NHS

University Hospitals Dorset

NHS Foundation Trust

Annual Report and Accounts 2025/26








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

1 April 2025 - 31 March 2026

University Hospitals Dorset NHS Foundation Trust

Annual Report and Accounts 2025/26

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

We are pleased to present our Annual Report for 2025/26. As we progress with reshaping both our urgent and elective care services, our commitment to patient safety and to supporting one another remains central, underpinning our ongoing efforts to drive continuous improvement.

It's been a year of significant change and challenge at University Hospitals Dorset (UHD). We know this has also been a time of ongoing change for our staff, and we want to say a heartfelt thank you for the commitment, care and hard work they show every day in supporting our patients.

Transforming Care Together

A £500m investment will transform our hospital services , ensuring patients get the right care in the right place at the right time. The Royal Bournemouth Hospital will become a major emergency centre, improving access to specialist urgent care, while Poole Hospital will become the UK's largest planned care centre, helping to reduce waiting times.

Over the past year, we've continued to engage with a wide range of stakeholders and local communities to make sure people are kept informed about the changes taking place across UHD. By regularly attending in-person events organised by partner organisations, such as Primary Care Networks (PCNs), we've been able to speak directly with hundreds of residents. These conversations have helped to address questions and ease concerns through open, face-to-face discussions.

Transforming Care Together

Better for patients, better for staff

These interactions have also given us valuable insight into the issues that matter most to our communities, helping us shape our engagement approach and communications.

Alongside public events, we've taken part in smaller, more focused meetings with business groups, such as the Ferndown Business Network, as well as residents' associations, patient groups and staff networks within partner organisations. We've also been out in the community, visiting libraries and shopping centres, and hosted a UHD marketplace at Poole's Dolphin Centre. This brought together a range of partners, including Dorset Police and the fire service, giving members of the public the chance to speak directly with both UHD staff and other local services.

Our governors have also played an important role, hosting listening events across Dorset and helping to promote surveys, events and key updates. They continue to build strong connections within local communities, and their commitment makes a real difference.

Staff Survey

The 2025 National Staff Survey results were published at the end of March 2026, with a 54.78% response rate for UHD (down from 57.8% in 2024), and the bank Staff Survey closed at 20.8% (27% in 2024).

I would like to thank all colleagues who took the time to tell us how they feel. Sharing their experience helps make UHD a better place to work and receive care.

Our results tell us that despite the challenges we faced at the time the survey was open, such as winter pressures, financial constraints, and huge transformation to our services, we are continuing to perform as well as we did in 2024 across many areas. This is a real positive and is testament to colleagues' dedication to our patients and each other.

In 2026, our goal is to focus on a clear cycle of listening, taking action and reporting outcomes. We will regularly celebrate continuous improvement and demonstrate how feedback sparks real change by using a 'you said, together we did' approach.

Improvements this year

In May, the relocation of Royal Bournemouth Hospital's (RBH) Emergency Department into the new BEACH Building was successfully achieved. This was a significant milestone for the Trust's transformational journey.

June saw the final structural element placed on the new Coast Building at RBH - marked by a topping out ceremony and the traditional nailing of the bough. Delivered by Darwin Group, the building will provide a modern ward and catering block, boosting capacity and care. The event was a great opportunity to welcome colleagues from across UHD and Dorset, as well as the senior leadership team from the New Hospital Programme, and local stakeholders including Tom Hayes MP and Councillor Millie Earl, Leader of BCP Council.

Also in June, we successfully moved our Outpatients Assessment Clinic (OAC) from Beales in the Dolphin Centre to the former St Mary's Maternity Unit in Poole. The new St Mary's site offers key outpatient services such as AAA screening, dermatology, dexa scans, ophthalmology, orthopaedics, phlebotomy, and ultrasound. Breast screening will now be expanded at Poole Hospital, with other services relocated within UHD.

Significant progress continues to be made across our transformation programme. A new play area has been installed within the Children's Emergency Department, enhancing the patient and family experience and supporting a more therapeutic environment for young patients. This was thanks to our fantastic fundraising by our UHD Charity for the BEACH Building, and we invited donors and children to the official opening on 21 October 2025.

At Poole the build of our new CDC Endoscopy hub continues. At the end of October 2025, a further 17 modules were craned into position, completing the full building outline. This represents a major milestone in the project's delivery timeline as we work towards the planned opening in summer 2026. Once operational, the facility will enable us to diagnose and treat more patients, enhance the quality of care, and contribute to a substantial reduction in waiting times.

Patient First

We continue to roll out the Improvement Boards to all clinical areas and our training and coaching is a critical part of this. We are working on the Board aspect of this work and visiting some other trusts to take their experience and learning so our work is aligned. Dorset has also been identified as the accelerator site for the South West region to access national training for our managers in improvement and operational management.

Patient First

Provide excellent healthcare. Be a great place to work.

Staff Awards

Our UHD Awards returned in May 2025, bigger and better than ever. Uplifting examples of inspiring care, teamwork and leadership were all celebrated as more than 360 members of staff and hospital volunteers gathered at The Pavilion in Bournemouth to hear how our finalists were placed in each of the 14 categories. They were joined by patients and members of our local community who put forward colleagues for recognition. We received an amazing 950 nominations this year, shining a spotlight on the work of #TeamUHD, giving our judging panel a real challenge. Congratulations to our winners and highly commended colleagues.

Executive Team

Tina Ricketts, our Chief People Officer (CPO), left the Trust on 30 April 2025. We thank her for her considerable contribution to UHD during her time here and wish her well for the future.

On 18 August 2025, Melanie Whitfield joined us as Chief People Officer from Salisbury NHS Foundation Trust. Before joining UHD, Melanie held a number of senior roles across the NHS and wider public sector. She played a national role at NHS England and Improvement, where she was one of the founding authors of the NHS People Plan.

