership

Members of our Appointments and Remuneration Committee were:



Rob Whiteman
Trust Chair



Pankaj Davé
Non-executive director
(until 30 November 2024)



Judy Gillow
Senior Independent
Director and
Non-executive director



Tracie Langley
Non-executive director
(from 8 January 2025)



John Lelliott
Non-executive director



Femi Macaulay
Non-executive director
(from 8 January 2025)



Helena McKeown
Non-executive director



Sharath Ranjan
Non-executive director



Cliff Shearman
Vice Chair and
non-executive director



Claire Whitaker
Non-executive director

The Chief People Officer attends the Appointments and Remuneration Committee, except when his/her own performance and/or salary are discussed, to act as expert advisor on personnel and remuneration policy. The Chief Executive attends to provide advice on issues concerning the performance of directors and salary ranges except when her own appointment, removal or remuneration are discussed.

The Appointments and Remuneration Committee is a committee of the Board with responsibility for:

- overseeing and taking forward the process for the appointment/removal of the Chief Executive and other chief officers of the Trust
- setting the remuneration allowances and other terms and conditions of office for the Trust's chief officers

The committee reviews information on remuneration for executive directors at other trusts of a similar size and nature, with the aim of ensuring that remuneration of executive directors is fair and appropriate.

Work of the Appointments and Remuneration Committee

The committee met three times during the period, with members' attendance shown below:

Committee member	3 June 2024	12 August 2024	5 March 2025
Rob Whiteman	✓	✓	✓
Pankaj Davé	✓	✓	
Judy Gillow	✓	✓	✓
Tracie Langley			✓
John Lelliott	✓	✓	✓
Femi Macaulay			✓
Helena McKeown	✓	✓	✓
Sharath Ranjan	✗	✓	✗
Cliff Shearman	✓	✗	✓
Claire Whitaker	✓	✗	✓

During the year, Tina Ricketts (Chief People Officer) attended various meetings of the committee to assist and advise.

Meeting date	Committee business considered
3 June 2024	<ul style="list-style-type: none"> Recruitment process for new Chief Digital Officer and the appointment of Hunter Healthcare to provide executive search services. The fee paid for such services was £28,500 and Hunter Healthcare were selected based on a quotation process, involving specific criteria against which potential providers were assessed. Proposed process for appointment of a Deputy Chief Executive with an additional responsibility payment consistent with that received by the former Deputy Chief Executive. Outcome of Executive Director annual performance evaluations. Increase in the Chief Operating Officer's salary to the midpoint of the recommended payscale, having regard to fair market rate and the Trust being in the 'supra-large' trust category.
12 August 2024	<ul style="list-style-type: none"> Appointment of Chief Digital Officer with regard had to the appointee's experience and the size and scale of the Trust's electronic patient record and digital agenda in determining their remuneration. Appointment of Deputy Chief Executive. Very Senior Manager Cost of Living Increase 2024/25 of 5% (as agreed by the Government) to executive directors and two other members of staff on very senior manager terms and conditions backdated to 1 April 2024. Chief Executive Officer - flexible retirement application, with a reduction in contracted hours and pensionable pay.

5 March 2025	<ul style="list-style-type: none"> Recruitment process for new Chief People Officer and the appointment of Odgers Berndston to provide executive search services. The fee payable for such services being £26,400 and Odgers Berndston were selected based on a quotation process, involving specific criteria against which potential providers were assessed. Acting Up: Deputy Chief People Officer from 1 May 2025.
--------------	---

Nominations and Remuneration Committee membership

Our Council of Governors is required to establish a committee consisting of all or some of its members to assist in carrying out specified functions relating to the appointment and remuneration of the Trust Chair and non-executive directors. The committee also reviews the structure, size and composition of the Board. It is chaired by the Trust's Chair, or in their absence, the Vice Chair.

Members of our Nominations, Remuneration and Evaluation Committee were:



Rob Whiteman
Trust Chair



Sharon Collett
Public Governor,
Bournemouth



**Councillor
Beryl Ezzard**
Appointed
Governor: Dorset
Council
(from 4 April 2024)



Rob Flux
Staff Governor:
Administrative, Clerical
and Management



Carrie Stone
Public Governor:
Poole and Rest of
Dorset



Michele Whitehurst
Public Governor:
Poole and Rest of
Dorset, Lead Governor
(from 4 April 2024)



Sandra Wilson
Public Governor:
Christchurch, East
Dorset and Rest of
England

The Committee met six times during the period. Each member attended all meetings that they were eligible to attend*.

In addition, Tina Ricketts, Chief People Officer, attended various meetings of the committee to assist and advise with its consideration of matters related to the recruitment and remuneration of non-executives and an associate non-executive director.

*Beryl Ezzard and Michele Whitehurst were not members of the Committee for its 2 April 2024 meeting.

Meeting date	Committee business considered (✓ = recommendations approved by the Council of Governors)
2 April 2024	<ul style="list-style-type: none"> • Report of the committee's work for 2023/24 for the Trust's annual report ✓ • Remuneration and allowance of the Trust Chair and non-executive directors payable from 1 April 2024 including a report from Korn Ferry prepared in the previous financial year ✓ • Succession planning for non-executive directors, including a non-executive director skills matrix
31 May 2024	<ul style="list-style-type: none"> • Non-executive directors' recruitment process including executive search agency to be used, timeline and marketing of roles to a diverse range of candidates to support the future diversity of the Board ✓ • Quotes were sought from three separate companies to support achieving value for money. Hunter Healthcare was appointed by the Chief People Officer following this exercise based on specific scoring criteria, which included (among others) focus on attracting a diverse range of candidates. The fees paid for such services were £21,400 plus VAT. • Outcome of the Chair's and non-executive directors' annual performance evaluation; Fit and Proper Persons ✓
29 July 2024	<ul style="list-style-type: none"> • Non-executive directors recruitment process - composition of shortlisting panel and interview panel as well as proposals for carousel sessions. • Committee terms of reference ✓
3 October 2024	<ul style="list-style-type: none"> • Non-executive and associate director preferred candidate appointments and proposed remuneration; extension of term of office for Pankaj Davé ✓ • Committee governance cycle • Governor absences from Council of Governors' meetings
9 January 2025	<ul style="list-style-type: none"> • Methodology for the Trust Chair and non-executive directors' 2024/25 performance evaluation ✓ • Proposed amendments to committee's governance cycle • Outcome of the Fit and Proper Persons process for the new non-executive and associate non-executive directors • Governors' absences from Council of Governors' meetings
31 March 2025	<ul style="list-style-type: none"> • Chair and non-executive director terms of office: recruitment process ✓ • Remuneration and allowance of the Trust Chair and non-executive directors payable from 1 April 2025 • Report of the committee's work for 2023/24 for the Trust's Annual Report ✓ • Governors' absences from Council of Governors' meetings ✓

The committee's terms of reference are available here: [Nominations, remuneration and evaluation Committee - terms of reference](http://www.uhd.nhs.uk/uploads/about/docs/our_publications/nrec_terms_of_reference_final_v2.0.pdf) (www.uhd.nhs.uk/uploads/about/docs/our_publications/nrec_terms_of_reference_final_v2.0.pdf).

Non-executive directors appointed during the period

During the year, we welcomed two new non-executive directors, Femi Macaulay and Tracie Langley to our Board. Following a long list meeting of the selection panel, shortlisted candidates were invited to attend preliminary interviews, with a final interview taking place.

Senior Managers' Remuneration Policy

The Trust Senior Managers' Remuneration Policy in relation to duration of contracts, notice periods, and termination payments is summarised here.

- All executive directors are required to provide six months' written notice, however in appropriate circumstances this could be varied by mutual agreement.
- There are no payments for loss of office other than standard NHS redundancy provisions.

Our Board vacancies are advertised nationally with a targeted approach to ensure we attract a diverse range of candidates that match the composition of our overall workforce and local community. The Trust operates a reverse mentor programme to support the development of a diverse pipeline. The effectiveness of the Board is evaluated annually through self-assessment. Equality, diversity and inclusion is a core component of the Trust's culture, with one of our values being 'we are inclusive'. Please refer to the Staff Report below in relation to the policy on diversity and inclusion.

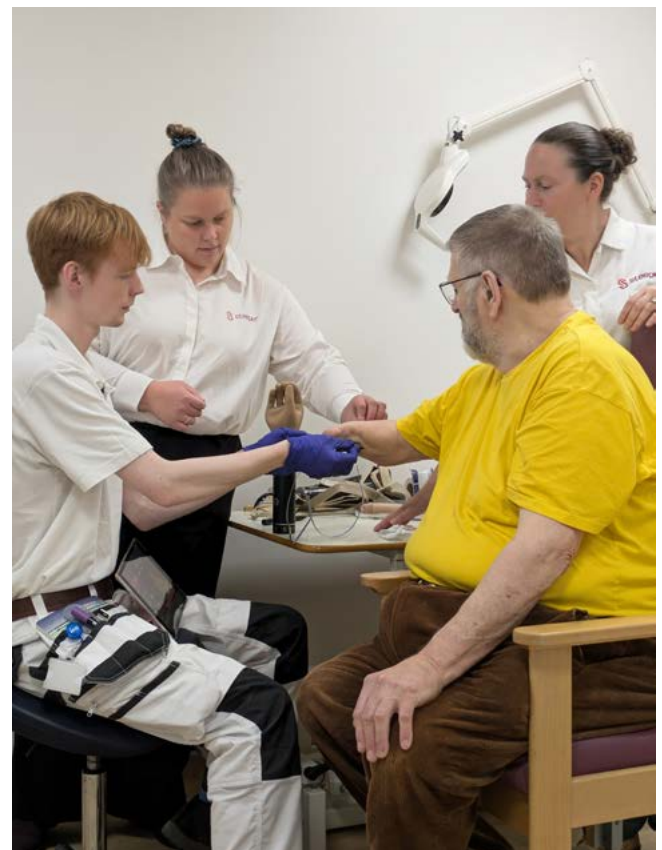
In addition, a skills assessment helps inform Board succession planning.

Disclosures relating to specific pay and remuneration matters

Remuneration for senior managers is set out below. Most other staff within the NHS have contracts based on Agenda for Change national terms and conditions, which is the single pay system in operation in the NHS.

Doctors, dentists, very senior managers and directors have separate terms and conditions. Pay circulars inform of changes to pay and terms and conditions for medical and dental staff, doctors in public health medicine and the community health service, along with staff covered by Agenda for Change.

The expenses of directors and staff governors are reimbursed in accordance with the Trust's policy on expenses applicable to all staff. Travel and other costs and expenses for all other governors are reimbursed in accordance with a separate policy. Governors are volunteers and do not receive any remuneration for their roles.



Service contracts

Name of senior manager	Title	Date of appointment	Unexpired term	Notice period
Siobhan Harrington	Chief Executive	1 June 2022	Current	6 months
Beverley Bryant	Chief Digital Officer	28 October 2024	Current	6 months
Sarah Herbert	Chief Nursing Officer	13 May 2024	Current	6 months
Fiona Hoskins	Acting Chief Nursing Officer	10 April 2024	10 May 2024	N/A
Mark Mould	Chief Operating Officer	1 October 2020	Current	6 months
Pete Papworth	Chief Finance Officer	1 October 2020	Current	6 months
Richard Renaut	Chief Strategy and Transformation Officer	1 October 2020	Current	6 months
Tina Ricketts	Chief People Officer	26 February 2024	30 April 2025	6 months
Paula Shobbrook	Chief Nursing Officer	1 October 2020	9 April 2024	6 months
Dr Peter Wilson	Chief Medical Officer	1 April 2023	Current	6 months
Rob Whiteman	Trust Chair	1 July 2022	31 March 2025	1 month
Pankaj Davé	Non-executive director	1 October 2022	30 November 2024	1 month
Judy Gillow	Senior Independent Director, Non-executive director	3 April 2023	1 May 2025*	1 month
Tracie Langley	Non-executive director	6 January 2025	5 January 2028	1 month
John Lelliott	Non-executive director	1 October 2023	30 September 2025	1 month
Femi Macaulay	Non-executive director	16 December 2024	15 December 2027	1 month
Helena McKeown	Non-executive director	1 October 2023	30 September 2026	1 month
Sharath Ranjan	Non-executive director	3 April 2023	2 April 2026	1 month
Cliff Shearman	Vice-Chair; Non-executive director	1 October 2023	30 September 2025	1 month
Claire Whitaker	Non-executive director	1 October 2023	30 September 2026	1 month

Note: Date of appointment to post shown above rather than date of contract. Where a non-executive director's term has been extended, the date of commencement of the extended term is shown above.

* Judy Gillow's role as Senior Independent Director and non-executive director ended contemporaneous with her becoming Interim Chair following internal expressions of interest having been invited from non-executive directors and the Council of Governors appointing her to the role.

Disclosures relating to specific pay and remuneration matters

Senior manager remuneration

Senior manager remuneration												
Name	Title (as at 31 March 2025)	Twelve months ended 31 March 2025					Twelve months ended 31 March 2024					
		Salary and fees	Other remuneration	Total salary and fees	Pension related benefits	Total	Salary and fees	Other remuneration	Total salary and fees	Pension related benefits	Total	
		(bands of £5000)	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £5000)	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Executive members												
Siobhan Harrington	Chief Executive Officer (See notes 1 and 2)	235-240	-	235-240	0.0	235-240	235-240	-	235-240	-	235-240	
Peter Wilson	Chief Medical Director (See note 3)	230-235	-	230-235	62.5- 65.0	290-295	215-220	-	215-220	120.0-22.5	340-345	
Pete Papworth	Chief Finance Officer (see notes 4 and 5)	175-180	-	175-180	32.5- 35.0	210-215	165-170	-	165-170	22.5-25.0	190-195	
Paula Shobbrook	Chief Nursing Officer (See note 6)	0-5	-	0-5	0.0	0-5	160-165	-	160-165	-	160-165	
Fiona Hoskins	Acting Chief Nursing Officer See notes (7 and 8)	10-15	-	0-5	0.0	10-15	N/A	N/A	N/A	N/A	N/A	
Sarah Herbert	Chief Nursing Officer (See notes 9 and 10)	125-130	-	0-5	175.0-177.5	300-305	N/A	N/A	N/A	N/A	N/A	
Mark Mould	Chief Operating Officer (See note 11)	170-175	-	170-175	105.0-107.5	275-280	155-160	15-20	175-180	-	175-180	
Richard Renaut	Chief Strategy and Transformation Officer (See note 12)	160-165	-	160-165	10.0-12.5	175-180	155-160	-	155-160	-	155-160	
Beverley Bryant	Chief Digital Officer (Seenotes 13 and 14)	80-8 5	-	80-85	17.5-20.0	100-105	N/A	N/A	N/A	N/A	N/A	
Tina Ricketts	Chief People Officer (see notes 15,16 and 17)	160-165	5 -10	170-175	215.0-217.5	385-390	10-15	-	10-15	-	10-15	
Non-executive members												
Rob Whiteman CBE	Chairman	50-55	-	50-55	N/A	50-55	50-55	-	50-55	N/A	50-55	
Cliff Shearman OBE	Non Executive Director	15-20	-	15-20	N/A	15-20	15-20	-	15-20	N/A	15-20	
Judy Gillow MBE	Non Executive Director	15-20	-	15-20	N/A	15-20	15-20	-	15-20	N/A	15-20	
Helena McKeown	Non Executive Director	15-20	-	15-20	N/A	15-20	5-10	-	5-10	N/A	5-10	
Sharath Ranjan	Non Executive Director	15-20	-	15-20	N/A	15-20	15-20	-	15-20	N/A	15-20	
Claire Whitaker CBE	Non Executive Director	15-20	-	15-20	N/A	15-20	5-10	-	5-10	N/A	5-10	
John Lelliott OBE	Non Executive Director	15-20	-	15-20	N/A	15-20	15-20	-	15-20	N/A	15-20	
Pankaj Davé	Non Executive Director (See note 18)	10-15	-	10-15	N/A	10-15	15-20	-	15-20	N/A	15-20	
Femi Macaulay	Non Executive Director (See note 19)	0-5	-	0-5	N/A	0-5	N/A	N/A	N/A	N/A	N/A	
Tracie Langley	Non Executive Director (see note 20)	0-5	-	0-5	N/A	0-5	N/A	N/A	N/A	N/A	N/A	

Notes:

- Siobhan Harrington is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- Siobhan Harrington drew her NHS pension on 31 October 2024 and reduced hours to 0.9wte.
- Peter Wilson is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- Pete Papworth is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- Pete Papworth also held the position of Chief Digital Officer from 1 April 2024 to 27 October 2024.
- Paula Shobbrook retired and drew her pension on 9/4/24.
- Fiona Hoskins was Acting Chief Nursing Officer between 10 April 2024 and 10 May 2024.
- Fiona Hoskins is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- Sarah Herbert was appointed Chief Nursing Officer on 13 May 2024.

- 10** Sarah Herbert is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 11** Mark Mould is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 12** Richard Renaut is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 13** Beverley Bryant was appointed Chief Digital Officer on 28 October 2024.
- 14** Beverley Bryant is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 15** Tina Ricketts is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 16** Tina Ricketts drew her pension on 31 January 2025 and reduced hours to 33.75 hours.
- 17** Tina Ricketts received £8,666 for relocation and removal expenses.
- 18** Pankaj Davé concluded his post as a Non-Executive Director on 30 November 2024.
- 19** Femi Macaulay commenced as Non-Executive Director on 16 December 2024.

- 20** Tracie Langley commenced as Non-Executive Director on 6 January 2025.
- 21** There are 21 governors (including staff governors) at the end of March 2025, of which four received expenses during the period amounting to a total of £296.
- 22** Senior management remuneration does not include any annual related bonus or long-term related bonuses for the period.
- 23** No individual above received any significant benefits in kind for the period.
- 24** No other categories in the proforma single table are relevant to the Trust for the period.
- 25** Of the 20 senior managers in the table above, there were £3,549 expenses claimed for the period.

Remuneration pay ratios

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce. The banded remuneration of the highest-paid director in the organisation in the financial year 2024-25 was £245k-£250k (2023-24, £235-£240k). This is a change between years of 4.2%. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2024-25 was from £20k-£25k to £245k-£250k (2023-24, £20k-£25k to £235k-£240k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 6.2%. No employees received remuneration in excess of the highest-paid director in 2024-25.

Table illustrating pay ratio disclosure and derivations

	2024/25	2023/24	Percentage Change
Band of highest paid director (Annualised)	245-250	235-240	4.2%
Median Total Remuneration	37,479	36,844	1.7%
Ratio	6.6	6.4	2.4%
25th Percentile Total Remuneration	29,114	27,596	5.5%
Ratio	8.5	8.6	-1.2%
75th percentile Total Remuneration	49,889	48,984	1.8%
Ratio	5	4.8	2.3%

Senior manager pension entitlements

Senior manager pension entitlements									
Name	Title (as at 31 March 2025)	Real Increase in pension at retirement age	Real Increase in pension lump sum at retirement age	Total accrued pension at retirement age at 31 March 2025	Lump sum at retirement age at 31 March 2025	Cash equivalent transfer Value at 1 April 2024	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2025	Employer's contribution to stakeholder pension
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£'000	£'000	£'000	£'000
Siobhan Harrington	Chief Executive Officer	0	0	85-90	215-220	472	0	237	34
Peter Wilson	Chief Medical Director	2.5-5.0	0.0-2.5	90-95	235-240	1,886	76	2,117	33
Pete Papworth	Chief Finance Officer	2.5-5.0	0	40-45	95-100	680	21	768	25
Paula Shobbrook	Chief Nursing Officer	0	0	0-5	0	1,674	0	3	1
Fiona Hoskins	Acting Chief Nursing Officer	0.0-2.5	0	45-50	125-130	1,026	0	1,111	5
Sarah Herbert	Chief Nursing Officer	7.5-10.0	17.5-20.0	35-40	85-90	506	166	745	17
Mark Mould	Chief Operating Officer	5.0-7.5	7.5-10.0	70-75	200-205	1,526	123	1,773	25
Richard Renaut	Chief Strategy and Transformation Officer	0.0-2.5	0	55-60	140-145	1,100	13	1,207	22
Beverley Bryant	Chief Digital Officer	0.0-2.5	0.0	50-55	0	718	12	817	12
Tina Ricketts	Chief People Officer	10.0-12.5	22.5-25.0	40-45	115-120	761	240	1,073	23

Notes:

- Siobhan Harrington is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- Siobhan Harrington drew her NHS pension on 31 October 2024 and reduced hours to 0.9wte.
- Peter Wilson is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.
- Pete Papworth is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- Paula Shobbrook retired and drew her pension on 9/4/24.
- Fiona Hoskins was Acting Chief Nursing Officer between 10 April 2024 and 10 May 2024.
- Fiona Hoskins is affected by the Public Service Pensions Remedy and their

membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.

- 8** Sarah Herbert was appointed Chief Nursing Officer on 13 May 2024.
- 9** Sarah Herbert is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 10** Mark Mould is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 11** Richard Renaut is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 12** Beverley Bryant was appointed Chief Digital Officer on 28 October 2024.
- 13** Beverley Bryant is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 14** Tina Ricketts is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
- 15** Tina Ricketts drew her pension on 31 January 2025 and reduced hours to 33.75 hours.

Cash Equivalent Transfer Values

CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated as prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.



Siobhan Harrington
Chief Executive
18 June 2025

Board's responsibility for the Annual Report and Accounts

The directors are required by the National Health Service Act 2006 (as amended) to:

- prepare, in respect of each financial year, Annual Accounts in such form NHS England, may, with the approval of the Secretary of State, direct
- comply with any directions given by NHS England with the approval of the Secretary of State as to the methods and principles according to which the accounts are prepared and the content and form to be given in the accounts

The Accounts must provide a true and fair view and comply with International Financial Reporting Standards and the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25. In preparing the Annual Report and Accounts, the directors are required to:

- select suitable accounting policies and apply them consistently
- make judgements and estimates that are reasonable and prudent; and prepare the Annual Report and Accounts on the going concern basis, unless it is inappropriate to do so.

The Board has reviewed the Annual Report and Accounts, having taken into account all the matters considered by the Board and brought to the attention of the Board during the reporting period. The Board consider that taken as a whole, the Annual Report and Accounts are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. In the case of persons who are directors as at the date when this report is approved:

- so far as each of the directors is aware, there is no relevant audit information of which the Trust's auditor is unaware
- each of the directors has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information. This confirmation is given and should be interpreted in accordance with section 418 of the Companies Act 2006.



Siobhan Harrington
Chief Executive
18 June 2025



Staff Report

Our People Strategy sets out how we will unite our workforce behind our vision and make our Trust a great place to work. We have a number of exciting developments due to take place over the next few years, coupled with an ambitious transformation agenda. That is why engagement, health and wellbeing, and support to our colleagues remains a key priority.



Be a great place to work

Our People Strategy drives the actions required to keep our people safe, healthy and well, both physically and psychologically, and provides the necessary support and development needed to continue to deliver the highest possible standards of care in an environment of high demand, and at a time of significant change in the way patient services are organised and delivered across Dorset.

Successful delivery of this strategy will create a positive staff experience where the communities we serve will see us as an employer of choice, enabling us to attract and retain the best people. We continue to recognise the importance of engaging and involving our people, and despite the challenging times ahead for us and the wider NHS, it is essential that we continue to hold this at the heart of everything that we do.

Our People Strategy has five key action themes which, through service integration, will enable appropriate support and care for our people while strengthening our organisational capabilities.

During the period of the report, high operational demands have continued, and our staff demonstrated unwavering commitment throughout to provide excellent patient care.

Our commitment aligned to our strategy

- 1 Our culture remains values based where colleagues feel they belong, they have a voice and feel valued and respected
- 2 Our workforce will be representative at all levels. Colleagues will be well led and empowered to deliver better outcomes and performance for our patients
- 3 Our staff offer will attract and retain the best people
- 4 Our workforce will be sustainable and organised to provide the optimum patient and staff experience
- 5 Our People and Culture function will be organised around the employee journey and will support teams across the Trust to deliver their priorities

Everyone at our Trust plays a part in creating a great place to work.

Our key focus has remained on enabling staff to be healthy in 'body and mind', help them function effectively, strengthening our organisational capability. Our Occupational Health Team has played a vital role in supporting the management of complex cases, offering expert guidance to managers to help staff remain in, or return to work safely, and have been instrumental in supporting the Trust's flu and Covid vaccination programme in easily accessible and efficient clinics. The team's commitment and innovation were recognised with an NHS Health at Work Network Recognition Award for their Grow and Enhance Occupational Health initiative, celebrating their dedication to continuously improving occupational health provision across the Trust.



Our in-house Psychological Support and Counselling Service is well established and provides psychological support to staff. In addition, TRiM (Trauma Risk Management) continues to be an important element of our staff support offer, providing structured peer support to colleagues who have experienced potentially traumatic events at work.

The Staff Physiotherapy Service continues to make a valuable contribution to workforce health by providing timely, evidence-based support for musculoskeletal issues. The service has also been recognised nationally, receiving a Highly Commended award from the NHS Health at Work Network for its innovative and embedded Musculoskeletal Therapy Service.

Work has continued to bring teams together at service and function level through a robust workforce planning 'People Ready' workstream as we move towards the Royal Bournemouth Hospital becoming the major emergency hospital and Poole Hospital becoming the major planned hospital.

Recruitment remains challenging with market forces meaning significant challenges in sourcing candidates for an increasing number of hard to fill roles, so improving our reach and attraction of candidates via an increased use of social media and focused marketing remains important to us.

Our student capacity and clinical apprenticeship programmes are expanding as we continue to work collaboratively with higher education institutions and Dorset Integrated Care System to support workforce demand, in line with the current NHS Long term Workforce Plan.

Healthcare support worker recruitment was an area of focus during the year, with a lot of progress being made in filling our vacancies. We have continued to hold large-scale recruitment events over the year, often interviewing, carrying out assessments and progressing recruitment checks to a high number of candidates on the day. These

roles are of great interest to a wide range of applicants, and offer full training, so is accessible for anyone looking for an entry point to a longer-term career within the NHS. We have been busy on social media over the year, growing and engaging our staff and the public, resulting in an increasing number of followers to our recruitment videos and activity, on Twitter, Facebook, Instagram and Linked In.

Our Temporary Staffing Service has experienced a continued high level of demand for temporary staffing across the Trust, within the period, The service has moved to a paperless provision for several processes, providing a positive, sustainable and secure user experience.

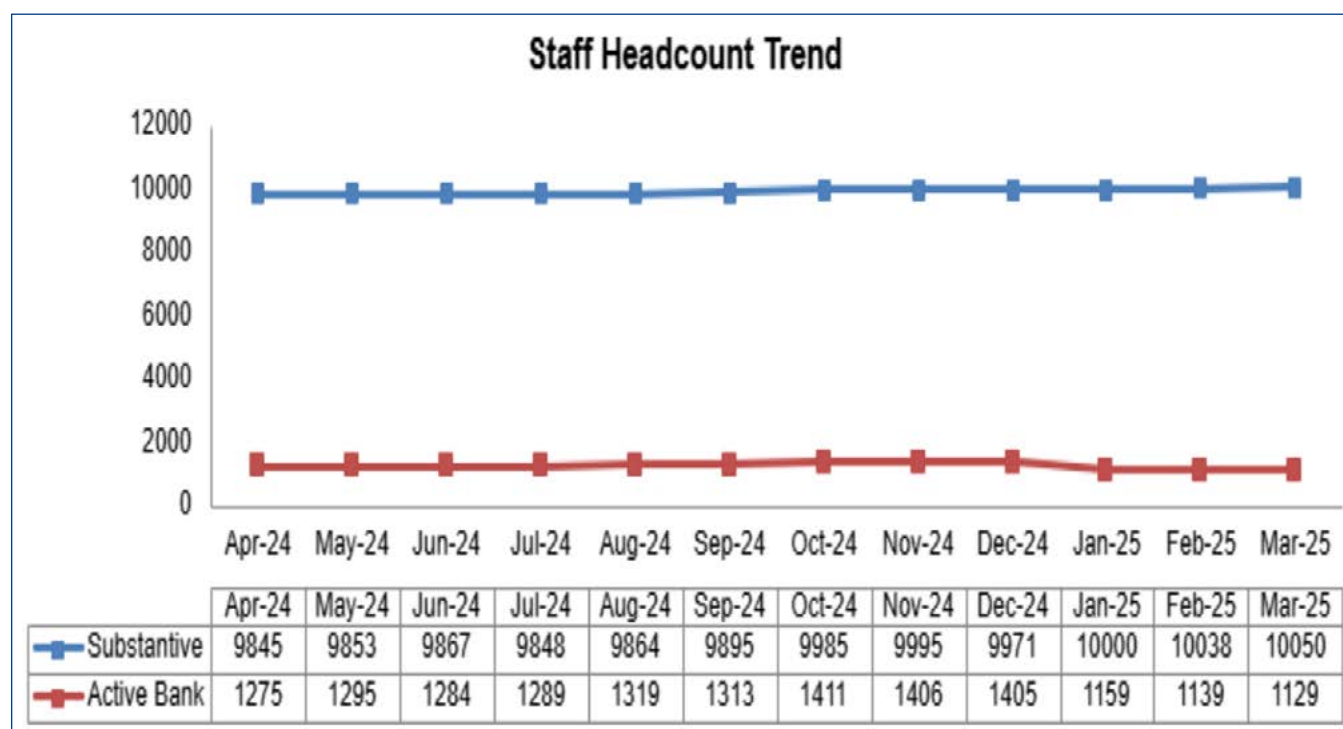
Retaining our current workforce continues to be a priority for the Trust and we continue to offer more flexible, varied roles. We recognise that flexible working is about more than just retention; flexible working can unlock new opportunities and contribute to people's mental health, wellbeing and engagement with their role, and we know that in the NHS more engaged staff leads to better patient care. This will be achieved through the previous developed flexible and agile working policies and through our People Strategy.

Within the Trust we pride ourselves on the delivery of safe and high-quality care. Every single person working within this organisation makes a difference to the quality of care provided.



Staff numbers

The headcount of substantive staff employed in April 2024 was 9,845 and this figure stands at 10,050 heads as at March 2025. This demonstrates an improvement with recruitment and retention, although it is recognised that there is more work and focus required in some areas.



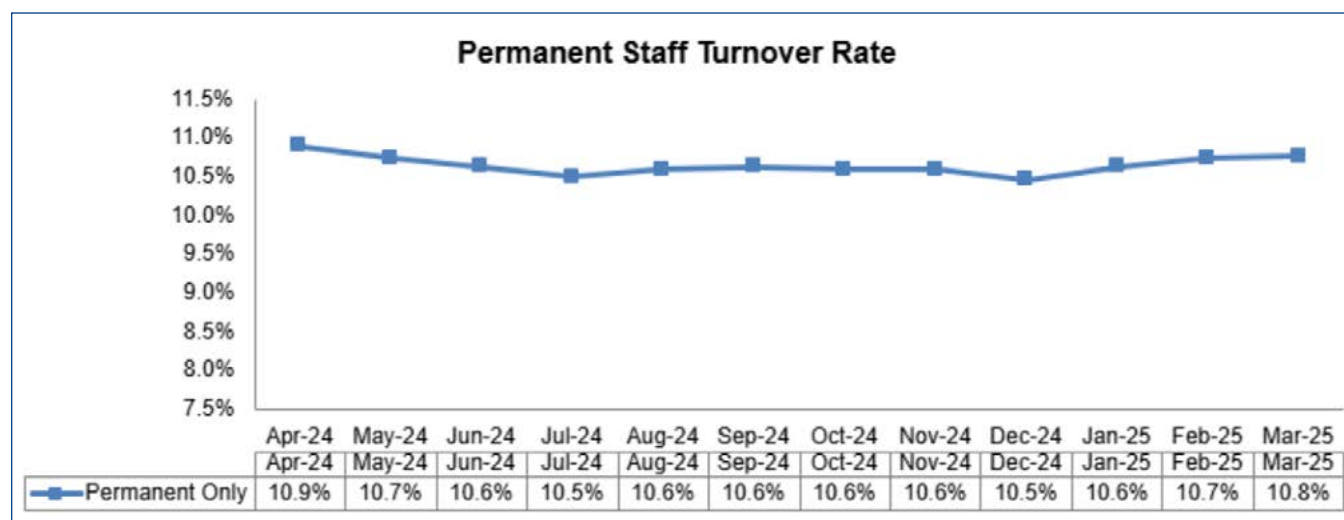
Average number of employees (WTE basis)

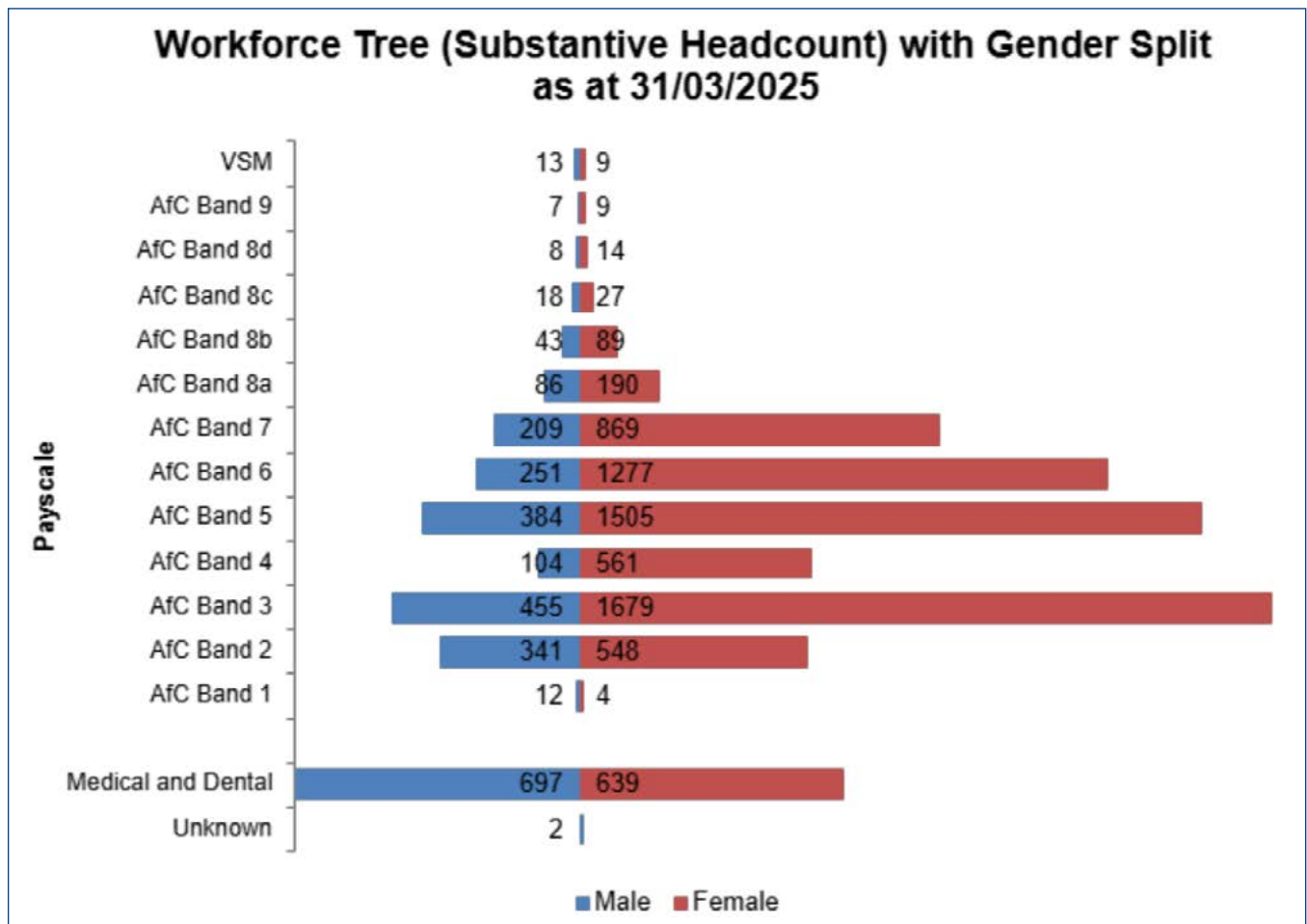
	2024/25			2023/24
	Permanent number	Other number	Total number	Total number
Medical and dental	1,245	198	1,443	1,476
Ambulance staff	1	-	1	0
Administration and estates	1,289	76	1,364	1,335
Healthcare assistants and other support staff	1,217	396	1,613	1,683
Nursing, midwifery and health visiting staff	2,500	322	2,821	2,923
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	2,327	93	2,421	2,336
Healthcare science staff	217	5	222	190
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	8,795	1,090	9,885	9,942
Of which:				
Number of employees (WTE) engaged on capital projects	117	4	120	84

Staff costs

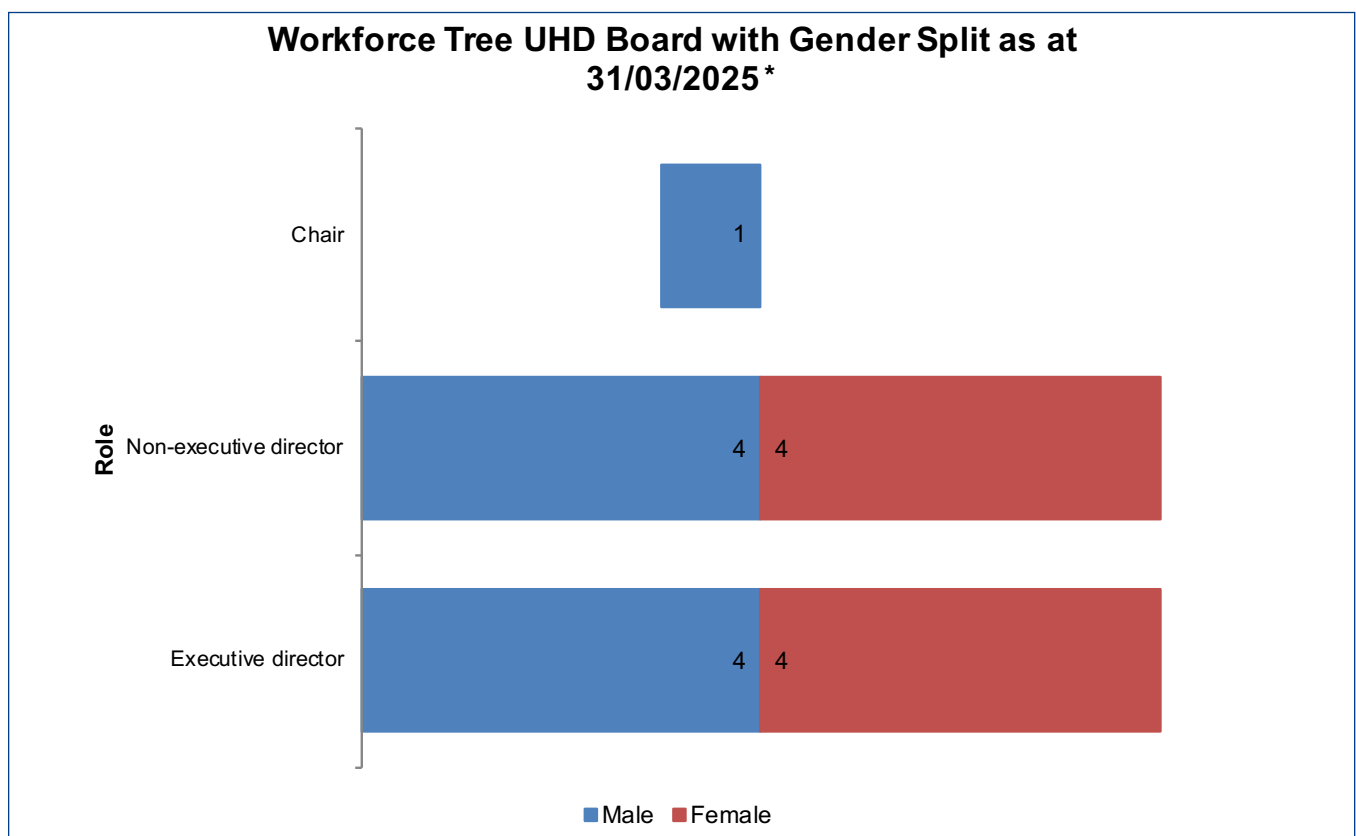
	2024/25			2023/24
	Permanent	Other	Total	Total
	£'000	£'000	£'000	£'000
Salaries and wages	461,284	-	461,284	414,027
Social security costs	46,919	-	46,919	44,178
Apprenticeship levy	2,269	-	2,269	2,139
Employer's contributions to NHS pension scheme	89,890	-	89,890	69,858
Pension cost - other	72	-	72	93
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	13,641	13,641	25,560
NHS charitable funds staff	-	-	-	-
Total gross staff costs	600,434	13,641	614,075	555,855
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	600,434	13,641	614,075	555,855
Of which				
Costs capitalised as part of assets	5,220	287	5,507	3,483

Across the Trust, turnover remained stable throughout the period, beginning at 10.9% in April 2024 and closing at 10.8% at the end of March 2025. This figure includes substantive staff who moved to bank-only contracts.





Information on gender pay gap can be found at: <https://gender-pay-gap.service.gov.uk>

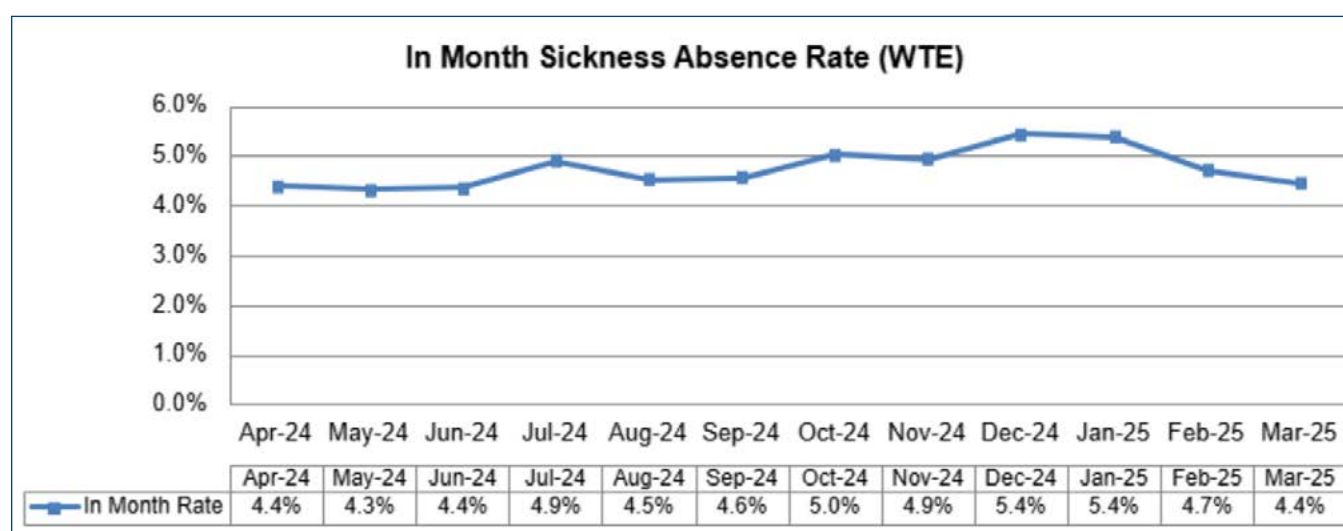


*This does not include one female and one male associate non-executive director and the one male Medical Director - Integrated Care (GP)



Sickness absence data

Sickness absence levels have improved and reduced from 2023. There were increases aligned to winter pressures and illnesses, but these saw an improvement from January 2025.



Information on counter fraud

The Trust has an Anti-fraud, Bribery and Corruption Policy in place, endorsed by senior management and the Trust's Audit Committee. The People Directorate maintain strong links with the Counter Fraud Team, and also take a lead as the Trust's counter fraud champion.

Exit packages/settlement agreements

Within all large organisations there will be occasional disputes between staff. We have several measures in place to prevent and address these when they happen, including a robust reporting system for bullying and harassment; facilitated meetings; mediation, performance management, disciplinary and grievance processes. Occasionally it may not be possible to resolve employee relations issues and consideration may be given to negotiating a settlement agreement, particularly where a case may escalate to an employment tribunal. Often settlement is made on commercial grounds and does not necessarily indicate any fault with our processes. There was one special severance payment (non-contractual) made within this period.

Reporting of compensation schemes - exit packages 2024/25

In 2024/25 there were no compulsory redundancies (none in 2023/24) and a total of 45 agreed departures (one in 2023/24 at a cost of £17,000), of these agreed departures none related to a senior manager of the Trust (none in 2023/24). A breakdown of the different price ranges and types of agreed departures are identified in the two tables below:

	2024/25		
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
< £10,000	-	33	33
£10,000 - £25,000	-	6	6
£25,001 - 50,000	-	3	3
£50,001 - £100,000	-	3	3
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total number of exit packages by type	-	45	45
Total cost (£)	£0	£495,000	£495,000

Risk management

Risk management and health and safety training is included on induction and mandatory training programmes, with additional risk assessment, duty of candour and root cause analysis training sessions for clinical leads, heads of department and ward leaders.

Staff policies

Our People Policy sub group, which includes representatives from People Services and Staff Side colleagues, continue to work in partnership to review our people policies, embedding fairness across the Trust through compassionate leadership and a restorative, just and learning approach. Policies are ratified through the Staff Partnership Forum. The number of existing or new HR policies, including medical staffing, that were agreed in partnership with trade unions from April 2024 - March 2025 was 28. As an accredited disability confident employer, job applicants

with a recognised disability who meet the minimum essential criteria for a role, are offered an interview. This applies to both internally and externally advertised posts.

Occupational health

The Occupational Health Service (OH) is a multi-discipline

service comprising of specialist nurses, specialist physiotherapists and a doctor working alongside a team of administration staff.