We'd like to thank Irene Mardon, Deputy Chief People Officer, who stepped into the CPO role prior to Melanie's arrival.

Dr David Broadley, our Medical Director for Integrated Care (GP), stepped down from his role at the end of May 2025. David worked hard to develop and improve relationships with primary care. He will be greatly missed by his colleagues but will continue to work alongside the Trust in his role as GP.

Dr Mufeed Ni'Man took over this role at the beginning of October 2025. His appointment will help us further develop the integration between primary and secondary care, supporting us to redesign care traditionally found in the hospital setting and moving it to the community or in people's homes.

Non-Executive Team

On 1 May 2025, Judy Gillow, MBE took up the role of our Interim Chair. Judy is a nurse by background and has an extensive career across the NHS, having worked in a range of clinical settings in acute, community, primary care and education. Her roles have included Director of Nursing and Organisational Development as well as having been a non-executive director. She has also served as our Senior Independent Director and is already well known to many of our staff, having been very visible across the organisation.

We saw two long-lasting and highly valued non-executive directors retire over the year: John Lelliott and Cliff Shearman. As chairs of Finance and Performance and Quality Committees respectively, they have had a significant and lasting impact.

Our two new non-executive directors are Michael Marsh, former Medical Director for NHSE South West, and Alastair Matthews, a former NHS Chief Financial Officer. They both already have non-executive experience and have taken up the chairmanship of Board committees.

Our governors

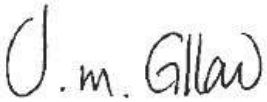
Following the governor elections held in Autumn 2025, the Council of Governors was pleased to welcome six new governors in January 2026. This included two governors from the Poole and Rest of Dorset constituency, two from the Christchurch and Rest of England constituency, and two new staff governors.

Throughout the year, our governors continued to play a valued role in supporting the Trust by hosting a range of in person listening and information events for the public. They also engaged with communities that are traditionally under represented, delivering targeted sessions in specific local areas to help address health inequalities and ensure a broader range of voices are heard.

We would like to thank all our governors for their ongoing commitment and support.

Thank you to Team UHD

Thank you, Team UHD, for everything you've accomplished over the past year. We're also grateful to our partners, governors, volunteers and patient groups for the vital role you've played in supporting our hospitals during what has been both an exciting and demanding time. We look forward to building on this progress together as we continue to improve and transform services for the communities we serve.



Judy Gillow
Interim Chair

Siobhan Harrington
Chief Executive

A year in pictures

April 2025

In April, we marked Admin Appreciation Day with Trustwide celebrations recognising the contribution of our administrative colleagues. Teams took part in a programme of events and created their own moments of appreciation for our #TeamUHD admin colleagues who form the backbone of the NHS.

May 2025

In May, we celebrated our third year of our bigger and better UHD Staff Awards, with a record breaking 950 nominations from staff and colleagues. Uplifting examples of inspirational care, teamwork and leadership were all celebrated.

June 2025

In June, the final structural element was placed on the new Coast Building at RBH - marked by a topping out ceremony and the traditional nailing of the bough. Delivered by Darwin Group, the building will provide a modern ward and catering block, boosting capacity and care. We welcomed leaders from UHD, the New Hospital Programme, and local stakeholders including Tom Hayes MP and BCP Council leader Councillor Millie Earl.

July 2025

Our Cultural Celebrations in July were a timely reminder of how important it is to make time for one another and celebrate the wonderful diversity of UHD. Our third UHD Cultural Celebrations were an inspiring and unforgettable event, and some 2,000 colleagues across all sites enjoyed the days offerings.

▲ August 2025

In August 2025, we celebrated our Stroke Research Team being the UK's leading recruiter for a national clinical study to support patients recovering from stroke. In a ground-breaking new trial, led by experts from the University of Nottingham, the team is assessing whether Pharyngeal Electrical Stimulation (PES) can help people to recover the ability to swallow again following a stroke.

▲ September 2025

We celebrated Debbie Daniels, our UHD Senior Health Play Specialist, as she was named Mentor of the Year in the 2025 Starlight Play in Healthcare Awards. With over 20 years' experience, Debbie has supported children through some of the most challenging hospital treatments, and now, by mentoring the next generation of health play specialists, she's making an impact that will last for years to come.

▲ October 2025

Black History Month celebrations in October were a time for reflection, education, and inspiration. The events were a great opportunity for colleagues to come together and raise awareness of Black History Month, while showcasing the rich diversity and 'One Team' value of our Trust.

▲ November 2025

Our Poole Hospital RACE (Rapid Access Consultation and Evaluation Unit) Team celebrated an incredible 15 years of service. Established in 2010, the ward provides short stay hospital care for patients and establish ties with the wider area so care can be managed within the community.

▲ December 2025

In December, we celebrated the new murals adorning the Energy Centre at the Royal Bournemouth Hospital (RBH). Part of a developing hospital art trail, the new artworks aim to create a welcoming environment for patients, visitors, and staff as they enter the hospital. These murals were created in partnership with our UHD Charity funded 'ArtSpace' and Arts University Bournemouth.

▲ January 2026

In January we were featured in NHS England's social media channels in a story that focused on Meredith, a little girl who inspired many hearts with her cancer journey. On 31 December, Meredith had her last chemotherapy session at Poole Hospital and rang the bell in January to signal the end of her cancer treatment. Her can-do attitude and costumes have been an inspiration to us all.

▲ February 2026

In February 2026, board members from NHS England met some of our brilliant colleagues and took a look around our state-of-the-art Barn Theatres and what will be our new Endoscopy Unit at Poole Hospital. At RBH they visited our Maternity, ED and Critical Care Departments and our new Same Day Emergency Care, Surgical Admissions Unit and new Oncology ward.