Occupational health is a specialist branch of medicine focusing on the health of staff in the workplace. We understand the impact work has on staff health and we provide support to manage health at work. Equally, we make sure that our staff are fit to undertake the role they are employed to do both physically and emotionally.



We advise on work-related illnesses and accidents, carry out assessments for new starters and existing employees, monitor the health of employees and support preventive measures.

Our OH services also assist the Trust in managing short and long-term absence and supporting staff to return to work and to work safely and effectively.

The Staff Physiotherapy Service offers physiotherapy appointments, advising on recovery from injury and musculoskeletal pain, supporting staff to remain in work in a healthy way.

The Psychological Support and Counselling Service is here to support colleagues with stress and mental health related symptoms and difficulties that affect their wellbeing at work. We provide assessment, intervention, referral, and signposting to promote the emotional and psychological wellbeing of all.

Our aim is to support staff to build resilience, achieve improved emotional wellbeing and maintain a healthy work-life balance, ensuring they feel supported and able to thrive both personally and professionally. We provide a totally confidential, evidence-based therapy and support service.

The Trade Union - (Facility Time Publication Requirements) Regulations 2019

University Hospitals Dorset NHS Foundation Trust **1 April 2024 to 31 March 2025**

Relevant union officials

The total number of employees who were relevant trade union officials during the relevant period:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
46	41.13

Percentage of time spent on facility time

Employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	30
1-50%	16
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

The figures requested in the first column of the table below determine the percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

Provide the total cost of facility time	£62,283
The total pay bill	£456,130,000
The percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.0137%

Paid trade union activities

If trade union activities have been paid, this will have been included in facility time calculations.

Organisational Development

We have continued to develop our organisational development offers to meet demand from colleagues for development opportunities and consultancy support and development from colleagues. Our work has become more defined and focused through our People and Culture Strategy, which has identified and outlined our commitment to delivering core programmes of work where organisational development plays a crucial role, ensuring the success and sustainability of the strategy as we strive to make our Trust a great place to work.

Culture and engagement

The UHD Culture Champions undertook the “UHD Big Conversation” to help share messages about our long-term strategy and Patient First Improvement Programme. Staff felt senior leaders needed to be more visible, poor behaviour needs to be addressed more consistently and improvement needs to be made in communication dissemination across all platforms. It was also noted that good leadership and culture across our Trust needs to be more widely showcased, and staff want to be able to access development.



Patient First

Provide excellent healthcare. Be a great place to work.

These messages were shared with our board and senior leaders and will support the design and direction of the 2025/26 People and Culture Champion Programme.

As part of the development of the People and Culture Strategy, we have focused on designing a ‘Culture Plan’ template to support care groups and directorates to

take ownership, and improve their National Staff Survey results from a 2023 baseline to ensure a values-based and inclusive culture where colleagues feel respected, valued and included at work. Work is being undertaken to share this framework across our Trust so that in the future, they are part of Care Group and Corporate Service Board meetings and the Strategy Deployment Reviews, ensuring that culture is seen as being just as important as performance.

Staff surveys

The National Staff Survey (NSS) is a fundamental measure of how our staff feel about working at our Trust, empowering

us all to take meaningful action to make UHD a great place to work. The NSS is now a crucial benchmark to measure the progress of our People and Culture Strategy and the Patient First strategic goals and breakthrough objectives. Further work was also carried out throughout the year to give teams a ‘heatmap’, giving them access to bespoke data and feedback for their area.

In 2024 we ran another successful campaign, making sure we remained one of the earliest trusts to ‘go live’ on the survey, giving staff as long as possible to share their views. Before the survey went live, we ran several open support sessions for managers to raise awareness of the NSS and share how it aligns with UHD’s strategy of continuous improvement. These were essential in enhancing their knowledge and understanding, growing their confidence on the core elements of the survey cycle and providing them with practical tools and tips to encourage and empower their staff to provide feedback and have ownership over action planning for improvement.

UHD results are benchmarked against 122 acute and acute community trusts and 65 comparators through IQVIA.



There are many positive areas of note in this year's National Staff Survey. Our continued support and engagement with our staff were reflected in our response rate of 57.6% (5,689 staff). Although a marginal decrease compared to 2023 (58.7%) this is significantly higher than the national comparator median response rate (122 acute and acute community trusts) of 49%.

The 2024 Staff Engagement Theme score is 6.90. While slightly lower than 2023 (6.96), it is better than the average result for our comparator group (6.84). The 2024 People Promise question 'I would recommend my organisation as a place to work' is 62.96%. While lower than 2023 (63.50%), it is significantly better than the average result for our comparator group (60.90).

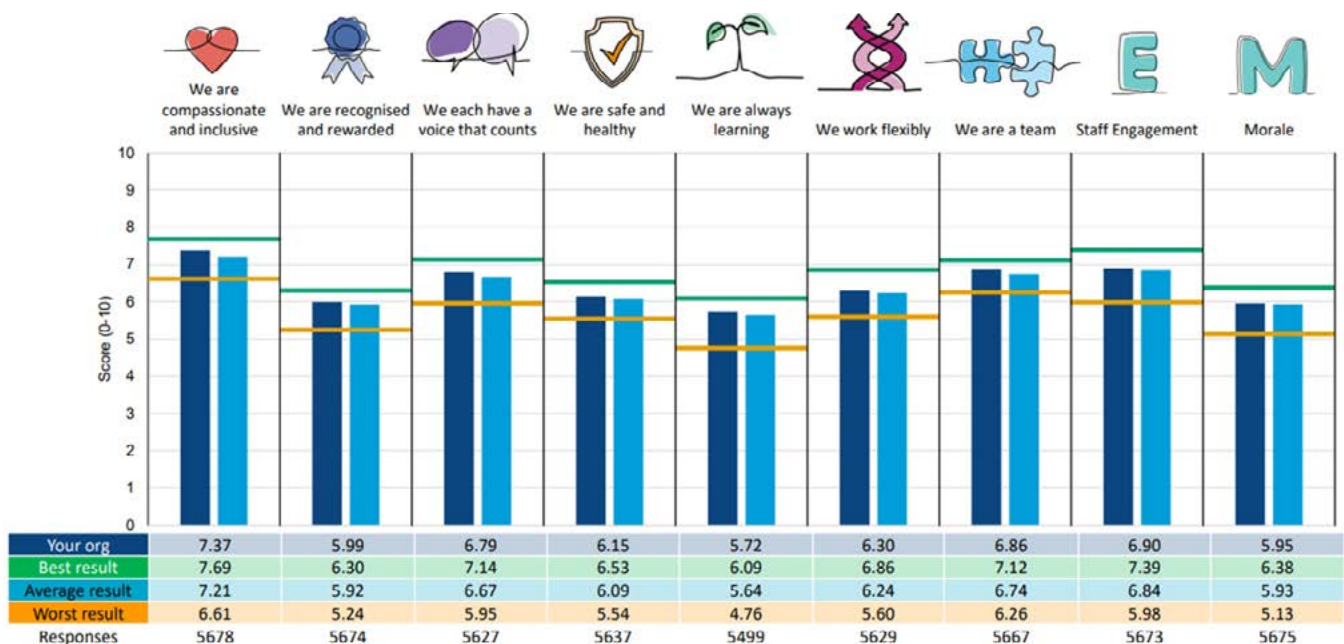
Bank staff responses are not included in the Trust's overall results for the 2024 survey and are reported separately. The response rate for 2024 (27%) showed a 4%

decrease compared to 2023 (31%) results. As we continue to survey Bank staff on their experience of working for the Trust, we will build a better picture in terms of trends and analysis.

Alongside this, we have consistently increased our engagement for the quarterly People Pulse Survey. This has provided us with a rich understanding of what our staff feel UHD is getting it right in terms of staff experience and where we need to focus our efforts to further improve.

Our results demonstrate that our performance is better than average in all People Promise elements and themes compared to our comparator groups. Compared to our 2023 survey, our People Promise element scores show no declining trends of statistical importance, with two showing significant statistical improvement. (People Promise 4: We are safe and healthy, and People Promise 5: We are always learning).

Here is an overview of the People Promise themes:



	People promise elements and themes	UHD 2024 Results	2024 Benchmarking group average results	UHD 2023 Results	2023 Benchmarking group average results	UHD 2022 Results	2022 Benchmarking group average results
	We are compassionate and Inclusive	7.37	7.21	7.38	7.24	7.30	7.2
	We are recognised and rewarded	5.99	5.92	5.97	5.94	5.70	5.7
	We each have a voice that counts	6.79	6.67	6.79	6.70	6.70	6.6
	We are safe and Healthy	6.15	6.09	-	-	5.80	5.9
	We are always learning	5.72	5.64	5.63	5.61	5.30	5.4
	We work flexibly	6.30	6.24	6.27	6.20	6.0	6.0
	We are a team	6.86	6.74	6.83	6.75	6.7	6.6
	Staff Engagement	6.90	6.84	6.96	6.91	6.8	6.8
	Morale	5.95	5.93	5.95	5.91	5.6	5.7

These insights from both the National Survey and People Pulse gives us the ability to review this data and share it at a team, departmental, and care group level. As a Trust there is a positive shift around staff safety within the organisation, staff health and wellbeing support, a more developed compassionate and inclusive culture and improvements around the staff appraisal cycle.

Agreed actions for the year ahead

There are many positive areas of note in this year's Staff Survey. As a Trust there is a positive shift around staff safety within the organisation, health and wellbeing support, a more developed compassionate and inclusive culture, and improvements around the appraisal cycle.

However, there must be ongoing efforts to sustain and improve this and the following actions below will support the Trust in achieving this:

Area of focus	How the Trust will achieve this
Progression of key focus areas	<ul style="list-style-type: none"> This will be overseen as part of the People and Culture Strategy and aligned to the agreed programmes of work (P and C 1-5). Progress will be monitored through quarterly highlight reporting and reviewed for assurance by the People and Culture Committee.
Data driven action planning	<ul style="list-style-type: none"> Breakdown data (including local team heatmaps) is cascaded to care groups and corporate areas to ensure the development of Directorate Culture Plans. These plans will be aligned to Speciality and Directorate Strategic Development Reviews (SDRs), creating a culture of continuous improvement.

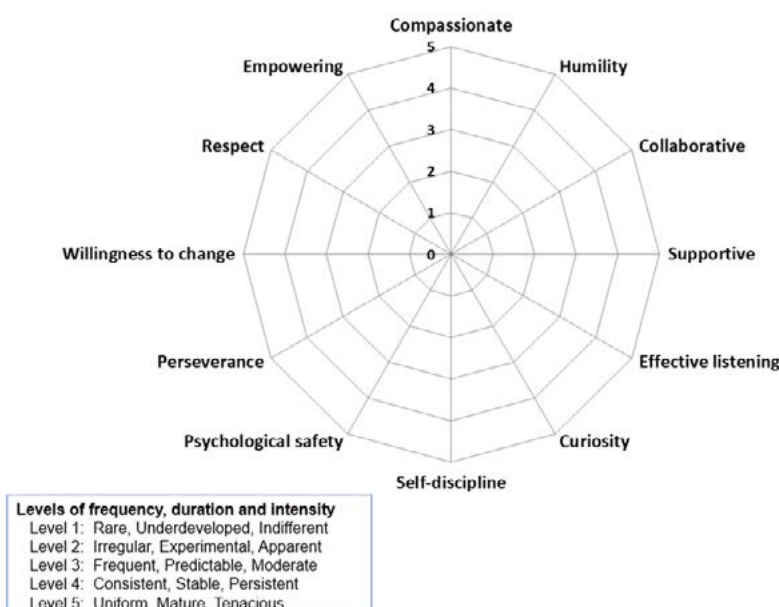
A robust communication plan	<ul style="list-style-type: none"> Amplifying ‘You said we did’ and ‘together we can’ updates will be an area of focus in 2025/26 to share positive practices across different areas of the Trust. Staff briefings, listening groups and connecting with our Staff Networks will align with our People and Culture focused programmes of work and strengthen communication with our frontline staff.
Education and training support	<ul style="list-style-type: none"> One-to-one coaching and education will be provided to support managers in navigating data and facilitating improvement discussions with their teams.

Leadership and talent

Developing the skills and confidence of our leaders and managers is a core part of our People and Culture Strategy. Building on our ethos at our Trust that “everyone is a leader”, we have an ambitious target for our in-house leadership development, enabling us to have a targeted and consistent approach to leadership to ensure that all staff are offered appropriate professional and personal development opportunities.

Through our work, we have maintained a close alignment with Patient First and we have worked to integrate this approach into all our skills workshops, programmes, and our leadership pathway. We have furthered our development of a coaching culture through growing our coaching network, offering our coaches continued professional development opportunities and supervision, and training another 18 coaches, eight Action Learning Set facilitators (ALS) and eight 360-degree feedback facilitators. The initial piloting and subsequent roll-out of our UHD Leadership Behaviour Framework 360-degree feedback tool has further connected our in-house leadership development with Patient First:

UHD Value We are.....	UHD Leadership Behaviours
Caring	Compassionate Humility
One Team	Collaborative Supportive
Listening to Understand	Effective listening Curiosity
Open and honest	Self-discipline Psychological Safety
Always Improving	Perseverance Willingness to change
Inclusive	Respect Empowering



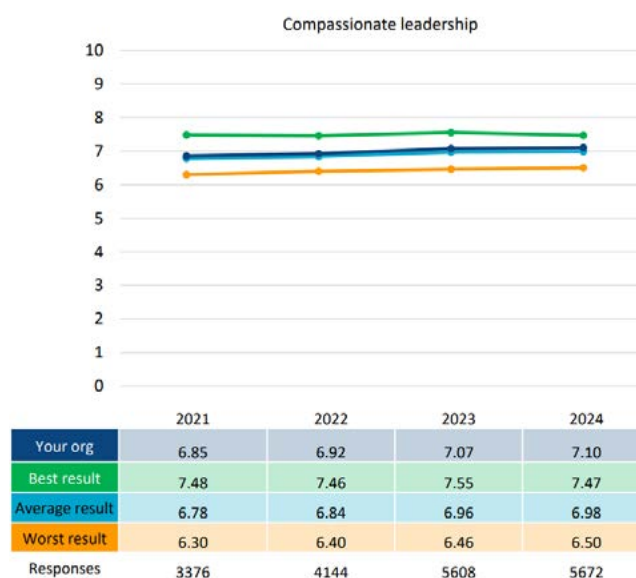
Over the past year, we have worked with many new and established leaders to support their continued development:



During this year, we have focused on the development of our People and Culture Strategy and have supported the Patient First for Leaders training to ensure a consistent message across all leadership development at UHD.

Recognising the continued significant change and transformation across our Trust, we have taken a proactive approach to develop bespoke learning and resources to offer tailored support for those leading through, or navigating, periods of change and uncertainty.

Our latest Staff Survey results illustrate the impact of our approach through our consistent improvement in the sub-theme of Compassionate Leadership (NSS questions 9f, 9g, 9h and 9i), where we are also considerably higher than the national average for our benchmarking group:



We have consistently improved our values-based appraisal compliance over the past year, reaching 83.8% by the end of March 2025, the highest completion rates that UHD has achieved. Exceeding the compliance for previous years has been largely due to undertaking work to make appraisals more accessible, developing our training and resources, maintaining an alignment to Patient First, and updating our procedure so

that it remains relevant and meaningful for all staff. Our 2024 Staff Survey results further evidence this significant improvement in staff receiving quality annual appraisals (NSS questions 23a, 23c and 23d):

- In the last 12 months, I've had an annual appraisal (2023: 83.13%; 2024: 86.43%);
- It helped me to improve how I do my job (2023: 24.46%; 2024: 25.7%);
- It helped me agree clear objectives for my work (2023: 35.81%; 2024: 37%).

Our People and Culture Strategy encompasses our continued investment to developing our leaders and unlocking the potential of our staff, detailing our longer-term aspirations and commitments so that anyone who wishes to develop at our Trust is supported to do so.

Team development

During a period of significant change across our Trust, we have had to tailor how we support our teams to ensure they are able to access the correct support in a way that works best for them. We have supported team development days, shorter workshops, as well as offered coaching to team leaders to be able to work on their own team development journeys. Our January 2025 People Pulse results showed that 74.6% of staff felt that in their team they supported one another.

We now have several team development resources available for team leaders and members to access and as part of the 'People Moves' toolkit, managers are able access a toolkit to support their teams through change which includes conversation starters and a checklist for working through change. All members of staff can also now access a 'Navigating Change' eLearning module to understand their own reactions to change and how these impact on their team.

Many teams have taken part in the Patient First Improvement System training (PFIS) to give teams the skills needed to take back to

their own workplace to support innovation and building a culture of continuous improvement across our Trust.



Equality, diversity and inclusion

We strive to ensure every patient and member of staff, regardless of their protected characteristics, has a positive experience of our services and we are a great place to work. We know that many of our people are also our patients and within the wider context of population health and reducing health inequalities, it is ever more important to achieve a strong link between equitable and inclusive services and the experience of our staff.

We also know that being truly inclusive involves commitment from all individuals across the Trust. By doing so, we enhance the compassionate and inclusive culture we need to recruit and retain a workforce that represents our patients, reflects our Trust's values and in turn, continually improves patient outcomes and experience.

Although we can now see Global Majority colleagues represented at all levels of the organisation, we must continue to question ourselves as an aspiring inclusive employer.

Equality, diversity and inclusion objectives

Despite efforts to promote inclusion and equality, our staff still report prejudice and discrimination in organisational and individual behaviours, as reflected in lived experiences of our staff and our workforce data.

Through our Patient First methodology we have identified one key objective. Our new equality objective for 2024-2026:

To have a representative workforce at all levels of the Trust

As outlined in our One Team EDI Plan, to achieve this we will:

- strengthen our staff networks to work more closely with the Trust's strategic needs and provide project support for engagement activity
- introduce clear guidance and requirements relating to inclusive recruitment with support from our Dorset partners and our Recruitment Team
- develop a one-stop shop approach to accessing reasonable adjustments
- increase cultural awareness and reduce prejudice through the introduction of Conscious Inclusion workshops

Our goal is to increase Global Majority representation in Band 8a and above to over 9% within 12-18 months and raise Band 6 and above by 3% in 24-36 months.

This ambitious target requires significant cultural improvement and sufficient vacancies. As of 23 April 2024, Global Majority representation is 18% at Band 6, 5% at Band 8a, and 7% at Band 8c.

Progress will be monitored through the new Culture Steering Group, membership includes Organisational Development, HR, staff network leads and service managers.

Workforce profile headlines 'at a glance'

The workforce profile was taken as of 31 March 2024; this data will also feature in the 2024 WRES and WDES reports. Nursing is our largest occupational group. The Trust has over 10,000 staff, an increase from 9,700 reported in 2023 serving a population base of 400,300 [Census: 2021 ONS] that extends to over 750,000 people across Dorset and surrounding areas.

Workforce Profile Headlines 'at a glance' reported in 2024

Protected characteristics

Ethnicity / Race: The percentage of Global Majority staff reported in March 2024 was 23.87% up from 21.5% in 2023. The Trust is reporting Global Majority representation across all bands for the first time. The 2021 ONS noted that the Dorset population increased to 379,584 residents up 4% from that reported in 2011. Bournemouth and Poole Council catchment increased by 5.7%. The Dorset population was reportedly 97.1% White.

%	UHD 2023	UHD 2024
White	75.5	73.3
Global Majority	21.5	23.87

Sex: The Trust reported male and female split to shows a slight increase in male staff headcount.

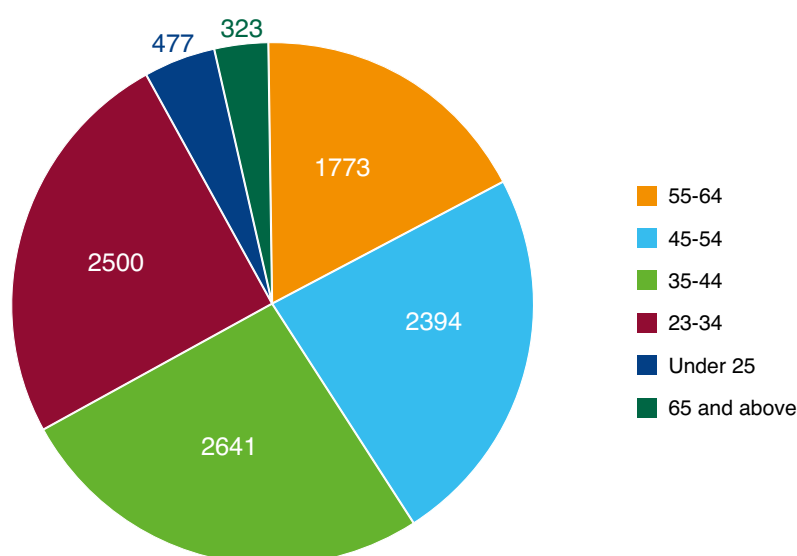


	31/03/2023		31/03/2024	
Gender	Headcount	%	Headcount	%
Female	7319	75.30%	7299	74.11
Male	2401	24.70%	2550	25.89
Grand Total	9716	100.00%	9849	100.00%

Disability: The reported declaration for staff who are 'Disabled' increased to 6.3% in 2024 an increase from the 5.6% reported in 2022. This is a significant increase that is largely attributable to our ProAbility Network's engagement with colleagues. When considering the NHS Staff Survey, our reported disability/long term condition rate is reported to be much higher at approximately 21%.

Age: The Trust reported 2,096 staff aged 55 and over.

Headcount by Age (31/03/24)



Religion or belief: Our chaplaincy service provides multi faith options and are notably an important source of support for our staff and patients. Some 1,919 staff chose not to disclose their religion or belief.

Headcount by religious belief (31/03/24)	
Atheism	1929
Buddhism	78
Christianity	4641
Hinduism	208
I do not wish to disclose my religion/belief	1919
Islam	264
Jainism	1
Judaism	16
Not recorded	480
Other	562
Sikhism	10

Sexual orientation: 75.5% of staff identify as heterosexual, 2% gay or lesbian and 1.2% as bisexual. The percentage in the not stated category has fallen to 16.09%.

Marriage and civil partnership: In 2023, 4,997 staff were married compared to 4,230 reported in 2024. The number of unknowns has increased from 294 for 2023 to 469 in 2024.

Pregnancy and maternity: The percentage of staff taking parental leave continues to be statistically significant for workforce planning and ward establishment reviews.

	31/03/2023		31/03/2024	
Accessing Parental Leave	Headcount	%	Headcount	%
No	9,247	95.17%	9,622	95.19%
Yes	469	4.83%	486	4.81%
Total	9,716	100%	9716	100%

The data tables and charts related to this summary are available on the internet within the EDI Annual Report and Workforce Profile 2023/24.

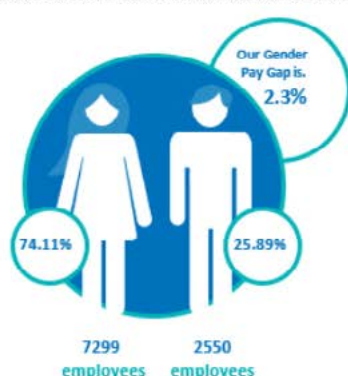
The gender pay gap

At the time of running the report our headcount had increased by 410 to 9,849 since the previous year with 249 more female and 162 more males across UHD (31 March 2023 vs 31 March 2024).

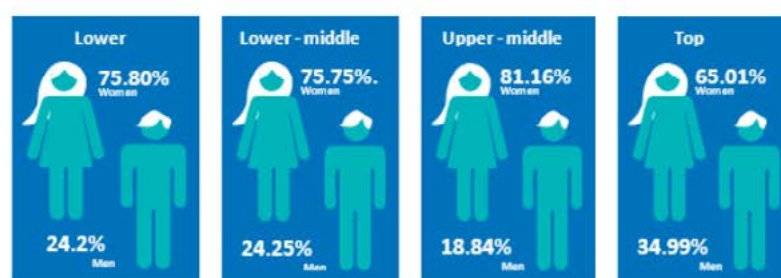
This year our reported Gender Pay Gap is 2.30%. This is an improvement on last year's reported figure of 3.53% and continues the positive trend following the organisational merger in 2020. There is an increase in representation at senior manager level (8a, 8b, 8c, 8d and 9) of female staff. This is a positive move towards equitable representation with our workforce demographics.

Story of our Gender Pay Gap Data taken from 31 March 2024

- The Gender Pay Gap at University Hospitals Dorset has fallen from 3.53% reported in March 2024 to 2.30% reported in March 2025.
- We fully support the equality of opportunity and recognise that further work is needed to achieve this.
- Female staff are represented in many senior positions, and we acknowledge there are still significant gaps | with variances evident in senior clinical roles which drive the greatest variations in our results.



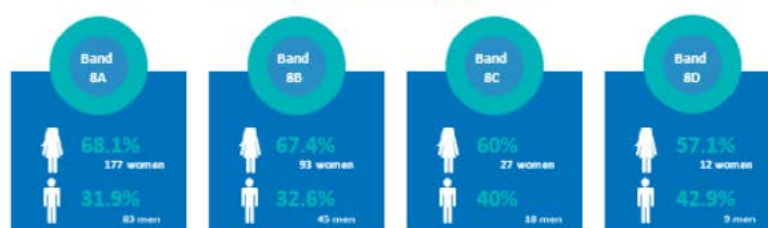
Proportion of males and females in each pay quartile



Our Workforce is predominantly female.



Senior agenda for change grades



Equality Delivery System Assessment

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance with EDS guidance documents provided by NHS England. This year the Trust and the Dorset ICS Services assessed for Domain 1 The Dorset Intelligence Information System Bagernet [PALs and Friends and Family] and Targeted Lung Health Checks. Submitted on 28 February 2025, our stakeholder assessment for EDS, Domains 1, 2, and 3 are Achieving, an improvement on previous assessments. The report and actions can be viewed on the UHD internet.

Workforce Race Equality Standard 2024 and the Workforce Disability Equality Standard 2024 National/UHD observations

The National reports for the Workforce Race Equality Standard 2024 and Workforce Disability Equality Standard 2024 have been published, this section includes a summary comparison with UHD.

Workforce Race Equality Standard 2024 National/UHD observations

Compared to the 2023 WRES data, we have seen a positive and improving trend in a number of indicators, however the disparity gap is still large across a number of indicators. In summary, this report highlights the need for sustained action to address existing racial inequity and discrimination within UHD.

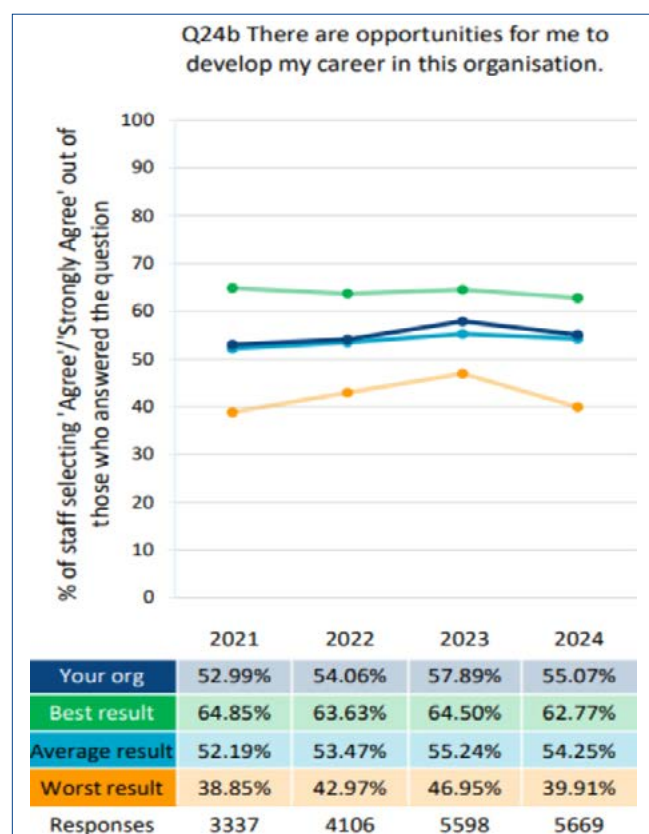
Key findings from the 2024 WRES submission

- Black Asian and Minority Ethnic or Global Majority represent 23.87% of the total workforce, an increase of 2.4% from the 2023 data position.
- Our workforce now shows representation across all bands from Global Majority staff with Global Majority 'Very Senior Manager' representation for the first time.
- White candidates remain 1.79 times more likely to be appointed from shortlisting than Global Majority staff.
- Staff from our Global Majority are now twice as likely to enter the formal disciplinary process compared to White staff.
- Global Majority staff remain less likely than White staff to access nonmandatory training and continued professional development opportunities Global Majority staff continue to experience more harassment, bullying or abuse from patients, relatives or the public than White staff.
- Global Majority staff report a higher level of experiencing harassment, bullying or abuse from other staff compared with White staff.
- The perception around the equal opportunities for career progression or promotion within the Trust is lower among Global Majority staff than it is for White staff.
- Global Majority staff are more than twice as likely as white staff to report personally experiencing discrimination at work by a manager/team leader or other colleagues.
- The representation of Global Majority staff on the Trust Board is 12.87% with a disparity of -11% compared to organisational representation.

Anti-Racism remains an area of priority focus for the organisation. Our intranet includes our Anti-Racism guidance and access to the Conscious Inclusion training module developed with the Dorset ICS for all.

Bespoke team development can also be contracted through Organisational Development. The third cohort of Reverse Mentoring successfully concluded in 2024 and further programmes will be developed with the Dorset ICS.

2023			2024		
UHD (5,619)	White (4,543)	BME (1,003)	UHD (5,689)	White (4522)	BME (1095)
58.2%	57.2%	64.3%	55.3%	53.9%	62.0%



Workforce Disability Equality Standard 2024 National/UHD observations

The Workforce Disability Equality Standard (WDES) came into force on 1 April 2019 and is a set of 10 key measures (metrics) which enable NHS organisations to compare the workplace and career experiences between disabled and non-disabled staff.

Key findings from the Staff Survey results incorporated into WDES reporting

- The declaration of Disability on the Electronic Staff Record is now 6.3% compared to 5.6% in 2023.

- The relative likelihood of a Disabled job applicant being appointed through shortlisting has improved from 1.24 reported in 2023 to 1.11 in 2024 (a score of 1 indicates equal opportunity).
- The relative likelihood of a Disabled colleague being in capability is 2.08. This means that Disabled staff are more than twice as likely to be in the capability process on the grounds of performance.
- Disabled staff are more likely than non-disabled staff to experience bullying, harassment and abuse from patients, service users, relatives, members of the public, managers and colleagues than non-disabled counterparts. The gap is also increasing.
- Disabled staff are less inclined to believe the Trust provides equal opportunities for career development as compared to those staff without disabilities.
- Disabled staff feel more pressure than non-disabled staff to come to work when unwell.
- 37.6% of Disabled staff reported that they felt valued for their contribution an increase from 31.48% reported in 2023.
- 78.16% of Disabled staff reported they had the reasonable adjustment(s) required to perform their duties.
- The staff engagement score for Disabled staff was 6.62, the first increase since the merger of our two trusts in 2020.
- There continues to be no declared representation of Disabled staff on the Trust Board.



The voice of our staff networks

Our Staff Networks are recognised at a national level and have been used as case study for other organisations. Network leads participate in a Community of Practice with Terms of Reference aligned to our People and Culture Strategy. Throughout 2024/25 there have been development training sessions and Community of Practice meetings for the network leads. Staff Network leads participate in the Culture Steering Group and are invited to attend committees, working groups and interview carousels for senior leaders and board members.

Staff Networks in the NHS foster a sense of belonging, promote diversity and create supportive communities for employees with shared identities and experiences. These networks facilitate peer support, mentoring and knowledge exchange, provide a safe space and a purpose of belonging all which contributes to a more inclusive, engaged and empowered workforce ultimately enhancing patient care.

Our Staff Networks now have additional support and coordination from a newly appointed Projects Support Officer, Chris Evans, who has time and experience with the networks after being a lead of the UHD Pride Network. Having this point of contact and planning support for the network leads should contribute to a more cohesive

approach in creating visibility and developing the Staff Networks.



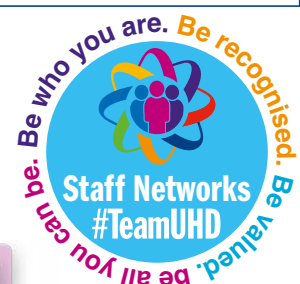
UHD Pride Network

Network leads: Melissa Armstrong, Kirsty Duncan and Maggie Baska

Executive sponsor: Pete Papworth, Chief Finance Officer

The UHD Pride Network has had several changes in leads during 2024/25. Dr Matthew Hodson left UHD to move to a new role and Chris Evans stepped down as co lead to remain unbiased after moving into the Organisational Development Team to support EDI and coordinate the Staff Networks. The network has now welcomed Kirsty Duncan as the Deputy Lead and Maggie Baska as Comms Support.

During 2024/25 the network continued to promote the 'Safe to be ME at UHD' campaign, asking members of the Trust to sign a pledge of support for their LGBTQIA+ colleagues and to wear and display our UHD PRIDE lanyards and pronoun badges to help promote awareness and show their support.



The network held its first ever UHD Pride Day in 2024 in the Marquee in RBH, annually attend the local Pride event 'Bournefree,' have created inclusive NHS flags to display across all sites and continue to work hard for equality and diversity across UHD.



ProAbility Network

Network leads: Elayne Goulding, Jo Olsen, Lisa Brinkman and Jo Pritchard
Executive sponsor: Tina Ricketts, Chief People Officer

We continue to support the recruitment, training, career development and promotion of disabled persons/employees.

The Trust holds 'Disability Confident' accreditation. It takes positive and proactive steps to maintain continued employment, provide training, and foster career development and promotion for disabled members of staff.

The Trust reports on the 'Workforce Disability Equality Standard' (WDES) on an annual basis. This national reporting standard includes providing statistics which demonstrate a proportionate comparison between disabled and non-disabled members of staff in relation to their experience at work and opportunities.

This data will enable a gap analysis to be conducted and the development of a targeted action plan in conjunction with the ProAbility Network.

This network aims to listen, understand and support people living and working with physical disabilities and long-term health conditions holding regular listening events. The network is working closely with the HR Department to understand the reasons for low declaration rates of disabilities and how this can be improved.



The Trust recognises there is a strong business case for adopting a positive approach to supporting and developing disabled staff both in terms of acquiring and maintaining valuable workplace skills.

Developing a culture where both our staff and patients can flourish is simply the right thing to do. It is the responsibility of the People Directorate Team to maintain up-to-date policies, taking into consideration revised employment law. The network has recognised the need to support neurodiverse employees in the workplace and the services of Lexxic experts in psychological support were sought in 2022 to provide introductory training and support the development of a suggested action plan.

Deaf Awareness Week in May 2024 was celebrated together with the ongoing promotion of British Sign Language training. In addition, the network championed red hearing aid boxes for use by patients to safeguard against loss of their devices with associated distress and cost. In December 2024, Purple Light Up Day was celebrated by the Network within UHD to recognise the contributions of disabled employees.



Armed Forces Support Group

Network lead: Rob Hornby

Sponsor: Abigail Daughters, Director of Operations (Surgical)

In July 2021, our Trust signed the Armed Forces Covenant marking an important step for the Trust. The Armed Forces Support Group (AFSG) continues to meet monthly and is a great place for support for the Armed Forces Community within our Trust.

The Armed Forces Community Advocate is Rob Hornby. Over his time with our Trust he has received very positive feedback from stakeholders, patients, staff and family members of the Armed Forces Community. UHD proudly achieved the Gold Award through the Armed Forces Covenant employee recognition scheme in 2023 and continue to strive to uphold the standards and behaviours accredited with this award.



In January 2025, our Trust received approval of its Veteran Aware Accreditation for a further three years. This acknowledges a number of key pledges our Trust has made, including: ensuring that the armed forces community is never disadvantaged compared to other patients, in line with the NHS's commitment to the Armed Forces Covenant; training relevant staff on veteran specific culture or needs; making veterans, reservists and service families aware of appropriate charities or NHS services beneficial to them, such as mental health services or support with financial and/or benefit claims; and supporting the armed forces as an employee.

Reservist Recruitment 243 Field Hospital continue to hold their regular recruitment days at Poole and the Royal Bournemouth hospitals. Both locations are getting plenty of encouraging enquiries and potential recruits. our Trust actively supported Armed Forces Week, hosting recruitments days and stands across the Trust.



Diverse Ethnicity Network (DEN)

Network leads: Judith Dube, Gabriel Adelaja and Fardowsa Ahmed-Timms

Executive sponsor: Sarah Herbert, Chief Nursing Officer

The DEN Network, formerly the BAME Network, hold monthly network meetings to listen to the experiences of Global Majority staff and to provide ongoing support as required.

Following successive annual WRES reports and the shared lived experiences of colleagues, the network raised the need for an organisational increase in focus on anti-racism.

The network has worked in partnership with Organisational Development to develop anti-racism guidance and associated support. Several listening events have been hosted to support our Global Majority colleagues here at UHD following global events - these were supported by Board members and many allies across the Trust.



The network also helps to lead the See Me First campaign across UHD to raise awareness about racism and to work towards putting a stop to discrimination in the workplace.



Women's Network

Network leads: Samantha Murray, Catherine Bishop and Jasmine Sharland
Executive sponsor: Beverley Bryant, Chief Digital Officer

The network has been instrumental in promoting women's health and wellbeing, including menopause, baby loss awareness and the Period Poverty project providing free sanitary products to staff in all unisex and female facilities. The network has increased engagement to support the Sexual Safety Charter that UHD has signed up to.

UHD annually celebrates International Women's Day where the network celebrated inspirational women speakers in collaboration with the Dorset ICS.



Charters and partners



UHD champions many charters and agreements with external organisations as we want to be a safe and inclusive place to work and receive care. Some of our charters include:

Armed Forces Covenant: The Armed Forces Covenant is a pledge to acknowledge and understand the needs of the Armed Forces community and aims to build a more open and honest relationship between employers, the Ministry of Defence and reservists. UHD has proudly been awarded the Gold Award. UHD has also had its Veteran Aware accreditation approved for a further three years until 2028, trusts gaining this accreditation are leading the way in improving veterans' care within the NHS, as part of the Veterans Covenant Healthcare Alliance (VCHA).

Hate Crime Charter: There is no place, excuse or reason for hate crime in UHD. A hate crime is subjecting people to harassment, victimisation, intimidation or abuse because of their ethnicity, faith, religion, Disability or because they are lesbian, gay, bisexual or transgender this includes 'any incident, which constitutes a criminal offence, which is perceived by the victim or any other person as being motivated by prejudice or hate'.

Disability Confident Employer: Disability Confident is creating a movement of change, encouraging employers to think differently about Disability and take action to improve how they recruit, retain and develop Disabled people. Being Disability Confident is a unique opportunity to lead the way in your community, and you might just discover someone your business cannot do without.

Stonewall Diversity Champion: UHD aims to ensure all staff and patients feel welcome, notably our staff should feel respected and

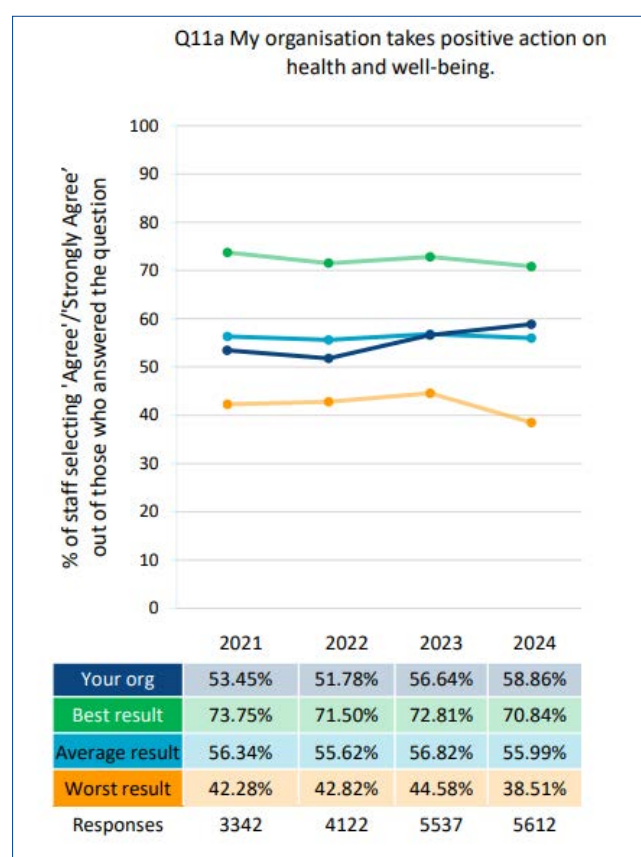
represented at work. Inclusion drives better individual, business and patient outcomes. When LGBTQ+ staff feel free to be themselves, everybody benefits.

Mindful Employer: Being a mindful employer demonstrates the UHD commitment to working toward achieving better mental health at work.

Sexual Safety Charter: UHD signed up to the new Sexual Safety Charter in 2023 with the aim to meet the 10 requirements for June 2024. We continue to develop guidance ahead of a campaign to be launched in 2025.

Health and wellbeing

A range of initiatives have been implemented to support staff wellbeing across the organisation. One such initiative is *Start Well, End Well* - a brief, guided relaxation and stress management exercise developed by the Psychological Support and Counselling Team to support staff within UHD.



Health and wellbeing champions

Health and Wellbeing Champions have continued to play a vital role ensuring colleagues' wellbeing needs are heard and acting as local points of contact, promoting resources, sharing updates, and signposting colleagues to available support services.



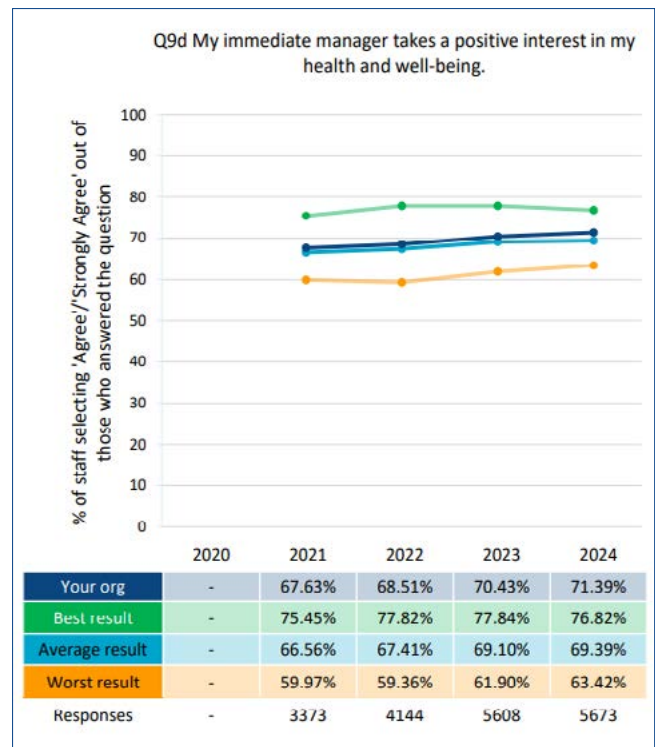
Health and wellbeing champions

Wellbeing conversations are a supportive, coaching-style one-to-one discussion focused on empowering individuals while also building individual and team resilience. The aim is to embed these conversations across the system and create cultures where people feel heard and valued, and in which diversity is respected.

Check-in conversations should consider holistic needs, identify areas of support and include effective signposting. Our NHS staff survey shows a continuous improving picture in relation to managers taking a positive interest in staff health and wellbeing.

Additionally, our winter guidance for managers was supported by a guidance for staff in 2023.

Question 9d from the 2023 NHS Staff Survey suggests these conversations are having a positive impact on staff.



University Hospitals Dorset NHS Charity support

In the last few years through local donations and grants from NHS Charities together, our University Hospitals Dorset NHS Charity has continued to provide support and interventions for staff health and wellbeing, including:

- wellbeing days and team building events for various departments
- additional kit to support our Occupational Health Department
- long Covid-19 rehabilitation
- staff area improvements across all sites
- psychological support
- improvements to existing gardens and outdoor spaces
- new sustainable outside spaces
- reverse mentoring
- contribution to refreshments for wellbeing events, for example Schwartz Rounds
- seasonal thank you to staff





Thrive Live health and wellbeing fair

A key highlight of 2023/24 was the Thrive Live Health and Wellbeing Fair, which brought together staff from across the Trust to engage with both internal and external providers. The event featured advice sessions, interactive activities, and a wide range of wellbeing resources. It served as a platform to explore important topics such as mental health, physical activity, nutrition, and financial wellbeing, while also reinforcing the Trust's ongoing commitment to a positive and supportive workplace culture.

This commitment is reflected in staff feedback. In response to the question "My organisation takes positive action on health and wellbeing," 58.86% of staff agreed or strongly agreed in 2024 - a steady improvement from 53.45% in 2021.

Thanks to funding from the UHD Charity, we are delighted to confirm that Thrive Live will return in September 2025 providing another valuable opportunity for staff to connect, recharge, and explore the comprehensive wellbeing support on offer.



Disclosures set out in the code of governance for NHS provider trusts

The code of governance for NHS provider trusts sets out a common overarching framework for the corporate governance of NHS trusts and NHS foundation trusts. As a foundation trust, we must comply with each of the provisions of the code or, where appropriate, explain why we have departed from the code. There are also some disclosures that we are required to provide in this annual report to meet the code of governance which are included in our Performance Report and our Accountability Report above.