▲ March 2026

In March 2026, two of our brilliant colleagues were invited to spend a day at 10 Downing Street recently for Chinese New Year celebrations. Bingbing Liu, Senior Surgical Clinical Lead, and Staff Nurse, Lixia Wang, were invited by NHS England to celebrate the importance of Chinese community and culture in British life.

We are #TeamUHD

A year of celebrations

Here at UHD, good news flows through our Trust constantly, and we're really proud to share the achievements of our colleagues and teams. Here are just some of the celebrations we've marked in 2025/26...

We teamed up with charitable organisation **'No Limits'** to introduce youth workers to UHD. The youth workers support young people aged 11-25 who have come to our emergency departments or been admitted to our hospitals, offering specialised emotional support, crisis intervention, and access to ongoing services for young people in need of help, significantly reducing the likelihood of future readmissions. The roles were generously funded by our UHD Charity and the Office of the Dorset Police and Crime Commissioner.

Our **Hospice at Home** service expanded to Poole and the surrounding areas under the care of Forest Holme Hospice, supporting patients with compassionate, personalised end of life care in the comfort of their own homes. The service was first established at the Macmillan Unit in Christchurch.

The culmination of 10 years work at UHD and Bournemouth University came to fruition with a paper published in the Lancet focusing on **CHAIN (Cycling against Hip pAIN)**. The programme was conceived by Professor Robert Middleton and Professor Thomas Wainwright with the aim of promoting the self-management of osteoarthritic symptoms through lifestyle change.

The Rt Revd Rhiannon King, Bishop of Southampton, and The Rt Revd Karen Gorham, Bishop of Sherborne, were the first senior faith leaders to visit our **Chaplaincy Centre at RBH** since its opening in March 2025. During the visit, they formally blessed the space and licenced our Lead Chaplain, Revd James Taylor.

We opened our **Macmillan Cancer Information Hub** in the Jigsaw Building at RBH. The hub is staffed by a cancer support worker and patient experience volunteers who are on hand to offer wellbeing support advice.

A number of our teams were recognised in our **Clinical Quality Accreditation Scheme**, a structured, externally validated process used to assess whether a clinical service meets defined, evidence based standards of quality, safety, and effectiveness. Both our Macmillan Unit and Forest Holme hospices received gold!

Our **Organ Donation Team** supported a number of families throughout the year and due to the selfless gift of nine individuals and their families, 17 lives have been saved through the gift of organ donation. We also had 16 corneas donated from UHD for their tissue. The team continues to work hard to improve staff knowledge and confidence, ensuring that critical conversations can be had early and sensitively.

Our **Vascular Therapy Team** won an Excellence award following an outstanding GIRFT review on length of stay for amputees - putting them third in the country of vascular networks.

Poole Hospital was awarded a gold level **NJR Quality Data Provider for 2025**, recognising its excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process.

Save lives, improve

A nod to our people

Julie Dowdney, UHD's Head Orthoptist and service manager, scooped the 'Outstanding Leadership' accolade at the British and Irish Orthoptic Service's (BIOS) annual award ceremony. The award reflects Julie's dedication to her work both as Vice Chair of BIOS for two terms, and for her role as Chair of the Leaders of the Orthoptic Profession.

Sam Whittle, a Diabetes Specialist Nurse, won the Innovation Award at the Diabetes Nursing Awards 2025 in recognition of her pioneering work to transform type 2 diabetes care. She was praised for developing the 'Refocusise' programme - an innovative eight-week diabetes rehabilitation initiative that combines structured education with tailored exercise sessions.

John Williams, Senior Biomedical Scientist in Cellular Pathology, continued his dominance during award season with the Southwest Healthcare Science Award 2025 for Emerging Talent. This came hot on the heels of him securing the highest mark in cellular pathology and the highest mark across all Higher Specialist Diploma disciplines nationally, and was awarded the R.J. Lavington Prize and the Institute of Biomedical Science (IBMS) Company Members Prize.

Ruth Pedwell, our Hepatology Nurse Specialist, was awarded Gastrointestinal Nurse of the Year. Ruth was the lead navigator on the HELIXR project, which developed a community champions programme to support under-served patients to get access to Hepatocellular Carcinoma (HCC) surveillance.

Dr Rachel Plant, Medical Oncologist, was presented with an award for Clinical Excellence in Immuno-oncology by the Immuno-Oncology Clinical Network (IOCN). This was in recognition of her outstanding contribution to improving outcomes for patients receiving immunotherapy and her leadership and innovation within oncology services at UHD.

Akeisha Robinson and **Beth Fletcher** won the RCM Excellence in Public Health Award while the Practice Development Team were shortlisted for the MDT of the year award.

A number of our teams were both shortlisted and triumphant at HSJ Awards throughout the year, including our **MSK Therapies Team**.

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 2025/26

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 2025/26 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

UHD delivered the first significant transformational milestone in May 2025 with the relocation of the Bournemouth Emergency Department (ED) into the newly commissioned BEACH Building. The new ED is one of the largest departments in the country and is well placed to deliver against the ambitions of the Dorset Clinical Services review that will see the Royal Bournemouth Hospital (RBH) becoming the emergency care site for east Dorset.

The Trust failed to deliver against its objective of ensuring 78% of patients attending our EDs were admitted or discharged within four hours, as per the 4-hour Organisational Safety Standard. This was due to a number of challenges. High occupancy - driven by a number of patients remaining in hospital who were unable to be discharged to ongoing services - increased demand, and internal processes all adversely impacted flow from our EDs.