Code of Governance 'Comply or Explain' Requirement	Explanation
B.1.1, B2.2, C.5.8 - Ensuring that directors and governors receive accurate, timely and clear information	An area of enhancement identified is more timely publication of reporting to Board, Committees and the Council of Governors. During 2025/26, enhancements are planned to be delivered through the Trust's Organising for Success corporate project.
B 2.5 and D.2.1 - Chair of the Audit Committee	Until 31 March 2025, the Audit Committee was chaired by the Senior Independent Director. Having regard to the composition of the committee and other committees - including from a skill mix perspective - it was considered preferable for the Senior Independent Director to be chair of such committee and this was permitted by the committee's terms of reference.
C.4.12 - The Remuneration Committee should not agree to an executive member of the board leaving the employment of the Trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	<p>During the period, the Appointments and Remuneration Committee agreed to Tina Ricketts, Chief People Officer, leaving the Trust with a shorter notice period to take up an opportunity at another organisation. The Committee approved Irene Mardon again acting up to Chief People Officer pending the appointed Chief People Officer taking up their post.</p> <p>Reductions in executive director contractual time commitment that have taken place during the year have been considered to be non-material.</p>
E.2.2 - Levels of remuneration for the Chair and non-executive directors should reflect NHS England's Chair and non-executive director remuneration structure	When the Chair and non-executive director remuneration structure was introduced by NHS England, the predecessor trusts to the Trust already paid non-executive directors at a higher remuneration than the levels stated in the structure document. The merged Trust was larger in size than the predecessor trusts, this being taken into account when establishing the remuneration for the non-executive directors of the new organisation. The level of non-executive director remuneration has remained static over some years since the Trust's inception.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems, including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- a** objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities, leadership and capability, finance and use of resources, and local strategic priorities)
- b** additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

The Trust has been placed in segment 3 by NHS England. This segmentation information is the Trust's position as at 9 May 2025.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: www.england.nhs.uk/publication/nhs-oversight-

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of University Hospitals Dorset NHS Foundation Trust

The NHS Act 2006 states the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require University Hospitals Dorset NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Dorset NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trusts performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the

NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Siobhan Harrington
Chief Executive
18 June 2025



Annual Governance Statement

(1 April 2024 to 31 March 2025)

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring the NHS Foundation Trust is administered prudently and economically and resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the System of Internal Control

The System of Internal Control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The System of Internal Control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals Dorset NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The System of Internal Control has been in place at University Hospitals Dorset NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership given to the risk management process

Within the Trust, the Board of Directors provides leadership on the overall governance agenda, including the management of risk. The Board of Directors is supported by a range of committees that scrutinise and review assurances on internal control including Audit, Finance and Performance, People and Culture and Quality Committees.

The Trust Management Group is the lead operational group for the Trust chaired by the Chief Executive and includes the executive directors and Care Group directors. It receives proposed new risks rated 15-25 for review and approval.

Our Risk Management Strategy defines key leadership roles in respect of risk management.

- Chief Executive has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements and guidance issued by the Department of Health and Social Care and Care Quality Commission in respect of governance.
- Chief Medical Officer and Chief Nursing Officer have joint delegated responsibility for managing the strategic development and implementation of organisational risk management and clinical governance.
- Executive directors agreeing (as part of the formal escalation process) to act as Lead Executive for risks and are responsible for monitoring compliance and supporting the management and progress of risks relevant to their delegated roles and responsibilities.

- Care Group directors, deputies and heads of nursing and professions' responsibilities include reviewing with directorate governance group leads, directorate manager and matrons the directorate risk register, integrated performance report, CQC action plan and other associated risk/quality reports.
- Directorate managers, senior matrons and matrons are responsible for ensuring that the directorate has a robust structure for the management of quality governance and risk, including ensuring that, as appropriate, risks agreed at Directorate Governance (Directorate Quality and Safety Groups) are escalated for consideration, review and acceptance at Care Group Board. consistent with the Trust's approach to the articulation and assessment of risks and that they have a current action plan.
- Managers / heads of department / ward leads are responsible the management of local risks. This includes carrying out local risk assessments and escalating these at directorate level and ensuring that all staff are made aware of the risks and associated risk control plans within their work environment and their individual responsibilities via the processes above.
- Every member of staff - including contractors and agency staff - must be aware of the Risk Management Strategy and their individual responsibilities in relation to maintaining safety. All staff have a responsibility for risk management and a commitment to identifying and minimising risks. Key responsibilities include understanding and supporting the controls in place in work areas to mitigate risks, reporting learning events, attending mandatory training and other risk management training necessary for their role. **Risk management is everyone's responsibility.**

Training and equipping staff to manage risk

Risk assessment, incident reporting and incident investigation training sessions are provided to relevant clinical leads, heads of department and ward leaders throughout the year.

The Trust has a licence to provide the Institute of Occupational Safety and Health (IOSH) Managing Safety course in house. The course was rolled out in year and is now provided on a bi-monthly basis. The course supports frontline leaders to effectively recognise, describe, escalate and manage clinical and non-clinical risk. Additional risk assessment, incident reporting, Duty of Candour, After Action Review and Patient Safety Incident Investigation training sessions for clinical leads, heads of department and ward leaders are run throughout the year.



As part of the Trust Essential Core Skills Policy, we have set out the minimum requirements for staff training. A training needs analysis informs our essential core skills training requirements. This sets out

the training requirements for all members of staff and includes the frequency of training in each case. Health and Safety, Fire, Security and Infection Control all form part of induction and mandatory training. In March 2024 we also made the decision to include the new Level 1 National Patient Safety training as part of essential core skill training for all staff.

Formal training is supported by a variety of other resources that seek to promote and facilitate individual, departmental, directorate and organisational discussion and learning. Incidents, complaints, audits, mortality reviews and patient feedback are routinely used to identify learning opportunities and improve risk controls. Lessons from learning are discussed locally at corporate, specially and directorate clinical governance groups and fed back to staff via a variety of methods, including Learn at Lunch sessions, Organisational Wide Learning (OWL) Safety Alerts, Learning Synopsis, Clinical Governance Group Top 10 newsletters, local team safety briefings and huddles. Actions and learning points are also shared with regulators and other stakeholders across the local healthcare system through patient safety specialist meetings, shared learning forums and multi-agency reviews.

The Trust's Risk Management Strategy is underpinned by the development of, and support for, a culture that encourages the open and honest recording of risks and organisation-wide learning where risks are continuously identified, assessed and minimised. The Trust's Organisational Development programme supports an open culture and this is encapsulated in the Trust's values.

As Chief Executive, I sponsor the role of the Freedom to Speak Up Guardian who regularly reports to the People and Culture Committee and bi-annually to the Board of Directors to provide assurance around the reporting, safety and learning culture within the Trust as well as identifying key themes.

The Risk and Control Framework

Key elements of the Risk Management Strategy

The Trust's Risk Management Strategy provides a clear framework for risk management covering various key elements, including the way in which risk (or change in risk) is identified, evaluated, transferred and controlled.

Identification of risk: Risk can be defined as the combination of the probability of an event and its consequences. The following risk definition is used by the Trust: 'The chance of something happening that will have an adverse effect on an objective'. Based on this definition, the Trust's Risk Management Strategy suggests, in terms of consistency, that a statement of risks should be framed as an 'if... 'then' statement, for example: 'If we continue to or fail to do something then the result will be...'

Evaluation of risk: The Trust uses a standardised approach to risk assessment that ensures consistency across the organisation. Risks are assessed based on the impact that the risk might have if it were to occur, and the likelihood of the risk occurring. The impact can be based on a variety of factors, including; financial implications, the number of service users affected and the severity of harm, or the impact on staff morale and wellbeing. We use a standard 5x5 risk scoring matrix for assessing the impact and likelihood of the risk. The matrix has been adopted as part of a pan-Dorset Risk Management Framework.

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

rating. To improve the effectiveness of controls, additional mitigating actions might need to be undertaken.

Existing assurances: Risk actions are identified for any identified gaps in controls or assurances in order to mitigate and close the identified gap. Actions should be specific, clear owners nominated and with a date provided for completion.

Risk Appetite Statement: Our Risk Appetite Statement is used to determine target risk scores in relation to the following key themes:

- Workforce risk
- Population and System Working risk
- Quality (Outcome and Safety) risk
- Sustainable Services risk
- Patient Experience risk

The Trust's Risk Appetite Statement makes clear the Board of Directors' expectations in relation to the category of risks they expect the Trust's management to identify and the level of such risk that is acceptable. The statement is based on the premise that the lower the risk appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk. The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls.

Risk appetite provides a framework which enables the Trust to make informed planning and management decisions. By defining risk appetite, we are able to clearly set the optimal position in pursuit of our strategy and vision.

The Trust has adapted definitions for risk appetite and risk tolerance from the 'Orange Book - Risk Appetite guidance note', Government Finance Function (October 2020), risk appetite is the level of risk with which the Trust aims to operate, while risk

tolerance is the level of risk with which the Trust is willing to operate.

The Trust has developed its risk appetite in an iterative manner between the Board, its committees, the Executive Team, specialist corporate governance and risk management advice both internally and externally and, internal audit support. Involvement from these key stakeholders will make future iterations of the Trust risk appetite easier to embed across the organisation. It is intended that the approach will become more developed over time. The Trust has set out the risk appetite level for each risk type and risk category. The matrix adopts a 5 point scale for all risk types, however the definition for what constitutes an 'averse' risk appetite will differ across risk categories. The following scales have been adopted:

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

The Trust's Risk Management Strategy, our approach to risk identification, assessment and control, and the management and investigation of adverse events is aligned with the Trust values and a culture of openness, accountability and transparency.

The Trust identifies, prioritises and manages all aspects of risk through its integrated Governance Framework. Risks to delivery of the Trust's strategic objectives are documented in the Board Assurance Framework, which is aligned through the UHD 'Patient First' methodology and has helped achieve greater alignment of our strategic themes, breakthrough objectives and strategic enabling programmes.

This year, as we have been developing our Patient First approach, risks under the Board Assurance Framework have been periodically reviewed at meetings of the relevant monitoring committees. They have also been reviewed quarterly by the Audit Committee and bi-annually by the Board of Directors.

The Trust uses a single risk register system and a standard risk register process. Risk mitigation is achieved through a continuous cycle of the identification, assessment, control, and review of risk. High risks (currently those with a risk rating of 15-25), including any changes to these, are reviewed by the Board of Directors at its Part 1 meetings.

The work of the Board of Directors and its committees is supported by a range of specialist groups including the Trust Management Group, the Clinical Governance Group, the Clinical Audit and Effectiveness Group and, Care Group Quality Governance Groups. The Board of Directors and its committees may commission 'deep dives' to review risks and also consider independent sources of assurance such as internal and external audit, counter fraud, clinical audit, national patient surveys and staff surveys.

The Trust has key aims that the Risk Management Strategy supports in the delivery of:

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

The effectiveness of the Risk Management Framework is regularly reviewed by the internal auditors with reporting reviewed by the Audit Committee.

Risks may be entered on the Trust's risk register as a result of risk issues being raised or identified by employees, directorates, external or internal reviews, internal or external audits, incident investigations, complaints reviews and comments from public stakeholders and/or service developments. Recommendations and learning from complaints, audits, peer reviews, claims and incidents are



discussed locally at care group, directorate and ward level. Actions and learning are shared but also used to inform how risk is both identified and managed.

Risks may also be raised by the Board or its committees or by specialist groups. These include the Quality Committee, Finance and Performance Committee, People and Culture Committee, Infection Prevention and Control Group, Medicines Governance Group, Clinical Governance Group and Health and Safety Group. All risks entered onto the risk register are categorised according to the Trust Risk Management Strategy using a standard risk matrix. The risk rating value is a combination of likelihood and consequence. All risks are assigned a current risk score and a target risk score following implementation of action plans and mitigation. All action plans have a responsible lead and timeframe noted. All high and Board assurance risks are also assigned an executive director lead.

Quality governance arrangements

Compliance with the provisions of the Health and Social Care Act 2008 (Registration Regulations) 2010 is coordinated by the Chief Nursing Officer. Compliance is managed by:

- reviewing and monitoring matters highlighted within the Care Quality Commission's (CQC) reports and inspections
- monitoring action plans associated with any CQC reports on Trust activity and registration requirements
- liaising with the CQC and Care Group teams to address specific concerns
- engaging with the CQC on the inspection process, open enquires requests and during planned engagement meetings
- analysing trends from incident reporting, complaints, patient surveys, staff surveys and national and local clinical audits to detect potential non-compliance or concerns in clinical specialities
- reviewing assurances on the effective

operation of controls

- reviewing details of internal audit reports, peer review reports, external accreditation reports, external reviews, system level audits and integrated performance reviews.










Board Assurance Framework (BAF) risks

The Board of Directors has reviewed the Trust's principal strategic themes and objectives and identified strategies and risks to the delivery of those objectives using the Board Assurance Framework process. Within the Board Assurance Framework document, principal risks together with key controls and gaps in controls or assurance are set out. The Board Assurance Framework is linked to the Trust's risk register with risk management achieved through a continuous cycle of the identification, assessment, control and review.

In addition, during 2024/25 a 'Strategy Deployment Review' (SDR) process has tracked progress at Care Group and Trust Management Group level, on a monthly basis. A 'counter measures' methodology has been used to ensure timely and effective responses to objectives or programmes being off track. This uses a statistical process control approach to ensure a consistent and proportionate response.

Through the Board Assurance Framework, we identified 10 major in-year risks which impact upon the achievement of our strategic priorities. These are detailed in the following table.



BAF risk title	Risk scores				Population and System	Our People	Patient Experience	Quality Outcomes and Safety	Sustainable Services	Target risk score
	Jun-24	Sep-24	Dec-24	Mar-25						
BAF Risk 1 Risk of not achieving 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance	12	12	9	1						3
BAF Risk 2 Risk of not meeting the patient national constitutional standards for emergency care	12	12	16	16						6
BAF Risk 3 Risk of not significantly improving staff experience and retention over the next three years (and not being in the NHS Staff Survey results top 20% of comparator trusts)	12	12	8	8						8
BAF Risk 4 Risk that the Trust does not have adequate systems and processes in place to promote, gather, triangulate and utilise patient feedback consistently across UHD - it is therefore recognised that this may result in missed opportunities for learning and improvement in patient experience	6	6	6	6						6
BAF Risk 5 Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next three years	8	8	8	6						6
BAF Risk 6 If insufficient resources are in place for the implementation and continuation of PSIRF then there is a risk the Trust will not learn from patient safety events and will not reduce patient safety harm events	9	9	9	6						Achieved and closed at year end
BAF Risk 7 Risk of not returning to recurrent financial surplus from 2026/27	16	16	16	16						8
BAF Risk 8 Risk of not successfully and sustainably adopting the Patient First approach across UHD	12	12	8	8	Cross cutting to support the five strategic objectives.					6
BAF Risk 9 Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals	16	16	16	16						12
BAF Risk 10 Risk that Trust's electronic patient record (EPR) not fit for purpose for UHD	25	25	20	20						6

Note: BAF Risk 5: At the year end, it was noted that this BAF risk would be closed.
Metrics would be fully embedded into the strategy deployment review process in 2025/26.

Of these, the following four areas are our top four risks, which are summarised from our Board Assurance Framework:

Meeting the National Constitutional Standards for Emergency Care

How we manage the risk

- Strategic breakthrough objective within Patient First Improvement Programme
- Timed admissions process evoked
- ED escalation plans/ SoPs
- Surge management criteria and plan
- 4 and 12 hour escalation process and ambulance divert policy

How we assess the outcome of actions

- Daily performance reporting against metrics to execs
- Daily operational meetings to support UEC flow and challenges seven days a week
- 4 hour performance metrics linked to ED escalation

Returning to financial surplus from 2026/27

How we manage the risk

- Budgets developed with directorate teams, accepted at Care Group level, devolved to named budget holders
- Dedicated financial support in place
- Scheme of delegation, Standing Financial Instructions, Financial Management Accountability Framework
- Enhanced vacancy and non-pay controls implemented to support financial recovery

How we assess the outcome of actions

- Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions
- Patient First 'driver' and 'watch' metrics agreed and monitored monthly

Integrating teams and services and then reconfiguring to create the planned and emergency hospitals

How we manage the risk

- Specialty level plans in place
- Service Reviews to assess readiness for moves with actions followed up by Care Groups
- Meeting structure, attendance, escalation and resolution from specialty steering groups into Care Group and then Service Ready Group
- Robust critical path timeline clearly articulating deliverables and interdependencies between specific deliverables
- Effective management of individual programmes

How we assess the outcome of actions

- Internal audit
- INHP scrutiny/ governance
- External gateway process
- Result of service review findings and progress on critical path actions
- Go/No Go checklist and criteria

Electronic Patient Record being fit for purpose for our Trust

How we manage the risk

- Strategic breakthrough objective within Patient First Improvement Programme
- Timed admissions process evoked
- ED escalation plans/SoPs
- Surge management criteria and plan
- 4 and 12 hour escalation process and ambulance divert policy

How we assess the outcome of actions

- Daily performance reporting against metrics to execs
- Daily operational meetings to support UEC flow and challenges seven days a week
- 4 hour performance metrics linked to ED escalation

The most significant risks in 2024/5 facing the Trust (in-year and immediate future) are the demand, capacity and operational flow constraints in the wider health and social care system and national and local staff shortages in key specialties.

The Trust's principal risks (in year and immediate future) are summarised below:

Partnership and Population

- Ability to meet urgent and emergency care 4-hour safety standard
- Lack of capacity for elective and non-elective activity due to long length of stay and no criteria to reside patients

- Caring for patients in non-clinical areas of the Emergency Department
- Ambulance handover delays
- Mental health in a physical health environment
- Glaucoma pathway capacity
- School age neurodevelopmental service

Our People

- Lack of capacity in Cellular Pathology
- Theatre staffing

Quality (Safety and Outcomes)

- Management of Point of Care devices
- Sterile Services provision
- Breast radiologist capacity
- Macular service capacity

Sustainable Services

- Electronic Patient Record and electronic referral system risk
- Cyber security
- Financial stability and financial controls

Risk mitigations are routinely reviewed at the relevant Board committee.

NHS Provider Licence

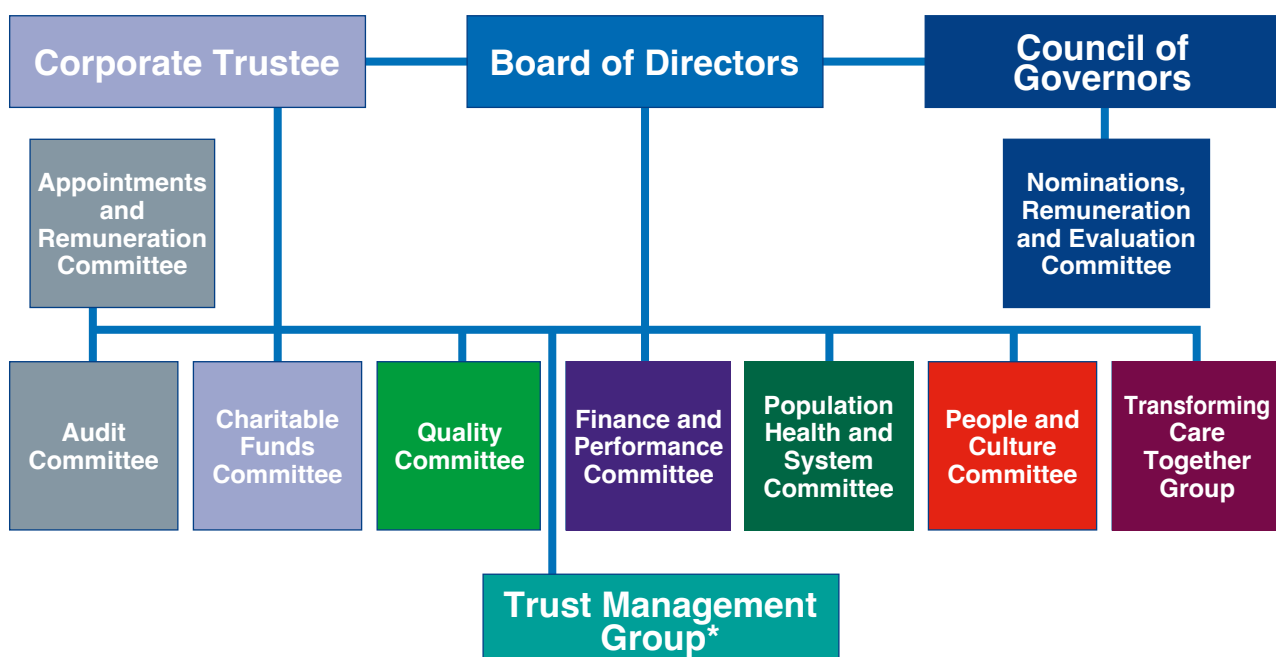
The NHS Provider Licence sets out specific responsibilities in relation to our governance arrangements.

The Board of Directors is supported by a range of committees that scrutinise and review assurance. Our assurance committees are: Audit, Quality, Finance and Performance, People and Culture and Population Health and System, with

membership of these committees comprising non-executive directors and executive directors. Other executive directors and invitees - including representatives from the Integrated Care Board and NHS Dorset - attend as business requires. Governor observers may also attend each meeting of these committees, particularly to support their role of holding our non-executive directors to account. Other Board committees are: the Appointments and Remuneration Committee, Charitable Funds Committee and a Transforming Care Together Steering Group. The chairs of all of these are non-executive directors. For further information about the work of these committees, please see page 58.

Key risks

The Board of Directors considers statements relating to compliance with the NHS provider licence on an annual basis supported also by areas highlighted to the Board of Directors in advance of this through regular performance reporting. Annual compliance with the principles of good corporate governance and more detailed provisions of the NHS Code of Governance for Provider Trusts is reviewed as part of the required disclosure which appears in this Annual Report.



Accountable to

* TMG accountable to Chief Executive, reports through executive directors to Board

More generally, the Board of Directors conducts its own reviews of its governance structures including reviews of performance by its committees to ensure information provided to the Board of Directors identifies the key performance risks and the risks to compliance with the Trust's provider licence and other local and national performance targets, including its own performance objectives. Appraisals of both non-executive directors and executive directors take place annually with objectives and development plans identified.

In 2025/26, our corporate projects will include 'Organising for Success', focused upon a single aligned governance structure across the Trust, including clearly defined roles and responsibilities at every level of the organisation to support delivery of the governance structure.

Workforce strategies and staffing systems

The year ending 31 March 2025 was another period of unprecedented challenge for our workforce, given the need to plan and enact the changes required under our New Hospital Programme and managing the pay budget within heightened financial and vacancy controls.

In this period, the Trust ensured that risk mitigation decisions were taken in the context of safe staffing levels, staff health and wellbeing, and value for money (reducing the reliance on temporary staffing/ premium staffing costs). The challenges of supporting our colleagues to do their essential work at the same time as transforming services leading up to the opening of our BEACH Building were significant.

The launch of the new UHD People Strategy identified 19 priority programmes of work. Alignment to the NHS People Plan confirmed that our plans are comprehensive and challenging in addressing risks and issues in both a local and national context.

The **People Strategy**, and plans that support the strategy, also supported the Trust's Patient First approach - developing a culture of continuous improvement to support a) the delivery of our refreshed strategy and strategic priorities and b) a focus on leadership capability and staff engagement across the organisation.

Health and wellbeing support that is accessible and available for all Trust staff remained a priority as we know that 'burnout' and fatigue remain a key issue for many of our staff given the NHS workforce pressures. Regular review and further development of a wellbeing culture continues with a focus on demonstrating impact and outcomes.

Our **staff networks** continue to provide insight and guidance to the organisation and are vital in developing UHD culture where everyone feels they belong.

The People and Culture Committee and Board of Directors continued to review, monitor and where appropriate, challenge performance and risks in relation to key workforce metrics (vacancies, new role requirements, absence, sickness, use of bank and agency).

Joint working has continued with Staff Side colleagues, supporting policy development and review of other arrangements to ensure we have transparent and supportive processes for managers and staff with the emphasis on a fair and just culture, providing early and informal resolution wherever possible.

Workforce planning and development have been a key focus over the year to meet the demands of the New Hospital Programme. Workforce plans have supported all services reviewing current and future workforce and aligning them to support staff moves, processes and advancement of workforce systems.

Workforce systems and technology have included medical staffing systems (being developed across the Dorset Integrated

Care System) with nursing and support staff rostering remaining a key priority as this will further support the work to reduce premium workforce costs.

The Trust continued to engage in **system-wide projects** through the Dorset People Committee - attended by senior executives across a range of health and social care organisations with key workforce issues raised and discussed. Spend and addressing the national shortages of key medical, clinical, and allied health professionals continued to be a priority.

Ongoing recruitment and retention initiatives, including regular recruitment events and an established programme of internationally educated nurse and midwife recruitment, saw consistent numbers of monthly new starters.

Compliance with the National Quality Board workforce safeguards was achieved through a variety of evidence-based tools and techniques that support safe staffing decision making.

Nursing and Midwifery establishment reviews were undertaken bi-annually in all inpatient areas by the senior nursing and midwifery teams, with review and reconciliation of acuity, outcomes, and staffing requirements. Following each review an evidence-based report outlining the recommendations was taken to the People and Culture Committee and Board of Directors in line with CQC and NHSE guidance.

Twice-daily safe staffing review meetings assess staffing levels against patient acuity data, through a triangulated review of the electronic roster, the SafeCare acuity tool and professional judgement. Within Maternity, daily safety reviews occurred each morning with additional reviews as per the escalation plan and continued four-hourly monitoring on the Labour Ward using the birth rate plus acuity tool.

The Trust follows the NICE safe staffing guidance with an electronic nursing red flag

system in place to escalate and monitor safe nurse and midwifery staffing events, enabling teams to raise in the moment concerns should their staffing levels not meet the actual care needs of the patients on the ward or in the Maternity Unit. Any areas of consistent significant concern relating to safe staffing were highlighted on the relevant risk register.

Care Quality Commission (CQC) registration requirements

The Trust considers it was compliant with the registration requirements of the CQC during 2024/25 and its current registration status is unconditional.

The Trust received an unannounced inspection of surgical services at Poole Hospital and Royal Bournemouth Hospital on 28 and 29 January 2025. A post inspection feedback letter was sent by the CQC in February, however the full report is not expected to be published until June 2025.

The feedback letter highlighted a few areas for improvement including the availability of clinical equipment, infection prevention and control standards, and staffing templates. Actions have already been taken to respond to the concerns raised. The feedback letter also noted improvements with the timeliness of the fractured neck of femur pathway at Poole Hospital and reported that generally the environment was clean and free from clutter. Across surgical services they highlighted that internationally trained staff gave positive feedback about working in the Trust, patients gave positive feedback about the care they received and overall staff were caring and responsive to their patients.

The CQC has also undertaken a visit to our new BEACH Building at the Royal Bournemouth Hospital as part of routine registration assessment under the New Hospital Programme (NHP) Framework. On 5 and 6 March 2025, the CQC visited the BEACH Building to assess the Emergency

Department, Critical Care, Maternity and Radiology and focused on the following areas:

- suitability of premises and equipment
- safe care and treatment
- staffing
- good governance

The Trust received a post visit letter on 7 May 2025 with positive feedback across all areas visited.

The CQC letter noted in summary that *“the opening of the BEACH will have a positive and beneficial effect on life for patients attending it and staff working in it”*. The CQC also extended thanks for the arrangements that were made at short notice to help organise the assessment and for the cooperation that they experienced from all staff who were involved in the visit.

Conflicts of interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the ‘Managing Conflicts of Interest in the NHS’ guidance.

NHS Pensions Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

Sustainability

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS Programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.



Review of economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through systems of internal control designed to ensure that resources are applied efficiently and effectively. We have a range of key financial policies in place. Our devolved structure is governed by our Scheme of Delegation and we have Standing Financial Instructions setting out financial responsibilities.

We have maintained systems to:

- set, review and implement strategic and operational objectives
- engage actively with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon
- monitor and improve organisational performance
- establish plans to deliver efficiency improvement



Every year the Board agrees a set of objectives for the following year which are communicated to colleagues and the public. This provides the basis for performance reviews.

Operational performance is kept under constant review by the Executive Team, through the Finance and Performance Committee and the Board of Directors.

At each formal meeting in public, the Board reviews an Integrated Quality and Performance Report covering patient safety, quality, access and experience metrics, and finance to keep under review the delivery of our annual objectives.

The Trust employs a number of internal mechanisms and external agencies to ensure the best use of resources. Externally, this includes reviewing Model Hospital data provided by NHS Improvement to improve productivity, and the Getting it Right First Time (GIRFT) efficiency programme. Internally, the Trust operates through the Patient First Improvement Programme under our Sustainable Services banner. This is a comprehensive, well-defined efficiency improvement programme with the core intention of organising activities differently rather than doing the same things the same way but for less money.

The Trust also includes the use of quality impact assessments as part of its cost improvement programme, drawing a link between quality improvement and achieving greater efficiency. Executive and senior managers in the organisation have responsibility for the effective management and deployment of their staff and other resources to maximise the efficiency of their directorates or departments.

In terms of longer-term financial planning, the Trust continues to work in partnership with other trusts in Dorset and commissioners as part of the Clinical Services Review and the broader Dorset system.

During 2024/25, we carried out a number of internal audits. These included:

Audit	Design	Effectiveness
Right to Work Checks	Moderate	Moderate
IT Asset Management	Substantial	Moderate
Staff Networks	Moderate	Moderate
Ward Identity Checks	Limited	Limited
Data Quality	Moderate	Moderate
Care Group Financial Governance	Moderate	Moderate
Complaints Follow Up	Substantial	Moderate
Cash Office Controls Follow Up	Substantial	Substantial
System Workforce Controls	Moderate	Moderate
Maternity Incentive Scheme	N/A - Advisory	N/A - Advisory
ICS System Operating Model Governance	N/A - Advisory	N/A - Advisory

Information governance

Information governance incidents within the Trust are managed through consistent, rigorous processes. Incidents are reviewed monthly through the Information Governance Steering Group, and where a serious incident occurs there is engagement from the Caldicott Guardian, Senior Information Risk Owner and the Data Protection Officer.

During the year ending March 2025, the Trust notified the Information Commissioner's Office (ICO) of one Information Governance related incident, using the Data Security Incident Reporting Tool. The incident that was reported did not originate within the Trust but affected a third-party supplier who process personal data regarding Trust staff; the incident was reported to the ICO for awareness. The ICO deemed that no action against the Trust was necessary. This incident involved the supplier of dosimetry monitoring services to the Trust. The supplier reported a cyber-attack which resulted in the exfiltration of personal data. This includes the first name and surname, plus radiation dose received, of 439 staff who use dosimeters for radiation exposure monitoring. The supplier reported that this information was exfiltrated in September/October 2023, and their subsequent investigations found that it was

posted to the 'dark web' by the 'threat actor' who had infiltrated their network. This breach was only reported to the affected parties in November 2024, with the justification being that the supplier had had to review the data that was exfiltrated to establish its origin.

The Data Security Protection Toolkit (DSPT) is a mandatory annual self-assessment audit produced by NHS England. In 2024/25 the DSPT provided acute trusts with numerous assertions to which a response was required, with the intent being to help to determine the extent to which an organisation is compliant with national guidance and legislation.

In advance of the 2024/25 publication of 30 June 2024, the Trust's internal auditors conducted a high-level review of a sample of Data Security Standards, which provided moderate overall assurance, and high levels of confidence in the Trust's submission. The purpose of the audit was to provide an independent review of the assertions and evidence items in the Trust's DSP Toolkit self-assessment return at the time of the audit and, where necessary, to identify how compliance could be improved for the year-end return.

As of 30 June 2024, the Trust submitted a fully compliant DSPT, with a confirmed status of 'Standards Met'.

Data quality and governance

The Trust reports on elective waiting times throughout the year, in nationally mandated submissions and in regular internal updates to committees and groups within its governance structure, including updates to the Finance and Performance Committee and Trust Board. Waiting list validation is undertaken to confirm the waiting time data recorded for patients waiting to be seen or treated. Training is provided to teams by the IT Training Team and additional support and training is provided by the Patient Access Team where concerns are identified or requests are made for additional support. A number of reports are available both nationally and internally to identify potential data quality concerns and areas for improvement. The Trust contributes data to the LUNA health system run by NECS which assesses performance for all trusts in relation to confidence in waiting list data and potential pathway issues to strengthen the accuracy of key data quality performance indicators. The Trust also uses a well-established clinical harm process to assess the extent of any harm associated with long waits and the risks of extended waits are recorded on the Trust's risk register.



Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the System of Internal Control. My review is informed by the work of the internal auditors, Clinical Audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the System of Internal Control by the Board of Directors, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.



2024/25 Internal Audit Programme

BDO provides our Internal Audit Service. They met with executive directors to bring a draft plan which was presented to our Audit Committee for review and subsequent approval. The plan was kept under continuous review during the year and was set within the context of a multi-year approach to internal audit planning, such that all areas of key risks would be looked at over a three year audit cycle. Our internal auditors' risk-based approach to internal audit uses our risk management process and risk register as a starting point for audit planning, representing our assessment of the risks to achieving our strategic objectives.

Internal Audit Opinion

*"The role of internal audit is to provide an opinion to the Board, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. Overall, we provide **Moderate Assurance** that there is a sound system of internal controls, designed to meet the Trust's objectives, that controls are being applied consistently across various services."*

The 2024/25 period covered an assessment of controls across a range of strategic, clinical, operational and financial areas.

The Trust's Accountability Framework supports the delivery of the Annual Operational Plan. It sets out the key enabling structures and processes to support the delivery and achievement of our vision, our strategic themes and objectives, and our key enabling programmes. The Framework enables us to support leaders, managers and staff in the delivery of continuous improvement, to achieve high class services and outcomes for our service users, patients and the local communities we serve.

As noted above, the Integrated Performance Report provides the Board with an integrated summary of key metrics and actions, linked to the Trust's strategic objectives and taking into account the CQC well-led domains.

The Audit Committee has held development sessions during the year to consider opportunities to further enhance and strengthen our risk management processes from ward to Board. These will be an area of focus during the coming year.

The annual Clinical Audit Plan, approved by the Trust Management Group and monitored via the Clinical Audit and Effectiveness Group, Quality Committee and Audit Committee, summarises the clinical audit activity across the Trust for the year. The plan adheres to the national requirements for clinical audit as well as reflecting specific local priorities. All clinical audits identified on the plan are discussed and reviewed at the Clinical Audit and Effectiveness Group with any learning and best practice shared wider via speciality and directorate governance meetings, the Trust Clinical Governance Group and Trust Management Group. The Quality Committee receives reports against the plan and details of any risks associated with compliance with national and local audit requirements.

Conclusion

Based upon available Department of Health and Social Care guidance, and the Trust's internal and external auditor's views, the Board of Directors has not identified any significant internal control issues at this time.



Siobhan Harrington

Chief Executive

18 June 2025

(For both the Accountability Report and the Annual Governance Statement)

Consolidated Financial Statements

For the year ended 31 March 2025



Contents

The Foundation Trust	3
Foreword to the accounts	4
Accounting Officer's Statement	5
Auditor's Report	6
Primary Statements	
Statement of Comprehensive Income	11
Statement of Financial Position	12
Statement of Changes in Taxpayers' Equity	13
Statement of Cash Flows	14
Notes to the accounts	
Note 1: Accounting policies	15
Note 2: Operating segments	30
Note 3: Income generation activities	30
Note 4: Operating income	31
Note 5: Private patient monitoring	32
Note 6: Mandatory and non-mandatory income from activities	33
Note 7: Operating expenses	33
Note 8: Operating leases	35
Note 9: Staff costs and numbers	36
Note 10: Retirements due to ill-health	37
Note 11: The Late Payment of Commercial Debts (Interest) Act 1998	37
Note 12: Investments	37
Note 13: Finance costs	38
Note 14: Intangible assets, property, plant and equipment	39
Note 15: Impairment of property, plant and equipment	43
Note 16: Capital commitments	43
Note 17: Inventories	43
Note 18: Trade and other receivables	44
Note 19: Cash and cash equivalents	45
Note 20: Trade and other payables	46
Note 21: Other liabilities	46
Note 22: Borrowings	47
Note 23: Finance lease obligations	47
Note 24: Provisions for liabilities and charges	48
Note 25: Related party transactions	49
Note 26: Post Statement of Financial Position events	50
Note 27: Financial risk management	50
Note 28: Financial instruments	52
Note 29: Intra-government and NHS balances	54
Note 30: Losses and special payments	54
Note 32: Senior manager remuneration	55
Note 33: Senior manager pension entitlements	55
Note 34: Charitable Fund Reserve	55



The Foundation Trust

NHS Foundation Trust Code: R0D

Registered Office:
Poole Hospital
Longfleet Road
Poole
BH15 2JB

Executive Directors:	Siobhan Harrington	Chief Executive Officer
	Sarah Herbert	Chief Nursing Officer
	Mark Mould	Chief Operating Officer
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy and Transformation Officer
	Tina Ricketts	Chief People Officer
	Peter Wilson	Chief Medical Officer
	Beverley Bryant	Chief Digital Officer
	David Broadley	Medical Director (Primary Care)

Non-executive directors:	Judy Gillow MBE	Interim Chair
	Cliff Shearman OBE	Non Executive Director
	John Lelliott OBE	Non Executive Director
	Helena Mckeown	Non Executive Director
	Sharath Ranjan	Non Executive Director
	Claire Whitaker CBE	Non Executive Director
	Femi Macaulay	Non Executive Director
	Tracie Langley	Non Executive Director
	Andrew Doe	Associate Non Executive Director

Trust Secretary: Ms Y Dossabhoy

Bankers:
Barclays PLC
London

Government Banking Service - Royal Bank of Scotland PLC
Edinburgh

Solicitor:
DAC Beachcroft LLP
Winchester

Internal Auditor:
BDO LLP
Southampton

External Auditor:
KMPG LLP
Southampton



Foreword to the accounts

These accounts for the period ended 31 March 2025 for University Hospitals Dorset NHS Foundation Trust (the “Foundation Trust”) have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Siobhan Harrington
Chief Executive Officer
18 June 2025

Accounting Officer's Statement

Statement of the Chief Executive's responsibilities as the Accounting Officer of University Hospitals Dorset NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals Dorset NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Dorset NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health

and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Siobhan Harrington
Chief Executive Officer
18 June 2025



Auditor's Report

Independent Auditor's Report to the Council of Governors of University Hospitals Dorset NHS Foundation Trust

Report on the audit of the financial statements

Opinion

We have audited the financial statements of University Hospitals Dorset NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers' Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and Trust as at 31 March 2025 and of the Group and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group and the Trust's ability to continue as a going concern for the going concern period.



However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations - ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Group by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the mainly fixed nature of the funding provided to the Group and the Trust during the year. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to completeness of expenditure around year end, in response to possible pressures to meet delegated targets.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account combinations and material post-closing journal entries.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- inspecting a sample of payments made in the period around 31 March 2025, to determine whether expenditure had been recognised in the correct accounting period and whether accruals were complete

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.



We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.



Accounting Officer's and Audit Committee's responsibilities

As explained more fully in the statement set out on page [A], the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

Report on other legal and regulatory matters

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page [X], the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance



to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health

Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of the financial statements of University Hospitals Dorset NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Jonathan Brown

for and on behalf of KPMG LLP

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

27 June 2025

Statement of Comprehensive Income

	Notes	Group		Trust	
		2024/25	2023/24	2024/25	2023/24
		£'000	£'000	£'000	£'000
Operating income from continuing operations	4	912,218	845,856	906,264	840,441
Operating expenses of continuing operations	7	(986,224)	(869,272)	(982,090)	(865,456)
OPERATING (DEFICIT) / SURPLUS		(74,006)	(23,416)	(75,826)	(25,015)
FINANCE COSTS					
Finance income: Interest receivable	12	6,477	5,352	5,547	4,890
Finance expense: Interest payable	13	(1,172)	(868)	(1,172)	(868)
Finance expense: Unwinding of discount on provisions	13	(34)	(32)	(34)	(32)
Public Dividend Capital: Dividends payable		(11,469)	(11,148)	(11,469)	(11,148)
Other gains / (losses)		(69)	6	(69)	6
Movement in fair value of investment property and other investments		116	827	-	-
Profit / (Loss) from Joint Venture	12.2	1,045	(124)	1,045	(124)
DEFICIT FOR THE YEAR		(79,112)	(29,403)	(81,978)	(32,291)
Other comprehensive Income					
Impairment (chargeable to revaluation reserve)		(39,176)	(9,618)	(39,176)	(9,618)
Revaluation (taken to revaluation reserve)		8,817	2,196	8,851	2,196
Other reserve movements		25	34	-	34
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		(109,446)	(36,791)	(112,303)	(39,679)

The notes on pages 15 to 55 form part of these accounts.

Note a. 2024/25 Control Total	2024/25	2023/24
	£'000	£'000
Deficit for the year (above)	(81,978)	(32,291)
Add back impairment	81,517	31,909
Add donated capital/fixed asset disposal adjustment	440	115
Control total deficit	(21)	(267)
Add BHT surplus	114	332
Control total surplus	93	65
Agreed control total surplus	-	-
Performance against control total	93	65

Statement of Financial Position

	Notes	Group		Trust	
		31 March 2024	31 March 2023	31 March 2024	31 March 2023
		£'000	£'000	£'000	£'000
Non-current assets					
Intangible assets	14	16,519	20,137	16,519	20,137
Property, plant and equipment	14	555,410	549,223	555,289	549,064
Right of use assets	14	12,059	12,186	12,059	12,186
Investment property	12.4	11,554	-	11,554	-
Investments in LLP Joint Venture	12.2	232	103	232	103
Other Investments	12.3	8,483	8,367	-	-
Trade and other receivables	18	827	758	827	758
Total non-current assets		605,084	590,774	596,480	582,248
Current assets					
Inventories	17	9,934	8,871	9,934	8,871
Trade and other receivables	18	20,190	27,831	19,303	28,894
Other financial assets		-	60	-	-
Cash and cash equivalents	19	113,227	118,426	98,603	105,045
Total current assets		143,351	155,188	127,840	142,810
Current liabilities					
Trade and other payables	20	(106,091)	(115,554)	(102,760)	(112,577)
Borrowings	22	(3,315)	(3,988)	(3,315)	(3,988)
Provisions	24	(893)	(1,560)	(893)	(1,560)
Other liabilities	21	(1,872)	(2,761)	(1,872)	(2,761)
Total current liabilities		(112,171)	(123,863)	(108,840)	(120,886)
Total assets less current liabilities		636,264	622,099	615,480	604,172
Non-current liabilities					
Borrowings	22	(39,508)	(42,004)	(39,508)	(42,004)
Provisions	24	(2,233)	(2,207)	(2,233)	(2,207)
Other liabilities	21	(723)	(755)	(723)	(755)
Total non-current liabilities		(42,464)	(44,966)	(42,464)	(44,966)
Total assets employed:		593,800	577,134	573,016	559,207
Taxpayers' equity					
Public Dividend Capital		585,114	459,001	585,114	459,001
Revaluation reserve		51,887	84,551	51,887	84,551
BHT Charitable Fund Reserve		2,819	2,679	-	-
Income and expenditure reserve		(63,985)	15,655	(63,985)	15,655
NHS Charitable Fund Reserve	34	17,965	15,247	-	-
Total Taxpayers' equity:		593,800	577,133	573,016	559,207

The notes on pages 15 to 55 form part of these accounts.

The financial statements comprising the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, and Statement of Cash Flows were approved by the Foundation Trust Board on 18 June 2025 and signed on its behalf by:



Siobhan Harrington, Chief Executive Officer, 18 June 2025

Statement of Changes in Taxpayers' Equity

	Trust				BPHT Charity	UHD Charity	Group
	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Trust Reserves	Other Reserves	Charitable Fund Reserve	Total Reserves
Current Year	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 31 March 2024	459,001	84,551	15,655	559,207	2,679	15,247	577,133
Surplus /(Deficit) for the year	-	-	(81,979)	(81,979)	115	2,752	(79,112)
Transfers between reserves	-	(2,339)	2,339	-	-	-	-
Impairment losses on property, plant and equipment	-	(39,176)	-	(39,176)	-	-	(39,210)
Revaluations of property, plant and equipment	-	8,851	-	8,851	-	(34)	8,817
Public Dividend Capital received	126,113	-	-	126,113	-	-	126,113
Other movements	-	-	-	-	25	-	25
Taxpayers' Equity at 31 March 2025	585,114	51,887	(63,985)	573,016	2,819	(39,176)	593,800

	Trust				BPHT Charity	UHD Charity	Group
	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Trust Reserves	Other Reserves	Charitable Fund Reserve	Total Reserves
Prior Year	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2023	378,776	94,570	45,298	518,644	2,348	12,707	533,699
Surplus /(Deficit) for the year	-	-	(32,290)	(32,290)	331	2,556	(29,403)
Transfers between reserves	-	(2,647)	2,647	-	-	-	-
Impairment losses on property, plant and equipment	-	(9,618)	-	(9,618)	-	-	(9,618)
Revaluations on property ,plant and equipment	-	2,212	-	2,212	-	(16)	2,196
Public Dividend Capital received	80,225	-	-	80,225	-	-	80,225
Other movements	-	34	-	34	-	-	34
Taxpayers' Equity at 31 March 2024	459,001	84,551	15,655	559,207	2,679	15,247	577,133

The notes on pages 15 to 55 form part of these accounts.