Despite this there have been several improvements during 2025/26. Strong partnership working with ambulance providers resulted in fewer ambulance delays. This enabled patients to be handed over to our EDs in a more timely manner, helping to ensure ambulances were able to respond to the emergency needs of our local population. In addition, **a successful piece of improvement work focused on emergency pathways**, resulted in more patients being cared for in a more appropriate care setting, avoiding an admission to hospital.

Planned care

We have continued to deliver an **increase in planned operations**, procedures and appointments for patients compared to the 2019/20 baseline period. We have increased elective activity to 115% of the activity delivered in 2019/20 for the same period, exceeding the Trust's operational plan trajectory of 109.1%. We also continue to see a reduction in the length of waits for patients on an elective list, with waits over 65 weeks eliminated for the fourth consecutive month at the end of 2025/26.

By the final quarter of 2025/26, we exceeded the 18-week RTT stretch target of 67.3% by achieving 67.5%. The waiting list size was better than the operational plan. Waits for a first attendance or diagnostic test within 18 weeks of referral continue to be better than the planned trajectory; supporting early identification of treatment pathways. By the end of March 2026, we had no patients waiting over 52 weeks for a first attendance.

In addition, we continue to make improvements in our cancer performance. By March 2026, we were achieving the target performance for two out of the three national cancer standards (28 Day Faster Diagnosis standard and the 31 Day standard) and saw continued improvement against the 62 Day Referral to Treatment standard.

Finance

The Trust has delivered a full year surplus of £4.948m against its break-even budget. This represents a £33,000 Trust underspend, together with an additional bonus payment from NHS England of £4.915m, being a national redistribution of Deficit Support Funding. This performance was supported by Efficiency Improvement Programme (EIP) savings of £55m representing 6.3% of planned turnover; together with additional income to off-set the savings shortfall of £14.6m relating to the cessation of the planned wholly owned subsidiary.

Our ambitious capital programme has been fully delivered in line with the Trust's Capital Departmental Expenditure Limit of £189.2m along with £1.9m of capital donations.

Diagnostics

The Dorset Community Diagnostic Centre (CDC) Programme continues to expand diagnostic capacity across the system, in line with the 2020 Richards Review and Dorset's delivery strategy. National guidance has prioritised increasing access to community-based diagnostics, and the Trust has played a key role in this expansion.

Performance against the six-week diagnostic standard remains strong. In March 2026, only 7.3% of patients were waiting over six weeks, with several months during the year achieving rates below 2%. This has been achieved despite rising demand, which increased by 6.8% over the same period.

The Trust delivered 19,672 additional diagnostic tests compared to 2024/25 maintaining its position as one of the **top-performing trusts in the south west**.

Quality performance

During 2025/26, the Trust continued to deliver its first Patient Safety Incident Response Plan, aligned to the Patient Safety Incident Response Framework (PSIRF). This year represented a period of consolidation and maturity, embedding a systems-based, learning-focused and compassionate approach to responding to patient safety incidents.

We focused learning and improvement activity on key safety themes including the deteriorating patient, VTE, falls, pressure ulcers, mental health, diagnostics and maternity and neonatal safety. Learning from incidents was increasingly embedded within the Patient First improvement approach, supporting **measurable and sustained improvements in the safety and quality of care**. Insight gained during the year also informed the development of our refreshed Patient Safety Incident Response Plan for 2026-2028.

Our risk profile

The Trust identifies, prioritises and manages all aspects of risk in accordance with its Risk Management Strategy and Governance Framework. We identified five principal Board Assurance Framework risks relating to the achievement of our strategic priorities.

The most significant corporate and operational risks in 2025/26 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.

For more information about our risk, please see page 36.

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 people. 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. A number of our colleagues work at our satellite sites at Yeomans House, Discovery Court and Alderney Sterile Services.

We employ 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 in 2025/26:

- 157,843 Type 1 Emergency Department (ED) attendances
- 79,193 non-elective admissions
- 11,863 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 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.

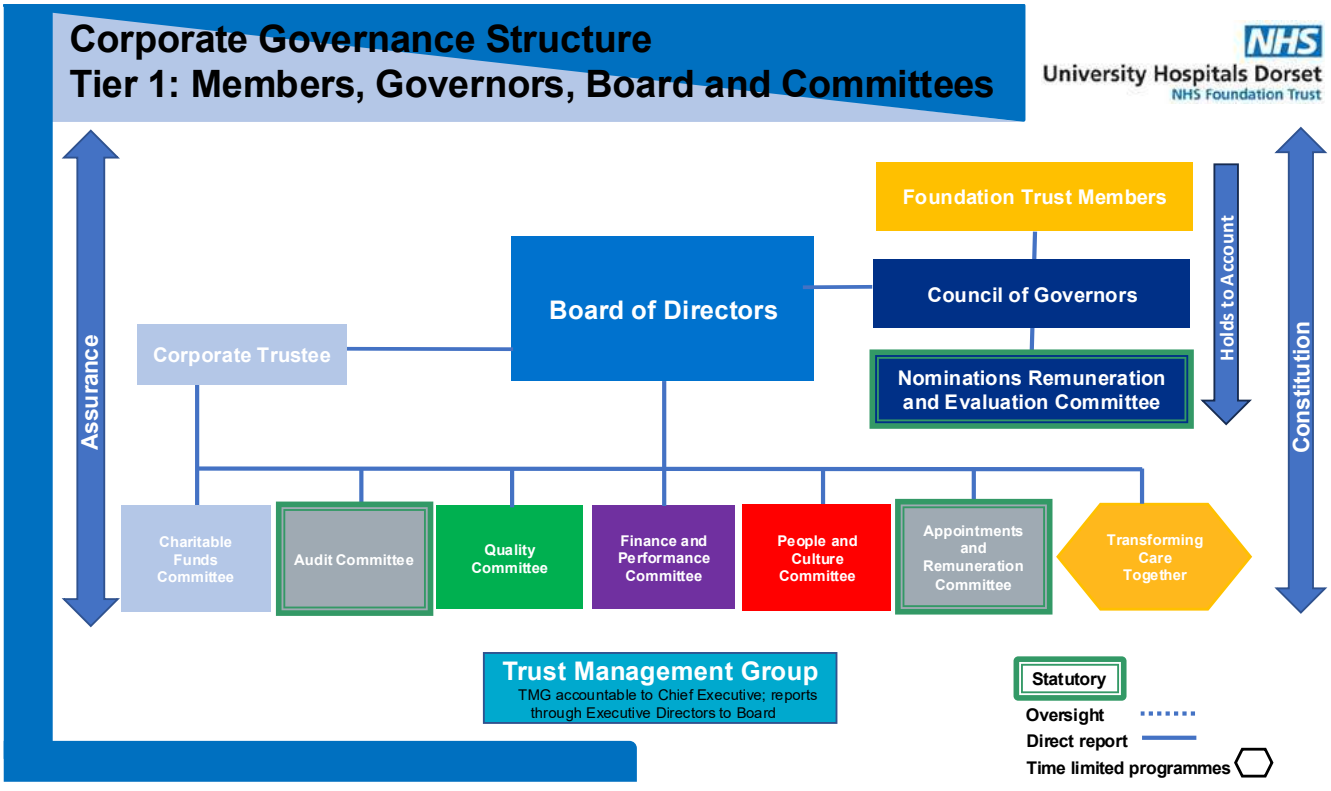
Our Board is made up of full-time executives, who are responsible for the day-to-day running of the organisation, and part-time non-executive directors. The executive directors work closely with the clinical leaders and managers throughout the hospitals in running the services. The Board also works closely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