Statement of Cash Flows

	Notes	Group		Trust	
		2024/25	2023/24	2024/25	2023/24
		£'000	£'000	£'000	£'000
Cash flows from operating activities					
Operating surplus from continuing operations		(74,006)	(23,416)	(75,826)	(25,015)
Operating surplus/(Deficit)		(74,006)	(23,416)	(75,826)	(25,015)
Non-cash income and expense					
Depreciation and amortisation	14	30,838	30,081	30,834	30,077
Impairments / Reversal of Impairments	14	81,517	31,909	81,517	31,909
Non-cash donations/grants credited to income		(1,256)	(1,561)	(1,256)	(1,561)
(Increase)/Decrease in Trade and Other Receivables		7,865	7,777	8,026	6,990
(Increase)/Decrease in Other Assets		-	1,543	-	1,543
(Increase)/Decrease in Inventories		(1,063)	(315)	(1,063)	(315)
Increase/(Decrease) in Trade and Other Payables		(2,084)	(3,177)	(2,119)	(2,791)
Increase/(Decrease) in Other Liabilities		(921)	(963)	(921)	(963)
(Increase)/Decrease in provisions		(675)	(1,041)	(675)	(1,041)
NHS Charitable Funds - net adjustments for working capital movements and non-cash transactions		(455)	(292)	-	-
Other movements in operating cash flows		-	(230)	-	(624)
		113,766	63,731	114,343	63,224
Net cash flow from operations		39,760	40,315	38,517	38,209
Cash flow from investing activities					
Interest received		5,547	4,890	5,547	4,890
Purchase of intangible assets		(322)	(5,705)	(322)	(5,705)
Purchase of property, plant and equipment		(162,640)	(89,012)	(162,640)	(89,012)
Sales of Property, Plant and Equipment		-	191	-	191
Cash donations to purchase capital assets		1,256	1,622	1,256	1,622
Net cash flow from investing activities		(156,159)	(88,014)	(156,159)	(88,014)
Cash flow from investing activities					
Public dividend capital received		138,364	80,225	138,364	80,225
Public dividend capital repaid		(12,251)	-	(12,251)	-
Loans received and repaid		(2,925)	(2,939)	(2,925)	(2,939)
Capital element of finance lease rental payments		(1,164)	(1,101)	(1,164)	(1,101)
Interest on DHSC loans		(1,012)	(535)	(1,012)	(535)
Interest element of finance lease		(136)	(411)	(136)	(411)
PDC Dividend paid		(9,676)	(12,514)	(9,676)	(12,514)
		111,200	62,725	111,200	62,725
Net increase in cash and cash equivalents		(5,199)	15,026	(6,442)	12,920
Cash and cash equivalents at 1 April		118,426	103,400	105,045	92,125
Cash and cash equivalents at end of year	19	113,227	118,426	98,603	105,045

The notes on pages 15 to 55 form part of these accounts.



Notes to the accounts

1 Accounting policies

1.1 Accounting policies and other information

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These financial statements have been prepared under historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken from outside the public sector. Activities are considered 'discontinued' if they transfer from one public

body to another. The Foundation Trust has no acquisitions or discontinued operations to report within these accounts.

Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually revised.

Details of key accounting judgements and estimations are contained within Note 31 to these accounts.

Operating segments

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Finance and Performance Committee that makes strategic decisions.

Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and amendments to be applied in DHSC group accounts 2024/25:

- IFRS 14 Regulatory Deferral Accounts: Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1 January 2023. Standard is not yet adopted by the FReM which is expected to be from April 2025: early adoption is not permitted.

- IFRS 18 Presentation and Disclosure in Financial Statements: Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures: Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Foundation Trust.

Prior year restatements

Each year, the reporting requirements of Foundation Trusts are refreshed, and as a result, some income and expenditure classifications may be updated to improve transparency. In these instances, both the current year and the prior year disclosures are updated. In addition, if in preparing the accounts, corrections are identified to prior year classifications, these will be updated and clearly marked as “restated”.

Basis of consolidation

The consolidated financial statements include the following, in addition to the Trust.

University Hospitals Dorset NHS Charitable Fund and Poole Hospital NHS Foundation Trust Charitable Fund

The NHS Foundation Trust is the corporate trustee of both University Hospitals Dorset NHS Charitable Fund (Charity Registration number 1057366) and Poole Hospital NHS Foundation Trust Charitable Fund (Charity Registration number 1058808, existing in shadow form only). The Foundation Trust has assessed its relationship to the respective charitable funds and determined

them to be subsidiaries because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable funds and has the ability to affect those returns and other benefits through its power over the funds.

The charitable fund’s statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice, which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity’s assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust’s accounting policies
- eliminate intra-group transactions, balances, gains and losses

Bournemouth and Poole Healthcare Trust (1) - Company Registration Number: 06430101

Private patient services within the NHS Foundation Trust are delivered through Private Health University Hospitals Dorset Limited (PHUHD Company Registration Number 06434541), which is a trading subsidiary of the registered charity, Bournemouth and Poole Healthcare Trust (1) (BPHT) (Charity Registration number 1122497). With effect from 1 February 2016, a number of the NHS Foundation Trust directors were appointed as directors on the PHUHD Board and as Trustees of BPHT. This secured a more integrated and robust approach to private patient provision and governance.

As a result of this, the NHS Foundation Trust assessed its relationship to BHT (including its trading subsidiary PHUHD), and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charity and has the ability to affect those returns and other benefits through its power over the charity.



The charity's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice, which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies
- eliminate intra-group transactions, balances, gains and losses

This resulted in £854,000 of income and £740,000 of expenditure being consolidated into the Foundation Trusts accounts together with a number of Statement of Financial Position balances, most notably the introduction of the BPHT Charitable Fund Reserve, with a closing balance of £2.8m.

Christchurch Fairmile Village Limited Liability Partnership: Company Registration Number OC395417

The Foundation Trust was a voting member of the joint venture, Christchurch Fairmile Village Limited Liability Partnership, which was incorporated on 19 September 2014.

In March 2019, the Foundation Trust sold half of its interest in this LLP. At this point, the NHS Foundation Trust reassessed the relationship and determined it to be an associate because the Foundation Trust had the power to exercise significant influence. In December 2024, the Trust ended its association with Christchurch Fairmile Village Limited Liability Partnership.

Dorset Heart Clinic Limited Liability Partnership: Company Registration Number OC414702

The Foundation Trust is a voting member of the joint venture, Dorset Heart Clinic Limited Liability Partnership, which was incorporated on 21 November 2016. The joint venture has been consolidated within these accounts using the equity method.

1.2 Revenue

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day



case), outpatient procedures, outpatient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High cost drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS15. Payment for CQUIN and BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time, depending upon the terms of the contract.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.



Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Charitable funds

Income is received from donations, legacies, fund raising events and from other charitable bodies.

Education and training

Revenue is recognised when the conditions of education and training contracts have been met.

Interest

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

Car parking

The Foundation Trust operates car parking services for employees and patients. Revenue is recognised when the Foundation Trust collects charges from employees and the public.

Catering services

The Foundation Trust operates canteen services for employees and patients. Revenue is recognised when the Foundation Trust sells to the employees and the public. Canteen sales are usually by cash or by debit card.

Rental income

The Foundation Trust owns some residential properties which are let out to members of staff and related parties. Rental income is recognised on a straight-line basis over the term of the lease.

Income from the sale of non-current assets

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item individually has a cost of at least £5,000, or
- collectively, a group of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates, and are under single managerial control, or
- it forms part of the initial equipping and setting-up cost of a new building, refurbishment of a ward or unit irrespective of its individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the entity and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is derecognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. They are measured subsequently at current value.

Non-current assets are stated at the lower of replacement cost and recoverable amount. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from the financing of the construction of fixed assets are not capitalised but are charged to the Statement of Comprehensive Income in the year to which they relate.



All land and buildings are revalued using professional valuations in accordance with International Accounting Standard (IAS) 16 every five years. A three yearly interim valuation is also carried out. Additional valuations are carried out as appropriate.

Professional valuations are carried out by the Foundation Trust's appointed external Valuer (Cushman & Wakefield). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A full valuation (excluding Assets Under Construction/ Work In Progress) was undertaken as at 31 March 2025. This value has been included in the closing Statement of Financial Position.

The valuations are carried out primarily on the basis of Modern Equivalent for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Assets in the course of construction are valued at current cost. Larger schemes are valued by the district valuer on completion or when brought into use, and all schemes are valued as part of the three/ five yearly revaluation.

Operational equipment is valued at net current replacement cost.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The estimated useful lives of assets are summarised below

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon this reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

As at 31 March 2025, there were no assets classified as 'Held for Sale'.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

	Minimum life (years)	Maximum life (years)
Buildings and dwellings	8	100
Furniture / fittings	5	25
Set-up costs	5	25
Medical and other equipment	5	15
Vehicles	7	15
Radiology equipment	5	15
IT equipment	2	15



Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable, for example:
 - management are committed to a plan to sell the asset
 - an active programme has begun to find a buyer and complete the sale

- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of the classification as 'Held for Sale'
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/ grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/ grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the product is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Foundation Trust intends to complete the asset and sell or use it
- the Foundation Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset
- the Foundation Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware (for example, an operating system) is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware (for example, application software) is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of assets are summarised below:

	Minimum (years)	Maximum (years)
Software	2	15

1.7 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those properties which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.8 Revenue government and other grants

Government grants are grants from Government bodies other than income from NHS England, NHS Commissioners, NHS Foundation Trusts or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. Due to the high turnover of stocks within the Foundation Trust, current cost is used as a fair estimate of current value.

1.10 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes current investments, cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability



to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.



The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.12 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 23 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is assets, arising from past events whose existence will only be confirmed by one or more future events not wholly within the Foundation Trust's control) are not recognised as assets, but are disclosed by note where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed by note unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Foundation Trust's control, or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

1.14 Public Dividend Capital (PDC) and PDC Dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets),



(ii) grant funded and assets purchased in repose to Covid-19, (iii) average daily cash balances held with the Government Banking Services (GBS) and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to short-term working capital facility, and (iv) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax (VAT)

Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation tax

Under current legislation, Foundation Trusts are not liable for corporation tax.

1.17 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.18 Foreign Exchange

The functional and presentation currency of the Foundation Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

1.19 Third party assets

Assets belonging to third parties, (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However, they are disclosed within Note 19 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.



1.22 Going Concern

These accounts have been prepared on a Going Concern basis.

International Accounting Standards (IAS1) require the directors to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a Going Concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 3.20, the accounts should be prepared on a Going Concern basis unless the directors either intend to apply to the Secretary of State for the dissolution of the Foundation Trust without the transfer of the services to another entity, or have no realistic alternative but to do so.

1.23 Investments

The Foundation Trust does not have any investments and the cash is held primarily in the Government Banking Service.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund does hold investments, both Fixed Asset Investments and Short-Term Investments:

Charitable Fund Fixed Asset Investments

Investment Fixed Assets are shown at Market Value, as detailed in the Statement of Financial Position.

The Trustee's policy is to invest charitable funds with investments that maximise capital and are the most suitable investment type. The long-term objective is to invest capital that will give the maximum growth on income with minimal risk. The investment held as at the Statement of Financial Position date are units within a managed Investment Portfolio and are included in the Statement of Financial Position at the closing price at 31 March 2023. Investments comprise equities, gilts, other fixed interest investments and pooled funds, the majority of which are quoted investments.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Charitable Fund Short-Term Investments

Short-Term Investments include Stocks and Equities that have been received as part of Legacy distributions given to the Charitable Fund. These are revalued at the year-end and any gain or loss on revaluation of the investment asset is shown in the Statement of Comprehensive Income.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.



2 Operating segments

The Foundation Trust has determined the operating segments based on the reports reviewed by the Finance and Performance Committee that are used to make strategic decisions. The Finance and Performance Committee considers the Foundation Trust's business from a services perspective as "Healthcare" and only one segment is therefore reported.

The segment information provided to the Finance and Performance Committee for the reportable segments for the year ended 31 March 2025 is as follows:

	Group		Trust	
	Healthcare 2024/25	Healthcare 2023/24	Healthcare 2024/25	Healthcare 2023/24
	£'000	£'000	£'000	£'000
Segment revenue	912,218	845,856	906,264	840,441
Patient and other income	912,218	845,856	906,264	840,441

It is appropriate to aggregate the Trust's activities as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- the nature of the products and services
- the nature of the production processes
- the type of class of customer for their products and services
- the methods used to distribute their products or provide their services
- the nature of the regulatory environment

3 Income generation activities

The Foundation Trust has not materially undertaken any other income generation activities with an aim of achieving profit.



4 Operating income

4.1 Income from patient related activities

	Group		Trust	
	Continuing Operations 2024/25	Continuing Operations 2023/24	Continuing Operations 2024/25	Continuing Operations 2023/24
	£'000	£'000	£'000	£'000
Foundation Trusts and NHS Trusts	6,327	5,664	6,327	5,664
Integrated Care Boards	659,172	626,453	659,172	626,453
NHS England	170,401	145,704	170,401	145,704
NHS Other	215	143	215	143
Non NHS:				
- Private patients	5,119	4,551	4,265	3,644
- Overseas patients (non-reciprocal)	327	634	327	634
- NHS Injury Scheme income	1,968	2,172	1,968	2,172
- Other	24	13	24	13
	843,553	785,334	842,699	784,427

The Trust recognises a notional income amount of £35,557,000 for the additional pension contribution that is funded centrally. This is included within the NHS England figures above and is matched by notional expenditure as detailed in Note 7.

The NHS Injury Cost Recovery Scheme Income above is reported gross and a 24.45% doubtful debt provision is included in expenditure, which represents expected recovery rates.



4.2 Other operating income

	Group		Trust	
	Continuing Operations 2024/25	Continuing Operations 2023/24	Continuing Operations 2024/25	Continuing Operations 2023/24
	£'000	£'000	£'000	£'000
Research and development	5,189	4,792	5,189	4,792
Education and training	28,046	25,018	28,046	25,018
Donations/grants of physical assets - received from other bodies	-	185	-	185
Cash grants for the purchase of capital assets - received from other bodies	1,256	1,376	1,256	1,376
Received from other bodies: Other charitable and other contributions to expenditure	2,918	3,104	2,918	3,104
Donated consumables from DHSC - contributions to expenditure for Covid response	-	139	-	139
NHS charitable funds: Incoming resources excluding investment income	5,100	4,508	-	-
Non-patient care services to other bodies	8,528	8,143	8,528	8,143
Education and training - notional income from apprenticeship fund	1,669	1,399	1,669	1,399
Other:				
- NHS drug sales	122	96	122	96
- Car parking	2,760	2,363	2,760	2,363
- Catering services	2,379	2,352	2,379	2,352
- Miscellaneous other	8,690	4,816	8,690	4,816
Income from operating leases	2,008	2,231	2,008	2,231
Total	68,665	60,522	63,565	56,014
Total income	912,218	845,856	906,264	840,441

5 Private patient monitoring

The Foundation Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.



6 Mandatory and non-mandatory income from activities

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£'000	£'000	£'000	£'000
Commissioner requested services	871,599	810,352	870,745	809,445
Non commissioner requested services	40,619	35,504	35,519	30,996
	912,218	845,856	906,264	840,441

7 Operating expenses

	Group		Trust	
	Continuing Operations 2024/25	Continuing Operations 2023/24	Continuing Operations 2024/25	Continuing Operations 2023/24
	£'000	£'000	£'000	£'000
Purchase of healthcare from NHS and DHSC bodies	5,417	3,201	5,417	3,201
Purchase of healthcare from non-NHS and non-DHSC bodies	14,499	16,272	14,499	16,272
Purchase of social care	7	39	7	39
Employee expenses - executive directors	1,878	1,641	1,878	1,641
Employee expenses - non-executive directors	188	204	188	204
Employee expenses - staff	571,126	529,565	571,126	529,565
Employee expenses - redundancy	7	-	7	-
Employee expenses - notional employer contributions paid by NHSE (6.3%)	35,557	21,166	35,557	21,166
Supplies and services - clinical (excluding drug costs)	73,097	66,582	73,097	66,582
Supplies and services - clinical: utilisation of consumables donated from DHSC group bodies for Covid response	-	139	-	139
Supplies and services - general	15,535	15,058	15,535	15,058
Establishment	5,034	4,366	5,034	4,366
Research and development (excluding Employee Expenses)	87	206	87	206
Education and training - non-staff costs	2,828	2,857	2,828	2,857
Education and training - notional expenditure funded from apprenticeship fund	1,669	1,399	1,669	1,399
Transport (staff travel)	500	471	500	471
Transport (patient transport services)	1,003	982	1,003	982
Premises - rates	3,516	2,991	3,516	2,991
Premises	26,941	29,937	26,941	29,937

	Group		Trust	
	Continuing Operations 2024/25	Continuing Operations 2023/24	Continuing Operations 2024/25	Continuing Operations 2023/24
	£'000	£'000	£'000	£'000
Movement in credit loss allowance: all other receivables and investments	(76)	(158)	(76)	(158)
Movement in credit loss allowance: contract receivables/assets	281	(149)	281	(149)
Provisions arising / released in year	(39)	(184)	(39)	(184)
Change in provisions discount rate(s)	6	14	6	14
Drug costs	87,286	80,982	87,286	80,982
Operating lease payments	8	17	8	17
Depreciation on property, plant and equipment	26,916	25,248	26,912	25,244
Amortisation on intangible assets	3,922	4,833	3,922	4,833
Impairments net of (reversals)	81,517	31,909	81,517	31,909
Audit fees:				
External audit services - financial statement audit	174	168	174	168
External audit services - charitable fund accounts	7	7	-	-
Internal Audit and Counter Fraud	196	187	196	187
Clinical negligence premium	16,650	15,502	16,650	15,502
Legal fees	638	420	638	420
Insurance	597	525	597	525
Other services	5,820	9,517	5,080	8,942
Losses, ex gratia and special payments	49	128	49	128
NHS charitable funds: Other resources expended (balance not analysed above)	3,383	3,230	-	-
Total	986,224	869,272	982,090	865,456

The Trust has made no donations / contributions to any political party.



8 Operating leases

8.1 Operating leases, as lessee

	Group	Trust
	2024/25	2023/24
	£'000	£'000
Total operating leases	8	17
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
No later than one year	-	10
Total	-	10

8.2 Operating leases, as lessor

The Foundation Trust owns some properties from which rental income is derived. These are properties which are leased out to members of staff and the contracts are normally one year. The Foundation Trust also leases some office spaces to some contractors and service providers at the hospital sites. None of the leases include contingent rents and there are no onerous restrictions. The income recognised through the Statement of Comprehensive Income during the year is disclosed as:

	Group	Trust
	2024/25	2023/24
	£'000	£'000
Total operating leases	2,008	2,231
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
No later than one year	2,008	2,231
Total	2,008	2,231



9 Staff costs and numbers

9.1 Staff costs

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£'000	£'000	£'000	£'000
Salaries and wages	461,284	414,027	461,284	414,027
Social security costs	46,919	44,178	46,919	44,178
Apprenticeship levy	2,269	2,139	2,269	2,139
Employer's contributions to NHS Pensions	54,333	48,692	54,333	48,692
Pension cost - other contributions	35,557	21,166	35,557	21,166
Agency/contract staff	13,641	25,560	13,641	25,560
Pension costs - other	72	93	72	93
Total	614,075	555,855	614,075	555,855

This note excludes non-executive directors, in line with national guidance.

9.2 Average number of persons employed

	2024/25	2023/24
	Number	Number
Medical and dental	1,443	1,476
Ambulance staff	1	0
Administration and estates	1,364	1,335
Healthcare assistants and other support staff	1,613	1,683
Nursing, midwifery and health visiting staff	2,821	2,923
Scientific, therapeutic and technical staff	2,421	2,336
Healthcare science staff	222	190
Total	9,885	9,943
Of which:		
Permanent	8,795	8,469
Other	1,090	1,474
Total	9,885	9,943

This note excludes non-executive directors, in line with national guidance.

10 Retirements due to ill-health

There were 10 early retirements from the Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill health retirements will be £2,003,000. Any costs of ill-health retirements are borne by the NHS Pensions Agency.

11 The Late Payment of Commercial Debts (Interest) Act 1998

There were minimal payments of interest for commercial debts.

12 Investments

12.1 Investment revenue

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
			£'000	£'000
Interest on bank accounts	5,547	4,890	5,547	4,890
NHS charitable funds: investment income	930	462	-	-
Total	6,477	5,352	5,547	4,890

Government Banking Service interest is paid at 0.11% below the Bank of England Base rate.

12.2 Investment in joint ventures

	Group / Trust	
	2024/25	2023/24
	£'000	£'000
Opening balance	103	1,646
Share of profit / (loss)	1,045	(124)
Disbursements / dividends received	(916)	(1,419)
Closing balance	232	103

University Hospitals Dorset NHS Foundation Trust holds a 50% share of the Dorset Heart Clinic Limited Liability Partnership (DHC LLP). DHC LLP was established in 2016 to provide the provision of cardiology services to patients requiring private healthcare.

The Trust also held a 25% share of the Christchurch Fairmile Village Limited Liability Partnership, established in 2014 to operate a residential care home and the sale of retirement living accommodation. The Trust ended its association with the venture in December 2024.



12.3 Charity investments

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
Opening balance	8,367	7,540	-	-
Movement in fair value	116	827	-	-
Closing balance	8,483	8,367	-	-

The Trust Charity has achieved an increase of £116,000 in its investment holding in 2024/25. Although currently performing slightly below the benchmark of MSCI Private Investor Income Index, the closing balance remains significantly above the initial amount invested.

12.4 Investment property

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
Opening balance	-	-	-	-
Additions	11,554	-	11,554	-
Closing balance	11,554	-	11,554	-

The Trust's investment property relates to an office building and is measured at fair value of future economic benefits.

12.5 Other financial assets

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
Fixed deposit (less than one year)	-	60	-	-
Total	-	60	-	-

13 Finance costs

	Group / Trust	
	2024/25	2023/24
	£'000	£'000
Loans from the Independent Trust Financing Facility	1,036	527
Finance leases	136	341
Unwinding of discount on provisions	34	32
Total	1,206	900

14 Intangible assets, property, plant and equipment

	Group											Trust TOTAL
	Intangible	Tangible									TOTAL	
	Software Licences (incl Work in progress)	Land (Freehold)	Buildings excluding dwellings (Freehold)	Dwellings (Freehold)	Assets Under Construction / Work In Progress	Plant and Machinery	Transport Equipment	Information Technology	Furniture and fittings	NHS Charitable fund assets	Non Current Assets	Less Non-Trust Assets
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2024	46,850	39,291	258,911	15,533	168,996	152,010	6349	43,559	15,099	173	741,071	173
Additions - purchased / internally generated	314	-	15,678	268	125,101	1,592	-	121	-	-	143,074	-
Additions - assets purchased from cash donations/grants	8	-	140	-	448	622	19	8	11	-	1,256	-
Impairments charged to operating expenses	-	(2,899)	(78,618)	-	-	-	-	-	-	-	(81,517)	-
Impairments charged to the revaluation reserve	-	(17,835)	(29,777)	(584)	-	-	-	-	-	(34)	(48,230)	(34)
Reversal of impairments credited to operating expenses	-	33	(246)	213	-	-	-	-	-	-	-	-
Revaluations	-	148	8,519	184	-	-	-	-	-	-	8,851	-
Reclassifications	-	-	154,879	(467)	(166,976)	7,674	-	5,120	(392)	-	(162)	-
Disposals	(25)	-	-	-	-	(6,775)	-	-	-	-	(6,800)	-
Cost or valuation at 31 March 2025	47,147	18,738	329,486	15,147	127,569	155,123	668	48,808	14,718	139	757,543	139
757,404												
Accumulated depreciation at 1 April 2024	26,713	-	8,714	467	-	98,200	461	32,735	4,407	14	171,711	14
Provided during the year	3,922	-	8,964	470	-	11,534	54	3,990	878	4	29,816	4
Impairments - Revaluation reserve	-	-	(9,020)	-	-	-	-	-	-	-	(9,020)	-
Reclassifications	-	-	361	(467)	-	-	-	-	(56)	-	(162)	-
Disposals	(7)	-	-	-	-	(6,724)	-	-	-	-	(6,731)	-
Accumulated depreciation at 31 March 2025	30,628	-	9,019	470	-	103,010	515	36,725	5,229	18	185,614	18
185,596												
Net book value												
Owned	16,519	18,738	307,018	14,677	126,311	48,061	112	12,008	9,428	121	552,994	121
Donated	-	-	13,449	-	1,258	4,051	41	75	61	-	18,935	-
NBV total at 31 March 2025	16,519	18,738	320,467	14,677	127,569	52,112	153	12,083	9,489	121	571,929	121
571,808												

14 Intangible assets, property, plant and equipment prior year

	Group											Trust TOTAL
	Intangible	Tangible									TOTAL Non-Trust Current Assets	Less Non-Trust Assets
		Software Licences (incl Work in progress)	Land (Freehold)	Buildings excluding dwellings (Freehold)	Dwellings (Freehold)	Assets Under Construction / Work In Progress	Plant and Machinery	Transport Equipment	Information Technology	Furniture and fittings	NHS Charitable fund assets	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2023	42,466	39,275	221,626	15,959	166,194	146,769	634	39,124	11,572	189	683,808	189
Additions - purchased / internally generated	5,635	-	15,471	-	82,071	3,022	13	-	183	-	106,395	-
Additions - donations of physical assets (non-cash)	-	-	-	-	-	185	-	-	-	-	185	-
Additions - assets purchased from cash donations/grants	70	-	447	-	547	514	-	-	24	-	1,602	-
Impairments charged to operating expenses	-	-	(31,664)	(245)	-	-	-	-	-	-	(31,909)	-
Impairments charged to the revaluation reserve	-	-	(16,618)	-	-	-	-	-	-	(16)	(16,618)	-
Revaluations	(1,321)	207	1,763	242	-	-	-	-	-	-	2,212	-
Reclassifications	-	-	67,886	(423)	(79,816)	4,586	2	4,445	3,320	-	1,321	-
Disposals	-	(191)	-	-	-	(3,066)	-	(10)	-	-	(3,267)	-
Cost or valuation at 31 March 2024	46,850	39,291	258,911	15,533	168,996	152,010	649	43,559	15,099	173	741,071	173
740,898												
Accumulated depreciation at 1 April 2023	23,201	-	7,693	423	-	92,265	385	28,063	2,114	10	154,154	10
Provided during the year	4,833	-	8,924	467	-	10,463	63	3,360	740	4	28,854	4
Impairments - Operating expenses	-	-	-	-	-	-	-	-	-	-	-	-
Impairments - Revaluation reserve	-	-	(6,755)	(245)	-	-	-	-	-	-	(7,000)	-
Revaluations	-	-	-	-	-	-	-	-	-	-	-	-
Reclassifications	(1,321)	-	(1,148)	(178)	-	(1,562)	13	1,322	1,553	-	(1,321)	-
Disposals	-	-	-	-	-	(2,966)	-	(10)	-	-	(2,976)	-
Accumulated depreciation at 31 March 2024	26,713	-	8,714	467	-	98,200	461	32,735	4,407	14	171,711	14
171,697												
Net book value												
Owned	20,137	39,291	238,181	15,066	167,938	49,130	162	10,734	10,643	159	551,441	159
Donated	-	-	12,016	-	1,058	4,680	26	90	49	-	17,919	-
NBV total at 31 March 2024	20,137	39,291	250,197	15,066	168,996	53,810	188	10,824	10,692	159	569,360	159
569,201												

The Foundation Trust leases various medical equipment/ IT under non-cancellable finance lease agreements. The lease terms are between five and seven years.

14.1 Intangible assets, property, plant and equipment - Right of use assets

	Group							Trust	
	Intangible	Tangible						TOTAL	
	Software Licences (incl Work in progress)	Property (land and buildings)	Plant and Machinery	Transport Equipment	Information Technology	Furniture and fittings	NHS Charitable fund assets	Non Current Assets	Less Non-Trust Assets
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2024	-	11,287	5,714	-	1,152	-	-	18,153	-
Additions - lease liability	-	60	835	-	-	-	-	895	-
Reclassifications	-	-	51	-	(1)	-	-	50	-
Disposals/derecognition - lease termination	-	-	-	-	-	-	-	-	-
Cost or valuation at 31 March 2025	-	11,347	6,600	-	1,151	-	-	19,098	-
Accumulated depreciation at 1 April 2024	-	1,338	3,589	-	1,040	-	-	5,967	-
Provided during the year - right of use asset	-	516	492	-	14	-	-	1,022	-
Reclassifications	-	-	50	-	-	-	-	50	-
Disposals/derecognition - lease termination	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2025	-	1,854	4,131	-	1,054	-	-	7,039	-
NBV total at 31 March 2025	-	9,493	2,469	-	97	-	-	12,059	-

The Foundation Trust leases various property, medical equipment and IT equipment under non-cancellable finance lease agreements. The remaining lease terms are between two and thirty years.

14.1 Intangible assets, property, plant and equipment - Right of use assets prior year

	Group								Trust	
	Intangible	Tangible						TOTAL	Less Non-Trust Assets	TOTAL Trust Assets
		Software Licences (incl Work in progress)	Property (land and buildings)	Plant and Machinery	Transport Equipment	Information Technology	Furniture and fittings	NHS Charitable fund assets		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2023	-	11,543	5,142	-	-	1,147	-	-	-	17,832
Additions - lease liability	-	218	181	-	-	5	-	-	-	404
Reclassifications	-	(474)	474	-	-	-	-	-	-	-
Disposals/derecognition - lease termination	-	-	(83)	-	-	-	-	-	-	(83)
Cost or valuation at 31 March 2024	-	11,287	5,714	-	-	1,152	-	-	-	18,153
Accumulated depreciation at 1 April 2023	-	690	3,053	-	-	1,026	-	-	-	4,769
Provided during the year - right of use asset	-	598	615	-	-	14	-	-	-	1,227
Reclassifications	-	50	(50)	-	-	-	-	-	-	-
Disposals/derecognition - lease termination	-	-	(29)	-	-	-	-	-	-	(29)
Accumulated depreciation at 31 March 2024	-	1,338	3,589	-	-	1,040	-	-	-	5,967
NBV total at 31 March 2024	-	9,949	2,125	-	-	112	-	-	-	12,186

The Foundation Trust leases various medical equipment/ IT under non-cancellable finance lease agreements. The lease terms are between five and seven years.



15 Impairment of property, plant and equipment

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Changes in market price (as advised by the Trust's external valuer)	81,517	31,909
Total	81,517	31,909

16 Capital commitments

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Property, plant and equipment	99,659	137,051
Intangible assets	2,161	2,496
Total	101,820	139,547

17 Inventories

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Drugs	3,416	3,374
Consumables	6,518	5,497
Total	9,934	8,871

17.1 Inventories recognised in expenses

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Inventories recognised as an expense in the period	102,526	87,116
Total	102,526	87,116



18 Trade and other receivables

18.1 Amounts falling due within one year:

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
Contract receivables (IFRS 15): invoiced	8,516	11,906	8,516	11,906
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	6,782	12,411	7,015	13,507
Allowance for impaired contract receivables / assets	(585)	(521)	(585)	(521)
Allowance for impaired other receivables	(2,219)	(2,425)	(2,219)	(2,425)
Prepayments (revenue) [non-PFI]	4,936	3,419	4,936	3,419
PDC dividend receivable	-	794	-	794
VAT receivable	1,605	2,204	1,605	2,204
Clinician pension tax provision reimbursement funding from NHSE	35	10	35	10
NHS charitable funds: receivables	1,120	33	-	-
Total	20,190	27,831	19,303	28,894
Amounts falling due over one year:				
Clinician pension tax provision reimbursement funding from NHSE	827	758	827	758
Total	21,017	28,589	20,130	29,652

The provision for impairment of receivables relates to specific receivables.

18.2 Allowances for credit losses (doubtful debts)

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Contract receivables and contract assets:		
At 1 April	521	670
New allowances arising	428	64
Changes in the calculation of existing allowances	31	(40)
Reversals of allowances (where receivable is collected in-year)	(178)	(173)
Utilisation of allowances (where receivable is written off)	(217)	-
At 31 March	585	521
All other receivables:		
At 1 April	2,425	2,583
New allowances arising	503	256
Changes in the calculation of existing allowances	(349)	-
Reversals of allowances (where receivable is collected in-year)	(230)	(414)
Utilisation of allowances (where receivable is written off)	(130)	-
At 31 March	2,219	2,425

19 Cash and cash equivalents

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
Balance 1 April	118,426	103,400	105,109	92,126
Net movement in year	(5,199)	15,026	(6,506)	12,919
Balance at 31 March	113,227	118,426	98,603	105,045
Made up of:				
Cash at commercial banks and in hand	14,652	13,504	28	123
Cash with the Government Banking Service	98,575	104,922	98,575	104,922
Cash and cash equivalents	113,227	118,426	98,603	105,045

The patient monies amount held on trust was below £1,000, and is not included in the above figures.



20 Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
Amounts falling due within one year:				
Trade payables	16,482	24,772	15,408	24,410
Capital payables (including capital accruals)	18,593	25,671	18,593	25,671
Accruals (revenue costs only)	47,005	42,100	47,005	42,100
Annual leave accrual	640	611	640	611
Receipts in advance (including payments on account)	-	5	-	5
Social security costs	5,977	6,137	5,977	6,137
VAT payables	-	366	-	366
Other taxes payable	6,499	6,036	6,499	6,036
PDC dividend payable	999	-	999	-
Pension contributions payable	7,639	7,241	7,639	7,241
NHS charitable funds: trade and other payables	2,257	2,615	-	-
Total	106,091	115,554	102,760	112,577

21 Other liabilities

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Amounts falling due within one year:		
Receipts in advance - Heart Club	15	15
Receipts in advance - Other	1,857	2,746
Total	1,872	2,761
Amounts falling due over one year:		
Receipts in advance - Heart Club	723	755
Total	2,595	3,516



22 Borrowings

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Finance lease liabilities		
- Current	955	999
- Non current	11,181	11,406
Total	12,136	12,405
Independent Trust Financing Facility (ITFF) Loan		
- Current	2,360	2,989
- Non current	28,327	30,598
Total	30,687	33,587

As at 31 March 2025, the Foundation Trust has three outstanding ITFF loans:

- £9.9m Christchurch Hospital site development
- £5.1m Poole Hospital capital programme
- £15.6m development of pathology facilities

The total loans figure above (£33,587,000) includes £65,000 of accrued interest.
Further details are available in Note 27.

23 Finance lease obligations

The Foundation Trust operates as lessee on a number of medical and operational equipment leases. These leases generally run for between 2-7 years with options to extend the terms at the expiry of the initial period. None of the leases include contingent rents or onerous restrictions on the Foundation Trust's use of assets concerned.

Additionally, the Foundation Trust operates as a lessee on a number of property finance leases, ranging between 2-31 years. A summary of the Foundations Trusts right of use assets resulting from these finance leases is recorded in Note 14 in these accounts.

	Group / Trust	
	31 March 2025	31 March 2024
	£'000	£'000
Amounts payable under finance leases		
Within one year	1,081	1,102
Between one and five years	3,657	3,240
After five years	8,695	9,441
Less future finance charges	(1,297)	(1,378)
Total	12,136	12,405

24 Provisions for liabilities and charges

	Group / Trust				
	£'000	£'000	£'000	£'000	£'000
	Early Retirement	Injury Benefit	Legal claims	Other	Total
Opening balance	119	1,255	630	1,763	3,767
Change in the discount rate	0	6	-	(8)	(2)
Arising during the year	4	57	361	307	729
Utilised during the year	(25)	(96)	(494)	(268)	(483)
Reversed unused	(13)	-	(352)	(596)	(961)
Unwinding of discount	3	31	-	42	76
At 31 March 2024	88	1,253	545	1,240	3,126
Expected timing of cashflows:					
Within one year	24	60	545	228	893
Between one and five years	64	385	-	258	707
After five years	(0)	772	-	754	1,526
	88	1,253	545	1,240	3,126

Current and non current

Legal claims

Liability to Third Party and Property Expense Schemes:

The Foundation Trust has liability for the excess of each claim.

The calculation is based on estimated claim values and probability of settlement.

Other claims

Clinician Pension Tax Scheme:

The provision for Clinician Pensions Tax Scheme has been created as at 31 March 2025 and is calculated using the average discounted value per estimated nomination.

Late Payment of Commercial Debts (Interest) Act 1998:

The Foundation Trust has liability for interest and debt collection fees for invoices settled outside terms.

The calculation is based on estimations of invoices settled and probability of a claim being received.

£182,790,000 is included in the provisions of NHS Resolution at 31 March 2025 in respect of clinical negligence liabilities of the Foundation Trust.

25 Related party transactions

The Foundation Trust is a public benefit corporation established by order of the Secretary of State for Health and Social Care.

During the year none of the Board members or parties related to them has undertaken any material transactions with the Foundation Trust.

During the year the Foundation Trust has had a number of material transactions with public organisations together with other government bodies that fall within the whole of the government accounts boundary. Entities are listed below where the transaction total (excluding recharges) exceeds £500,000:

	Group / Trust			
	£'000	£'000	£'000	£'000
	Income	Expenditure	Receivables	Payables
NHS Dorset ICB	610,889	291	829	3,184
NHS Hampshire and Isle of Wight ICB	41,083	-	464	-
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	1,763	-	-	-
NHS Resolution (formerly NHS Litigation Authority)	-	17,340	-	9
NHS England - Core	28,067	6	236	-
NHS England - Central Specialised Commissioning Hub	15,537	-	1,271	-
NHS England - South West Regional Office	112,318	-	909	-
NHS England - South East Regional Office	4,486	-	20	-
Care Quality Commission	-	454	-	-
Dorset County Hospital NHS FT	3,270	3,859	834	1,747
Dorset Healthcare University NHS FT	6,650	2,506	2,223	402
Hampshire Hospitals NHS FT	313	440	25	80
Lancaster Teaching Hospitals NHS FT	-	659	-	2
Oxford Health NHS FT	-	2,629	-	66
Salisbury NHS FT	509	886	122	110
University Hospitals Bristol and Weston NHS FT	1,708	58	82	18
University Hospitals Southampton NHS FT	4,832	1,926	1,797	925
Other transactions less than £500,000	7,045	2,152	684	411
	838,470	33,206	9,496	6,954

The Foundation Trust is an agent on behalf of employees and below are material transactions exceeding £500,000:

	Group / Trust			
	£'000	£'000	£'000	£'000
	Income	Expenditure	Receivables	Payables
NHS Pensions Agency	-	89,890	-	7,639
HM Revenue and Customs (VAT)	-	-	1,605	-
HM Revenue and Customs (Income tax and National Insurance)	-	49,188	-	12,476
	-	139,078	1,605	20,115

26 Post statement of financial position events

There were no post statement of financial position events.

27 Financial risk management

Financial instruments are held for the sole purpose of managing the cash flow of the Foundation Trust on a day-to-day basis or arise from the operating activities of the Foundation Trust. The management of risks around these financial instruments therefore relates primarily to the Foundation Trust's overall arrangements for managing risks in relation to its financial position.

Market risk

Interest rate risk

The Foundation Trust has a fixed rate loan from the Independent Trust Financing Facility; plus capitalised finance lease obligations which each have fixed interest rates. As a result of these fixed rates; any interest rate fluctuations will only affect our ability to earn additional interest on our short-term investments.

The Foundation Trust earned interest of £5,547,000 during 2024/25, which is reflective of recent Bank of England base rate changes.

Currency risk

The Foundation Trust has minimal risk of currency fluctuations. Most transactions are in sterling. Although there are some purchases of goods from Ireland, where prices are based on the Euro, all payments are made in sterling.

Other risk

The inflation rate on NHS service level agreements is based on the NHS funded inflation, and therefore there is a small risk of budgetary financial pressure.

The majority of pay award inflation is based on the nationally agreed Agenda for Change pay scale, and although funding through the Payment by Results (PbR) tariff does not cover the entire cost (there is an assumed efficiency requirement within the tariff), this represents a small risk.



Credit risk

Debtor control

The Foundation Trust has a treasury function which includes a credit controller. The Foundation Trust actively pursues debts and use an external company to support specific aged debts.

The majority of the Foundation Trust's payables are short term and the Foundation Trust participates in the national NHS payables reconciliations at 31 December and 31 March each year. This helps to identify any significant NHS receivable queries.

Provision for doubtful debts

The Foundation Trust reviews non NHS receivables as at 31 March 2025 and as a result of this review, has provided £2,219,000 in relation to doubtful debts. A further £585,000 has been provided for in relation to the Injury Cost Recovery Scheme income, in accordance with national requirements.

The Foundation Trust has also reviewed NHS receivables and has provided for doubtful debts amounting to a total of £349,000. This represents either the maximum or probable risk in specific areas and reflects the uncertainty of the financial climate within the healthcare market.

Liquidity risk

Loans

The Foundation Trust has four fixed rate loans from the Independent Trust Financing Facility:

- 1** £9,935,000 relating to the Christchurch Hospital site development - initial loan £20,400,000 taken in May 2014 at a fixed annual rate of 2.89%, repayments commenced September 2014 and will finish March 2034.
- 2** £5,095,000 relating to Poole Hospital capital programme - initial loan £9,100,000 taken in September 2015 at a fixed annual rate of 2.63%, repayments commenced November 2015 and will finish November 2034.
- 3** £15,568,000 relating to the development of pathology facilities - initial loan £16,217,000 taken in March 2022 at a fixed annual rate of 1.58%, repayments commenced August 2024 and will finish February 2049.

Creditors

The Foundation Trust has reported a surplus in the current financial year and continues to have a surplus on the retained earnings reserve. In addition, the Foundation Trust has a cash balance of £102,500,000. As such, the Trust is a minimal risk to its creditors.



28 Financial instruments

28.1 Financial assets

	Group				Trust	
	31 March 2025		31 March 2024		31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000	£'000	£'000
	Loans and receivables	Assets at fair value through Income and Expenditure	Loans and receivables	Assets at fair value through Income and Expenditure	Loans and receivables	Loans and receivables
Assets as per the Statement of Financial Position						
Trade and other receivables excluding non-financial assets	13,356	-	22,139	-	13,356	22,139
Other investments	4,936	-	3,419	-	4,936	3,419
Cash and cash equivalents at bank and in hand	102,496	-	108,725	-	98,816	105,045
NHS charitable funds: financial assets as at 31 March	11,851	8,483	9,730	8,367	-	-
Total	132,639	8,483	144,013	8,367	117,108	130,603
Assets held in £ sterling		141,122		152,380	117,108	130,603



28.2 Financial liabilities

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£'000	£'000	£'000	£'000
	Other financial liabilities	Other financial liabilities	Other financial liabilities	Other financial liabilities
Liabilities as per the Statement of Financial Position				
Borrowings excluding finance lease and PFI liabilities	30,686	33,587	30,686	33,587
Obligations under finance leases	12,136	12,405	12,136	12,405
NHS trade and other payables excluding non-financial liabilities	6,954	3,964	6,954	3,964
Non-NHS trade and other payables excluding non-financial liabilities	75,126	95,820	75,126	95,756
Provisions under contract	3,126	3,767	3,126	3,767
NHS Charitable funds: financial liabilities as at 31 March	2,257	2,615	-	-
Total	130,285	152,158	128,028	149,479
Liabilities held in £ sterling	130,285	152,158	128,028	149,479

28.3 Financial assets / liabilities - fair values

	Group		Trust	
	31 March 2025		31 March 2025	
	£'000	£'000	£'000	£'000
	Book Value	Fair Value	Book Value	Fair Value
Financial assets				
Receivables over one year				
Other	827	827	827	827
NHS charitable funds: non-current financial assets	8,483	8,483	-	-
Total	9,310	9,310	827	827
Financial liabilities				
Non-current trade and other payables excluding non-financial liabilities	723	723	723	723
Provisions under contract	3,126	3,126	3,126	3,126
Total	3,849	3,849	3,849	3,849



29 Intra-Government and NHS balances

	Group / Trust	
	31 March 2025	
	Receivables: amounts falling due within one year	Payables: amounts falling due within one year
	£'000	£'000
Providers	5,195	3,704
NHS and Department of Health	3,970	3,250
Local Government	185	-
Other Government Bodies	1,806	20,115
Total	11,156	27,069

30 Losses and special payments

	Group / Trust			
	Twelve months to 31 March 2025		Six months to 31 March 2024	
	Number	£'000	Number	£'000
Losses				
Losses of cash due to:				
Other causes	1	-	4	1
Damage to buildings, property and equipment	24	583	24	393
Bad debts - overseas visitors	26	121	-	-
Total losses	51	704	28	394
Special payments				
Ex gratia payments in respect of:				
Loss of personal effects	45	36	60	54
Personal injury with advice	7	42	9	40
Miscellaneous other	5	7	6	2
Special severance payments	1	32	1	17
Total special payments	58	117	76	113
Total	109	821	104	507

There were no individual cases where the net payment exceeded £25,000.

Note: The total costs in this note are compiled directly from the losses and compensations register which reports on an accrual basis, with the exception of provisions for future losses.

31 Judgements and estimations

Key sources of estimation uncertainty and judgements

In the application of the Foundation Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

- Expenditure 'accruals' are included within the total expenditure reported with these financial statements. These accruals represent estimated costs for specific items of committed expenditure for which actual invoices have yet to be received, together with the estimated value of capital works completed, but not formally valued as at 31 March 2025. Estimates are based on the Foundation Trust's current understanding of the actual committed expenditure.
- An estimate is made for depreciation and amortisation of £30.8m. Each capital or donated asset is added to the asset register and given a unique identifier. The value and an estimated life is assigned (depending on the type of asset) and value divided by the asset life (on a straight-line basis) is used to calculate an annual depreciation charge.
- A net downwards revaluation of land and buildings of £30.3m has been charged to the revaluation reserve, with a further £2.3m transferred from the revaluation reserve to the income and expenditure reserve. This reflects the on-site valuation of Trust land and buildings carried out by the Trust's external valuers.
- The valuation exercise was carried out in March 2025 with a valuation date of 31 March 2025. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'). This interim revaluation included physical onsite attendance.

32 Senior manager remuneration

Directors' remuneration totalled £1,878,000 for the 12 months ended 31 March 2025. Full details are provided within the Remuneration Report.

33 Senior manager pension entitlements

There were benefits accruing to two of the Foundation Trust's Executive Directors under the NHS Pension Scheme in 2024/25. Full details are provided within the Remuneration Report.

34 Charitable Fund Reserve

The Charitable Fund Reserve comprises:

	31 March 2025	31 March 2024
	£'000	£'000
Restricted funds	7,606	5,562
Unrestricted funds	10,359	9,685
Total	17,965	15,247

University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East, Bournemouth, BH7 7DW

Poole Hospital
Longfleet Road, Poole, BH15 2JB

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

Further copies of this report can be found online at
www.uhd.nhs.uk

If you would like a copy of the Annual Report and Accounts
in a different format please contact the Communications Department
on **0300 019 4271**