The Board and its committees are established. The Transformation Care Together (TCT) Committee is time limited, until completion of major service reconfiguration.

The Trust Management Group (TMG) is the main operational group, made up of executive care group leaders and other senior colleagues. Reporting in to this are groups with defined remits and responsibilities.



Corporate Governance Structure
Tier 2 and 3: Executive Led Groups

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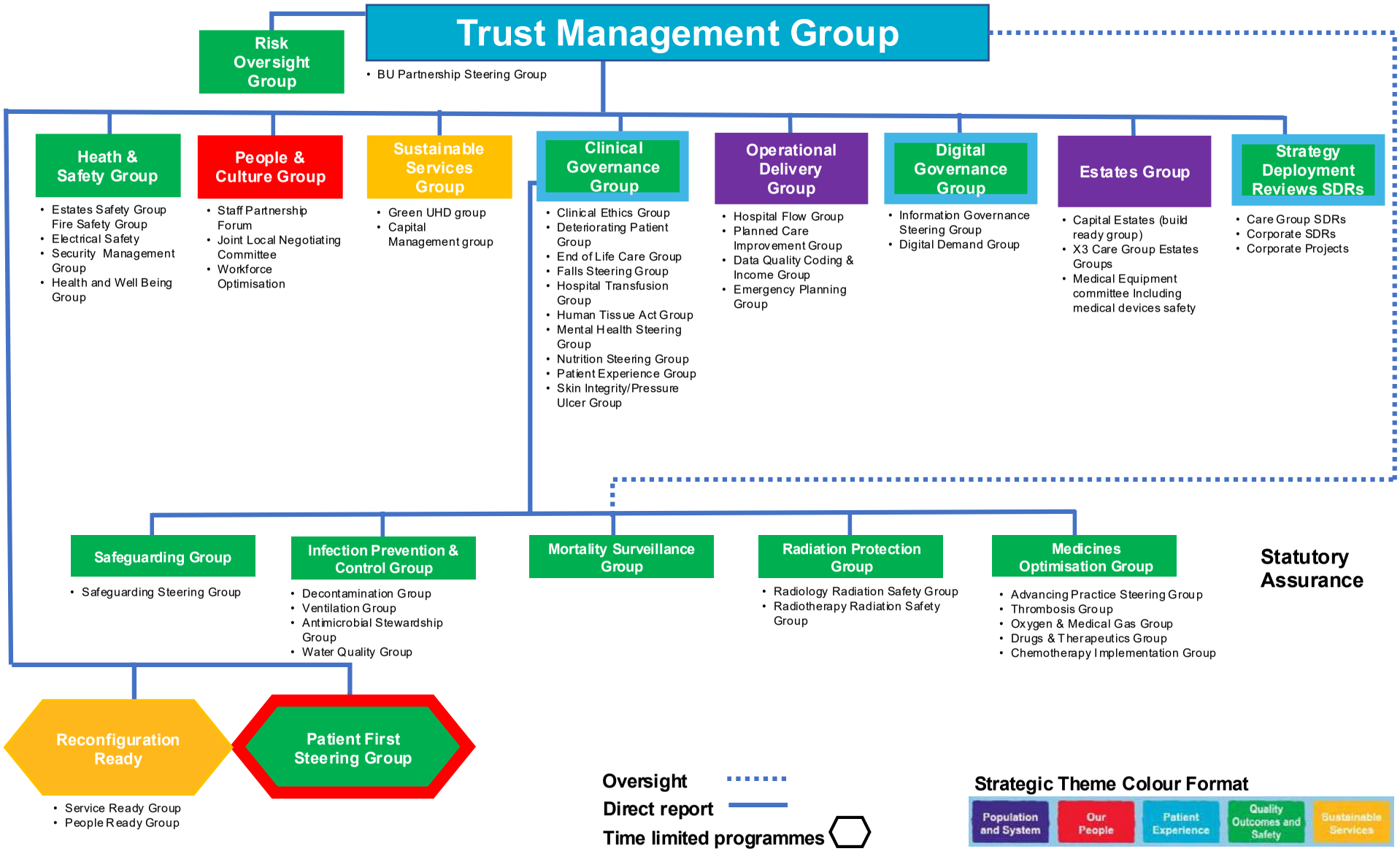


During 2025/26, the Trust implemented the Organising for Success programme to strengthen and align governance arrangements. This established clearer roles, responsibilities and accountability, introduced standardised templates, aligned governance cycles, and improved the structure of information flow, enhancing consistency, clarity and assurance in decision making.

Use of Alert, Assure, Advise reports have also improved clarity and governance in 2025/26. Of note, the Risk Oversight Committee has been established and ensures dynamic, whole organisation alignment and active risk management. The Good Governance Institute (GGI) provided valuable independent assessment of the Trust, including recommendations. Overall, we were confirmed as 'Amber-Green' in the Provider Capability Assessment, confirmed by NHS England.

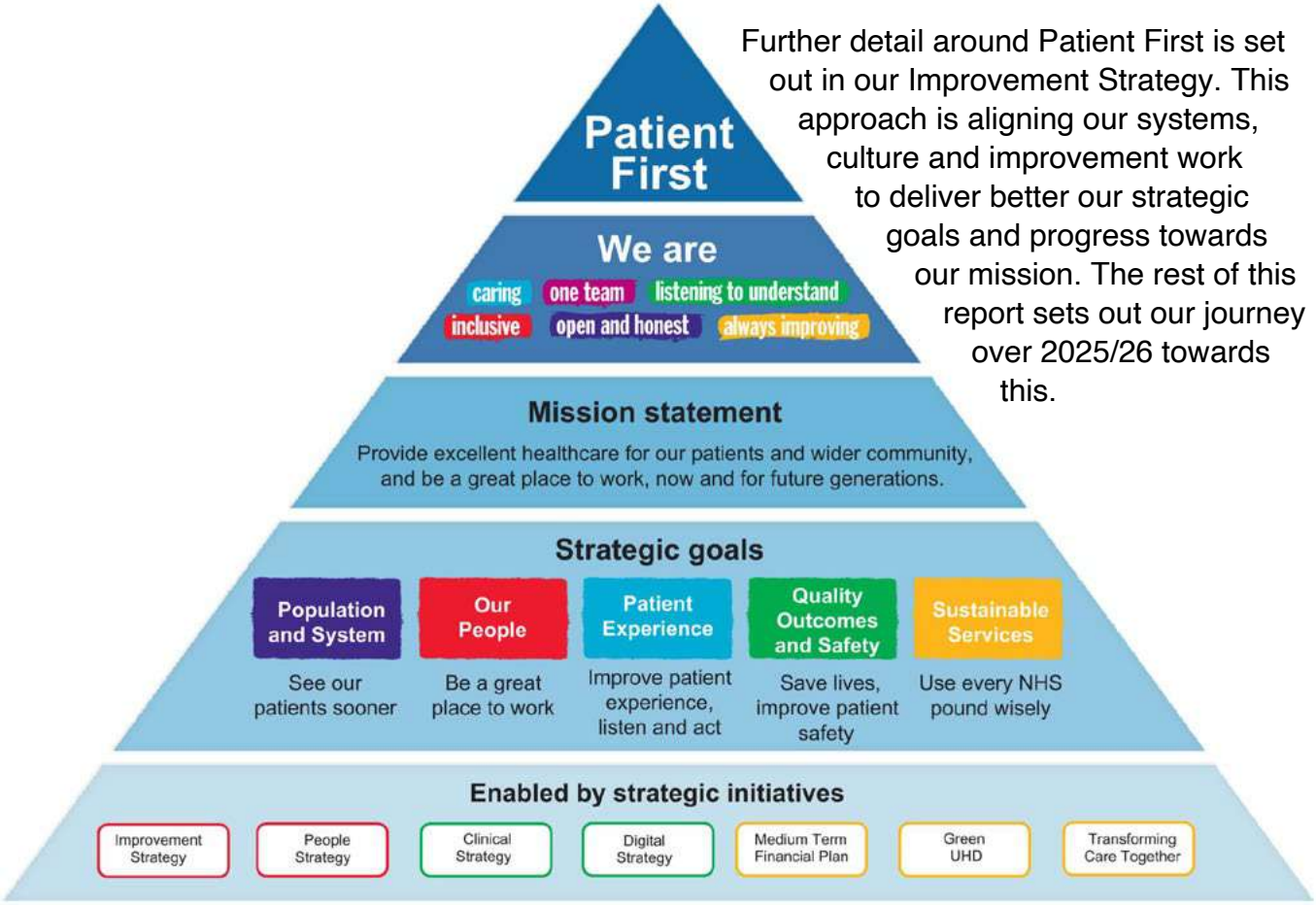
Our vision, values and strategic objectives

Our vision is our 'true north' of Patient First, the change methodology used at UHD. Our mission is to **'provide excellent healthcare for our patients and wider community and to be a good place to work, now and for future generations'**.

This is achieved by progressing our five strategic themes, and the enabling programmes that underpin these, which include delivery specific strategies.

Each year, breakthrough objectives are set, which are stretching, aspirational improvements. Progress against these are set out in the performance sections.

How we work is as important as what we work on. Our values are well established, having been developed by staff, and reviewed in every staff members appraisals, as well as through everyday work and also celebrated in our Trust awards.



Further detail around Patient First is set out in our Improvement Strategy. This approach is aligning our systems, culture and improvement work to deliver better our strategic goals and progress towards our mission. The rest of this report sets out our journey over 2025/26 towards this.

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

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 here. Within the next 12-18 months we aim to achieve the following breakthrough objectives, shown below.

Strategic Goal	Breakthrough Objective SHORT TERM: ~1 YEAR	Driver metrics AND TARGETS
POPULATION AND SYSTEM Chief Operating Officer "See our patients sooner"	• To achieve shorter waiting times and improved outcomes for patients as measured by achievement of access trajectories within the operational plan (Planned, UEC, Diagnostics and Cancer).	• 82% of emergency department attendances admitted, transferred or discharge within four hours. • 7% improvement in patients waiting 18 weeks or less for elective treatment (18-week RTT). • 80% of patients treated for cancer within 62 days of referral.
OUR PEOPLE Chief People Officer "Be a great place to work"	• To improve permanent staff availability across all professions as measured by the reduction in temporary staffing spend.	• To have favourable variance of WTE against the budgeted establishment. • To reduce premium (bank) spend by 10% against the 2025-26 baseline.
PATIENT EXPERIENCE Chief Nursing Officer "Improve patient experience listen and act"	• To understand the experience of our patients by actively listening to feedback and using it to inform change in the way we deliver care in a timely way.	• 90% of total complaints to be closed within 35 days • 95% for % of good/very good recorded on FFT for all areas.
QUALITY OUTCOMES AND SAFETY Chief Medical Officer "Save lives, improve patient safety"	• To improve mortality and morbidity across the trust as measured by a 5% reduction in hospitalised standardised mortality rate though an improvement in key morbidity metrics.	• 95% compliance on VTE prescribing within 24 hours of admission. • To reduce the number of hospital acquired E.coli infection by 20% • Uptake of ICE filing - improved % sign off on a monthly rolling basis.
POPULATION AND SYSTEM Chief Operating Officer "See our patients sooner"	• To operate within the approved budget, including delivering the budgeted Efficiency Improvement Programme target, with at least 60% achieved recurrently.	• To have favourable Forecast Outturn Variance to Budget. • To achieve 60% Forecast EIP Recurrent Delivery.

Alongside the objectives, we also have our major change programmes. These help us improve in carefully selected, Trustwide complex projects. They all need to deliver within one to two years to enable us to achieve our strategy. They are 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.

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.

Corporate projects 2025-26 and 2026-27

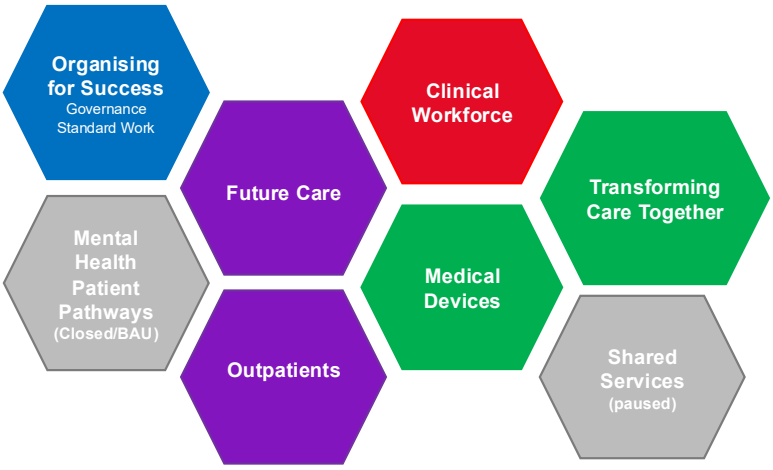
Population and System *See patients sooner*

Our People *Be a great place to work*

Patient Experience *Improve patient experience, listen and act*

Quality Outcomes and Safety *Save lives, improve patient safety*

Sustainable Services *Use every NHS pound wisely*



The colouring of the hexagon indicates just the lead theme

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

Our Digital Strategy

The Our Dorset Digital Strategy received full Board approval across the Dorset system. The Strategy was developed through a highly collaborative and iterative co creation process, bringing together digital, clinical and operational leaders from across health and care organisations.

Extensive engagement and evidence-based development ensured shared ownership and alignment with the wider Dorset vision, resulting in an ambitious yet deliverable strategy to support integrated, high-quality care.

A key enabler of the Strategy is the HealthSet Electronic Health Record (EHR) Programme, which underpins UHD's digital transformation and aligns with NHS England's Frontline Digitisation initiative and the NHS Long Term Plan.

A contract with Epic to deliver our new EHR was finalised in March 2026 following a long procurement process and business case approval process.

The implementation of Epic will provide real-time visibility of patient information, support standardised care pathways and improve coordination for acute, mental health and community services across Dorset and Somerset. This will enable earlier identification of discharge delays, support reductions in unwarranted variation and contribute to improved patient flow and length of stay over time.

Implementation is progressing towards an April 2028 system-wide go live, alongside work to strengthen digital operating models and leadership capacity across Dorset.

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 (IAS1) 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 detailed financial plan for 2026/27 alongside a medium-term financial plan up to the end of March 2029. 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

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'. Our performance delivery plans are highly aligned with this framework.

How we measure performance

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5. NHS England's oversight response to an organisation is based on: a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity) b) considering financial override which may limit a segment to be no better than 3 c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and d) capability assessments which consider the organisation's leadership and governance.

Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: **www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables**

UHD was rated segment 3 overall. The sections listed below look at our performance in more detail, and insights into area of strength and those needing to improve further, for example emergency care standard.

Our Strategic Plan is closely monitored for progress, effectiveness and continuous improvement. Supporting the Trust during its transition towards fully implementing 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 SDR meetings are attended by members of the Executive Team, the Care Group triumvirate - comprising the Group's Director of Operations, Nursing and Medical Director - plus business partners. The triumvirate is accountable for the delivery of their key performance indicators for quality, performance, finance, workforce and patient experience, together with their strategic and Trustwide programme responsibilities. SDRs 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.**

UHD Oversight Rating 2025/26

Q1	Q2	Q3	Q4	Capability Assessment
Segment 3	Segment 3	Segment 3	Segment 3	Green /Amber

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 **www.uhd.nhs.uk**, 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. We also monitor our progress against the recommendations from the most recent CQC reports, through our Quality Committee.

Performance in 2025/26

Trust breakthrough objectives performance in 2025/26

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 2025/26 objectives is described below.

For 2025/26 the Trust set very stretching breakthrough targets across a wide range of areas. Those were designed to be challenging, and not all have been met.

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

This objective was exceeded, 115% weighted value activity compared to the baseline year of 2019/20 was delivered to patients in 2025/26. This included around 2.6% specialist advice and guidance.

No more than 66.1% of patients on incomplete Referral to Treatment (RTT) pathways should have been waiting more than 18 weeks for treatment

This objective was exceeded, 67.52% of patients were discharged or treated within 18 weeks from referral.

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

This objective was not met and the Trust's position at the end of 2025/26 was 67.7%. This reflects a sustained internal and system-wide challenge related to flow, capacity and demand.

To deliver improvements in the NHS Staff Survey results for:

- *I would recommend my organisation as a great place to work' > 65%*
  This objective was not achieved in our 2025 NHS Staff Survey. Our score was 60.16% (2.8% lower compared to 2024), however our rating was above the NHS national average of 57.77% for comparator trusts.
- *A Staff Engagement Score > 7.1/10*
  This objective was partially achieved. The Trust's staff engagement score was 6.83, which was above the NHS average but below the internal target set for the year.

100% of total complaints closed within 35 days, with associated action plan and increase the number of early resolutions or complaints by 20%

Performance against those objectives was not achieved in the reporting period. Although sustained improvement was recorded over a seven-month period during 2025/26, this was not maintained in the latter part of the year, resulting in the targets not being met overall. Those objectives have been carried forward into 2026/27, with continued focus on improving timeliness and consistency of complaint handling.

Reduce the number of complaints received per 1,000 contacts for clinical services by 10% from baseline

This objective was not met, the rate of complaints received per 1,000 contacts for clinical services rate increased from 0.30 to 0.36 in 2025/26, an increase of 19% year on year.

To statistically reduce our rate of falls per 1,000 bed days

This objective was exceeded, falls per 1,000 bed days rate improved from 0.21 to 0.19 per 1,000 bed days in 2025/26, a reduction of 8% year on year.

To ensure the % of patients given timely VTE prophylaxis is 95% or higher

VTE prophylaxis was 66.8% at the close of February 2026. The 95% target has not been achieved this year, and this is an area to focus for 2026/27.

To statistically reduce the rate of pressure ulcers (hospital acquired) per 1,000 bed days

The pressure ulcers (hospital acquired) per 1,000 bed days rate increased from 0.36 to 0.46 per 1,000 bed days in 2025/26, an increase of 30% year on year.

Doctors to achieve 100% compliance in eMortality reviews

This objective saw significant improvement. eMortality review compliance as at 31 December 2025 remained just below target at 92.1%. This is reported three months in arrears.

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

This is against the largest savings we have ever delivered as a Trust. However, while 3.9% recurrent savings is highly commendable, it was less than 80% of the total savings.

To have reconfiguration efficiency plans in place

Reconfiguration efficiency plans are in place and continue to be developed in line with the Trust's reconfiguration programme.

Performance Metric

Performance Metric	31 March 2025 Performance	Trust Operational Plan 25/26	31 March 2026 Performance	Achieved Y/N
4-hour care Emergency Department (ED) standard	72.1%	78%	67.7%	N
% of Type 1 ED attendances >12 hours	5.40%	6.0%	8.0%	N
Number of patients with No Criteria to Reside	182	148	221	N
Diagnostic 6-week standard - % greater than 6 weeks	7.5%	5%	7.3%	N
Referral to Treatment - % patients within 18 weeks	60.9%	66.1%	67.5%	Y
Referral to Treatment - % of patients waiting >52 weeks as a proportion of the waiting list:	2.35%	1%	0.95%	Y
Referral to Treatment - number of patients waiting >65 weeks: Trust target	10	0	0	Y
Referral to Treatment - number of pathways	67,109	66,585	66,516	Y
28-day Faster Diagnosis Standard	79.8%	80%	79.8% February	Y
31-day Cancer Standard - % patients diagnosed being treated within 31 days	96.6%	96.2%	96.2% February	Y
62-day Cancer Standard - % patients being seen 62 days from urgent GP referrals	72.0%	75.2%	67.1% February	N

Urgent and emergency care

Urgent and emergency care demand

During 2025/26, our Emergency Department (ED) and Urgent Treatment Centres (UTC) treated around 230,000 patients, showing a rise in demand for urgent and emergency care. Of these, 50,000 patients needed to be admitted to hospital for further treatment.

This included a 9.7% increase (15,319 more patients) in people attending with serious emergency needs compared to 2024/25. At the same time, there was a 4% decrease (2,364 fewer patients) in those coming to our services with minor injuries or illnesses.

Urgent and emergency demand management

Our Alternatives to Admission programme is central to ensuring patients are cared for in the right place, first time, reducing unnecessary hospital admissions and supporting more personalised care closer to home.

In 2025/26, our Same Day Emergency Care (SDEC) services saw a 20% increase in activity compared to 2024/25, achieved without additional hours or staffing. Alongside this, our Hospital at Home services continue to expand, helping manage demand at the front door and preserve hospital capacity for those who need it most.

With emergency demand continuing to rise, further focus and investment in these services is essential. Strengthening collaboration with system partners will also support approaches such as 'call before convey' and wider use of Hospital at Home, enabling more patients to be treated safely without attending hospital.

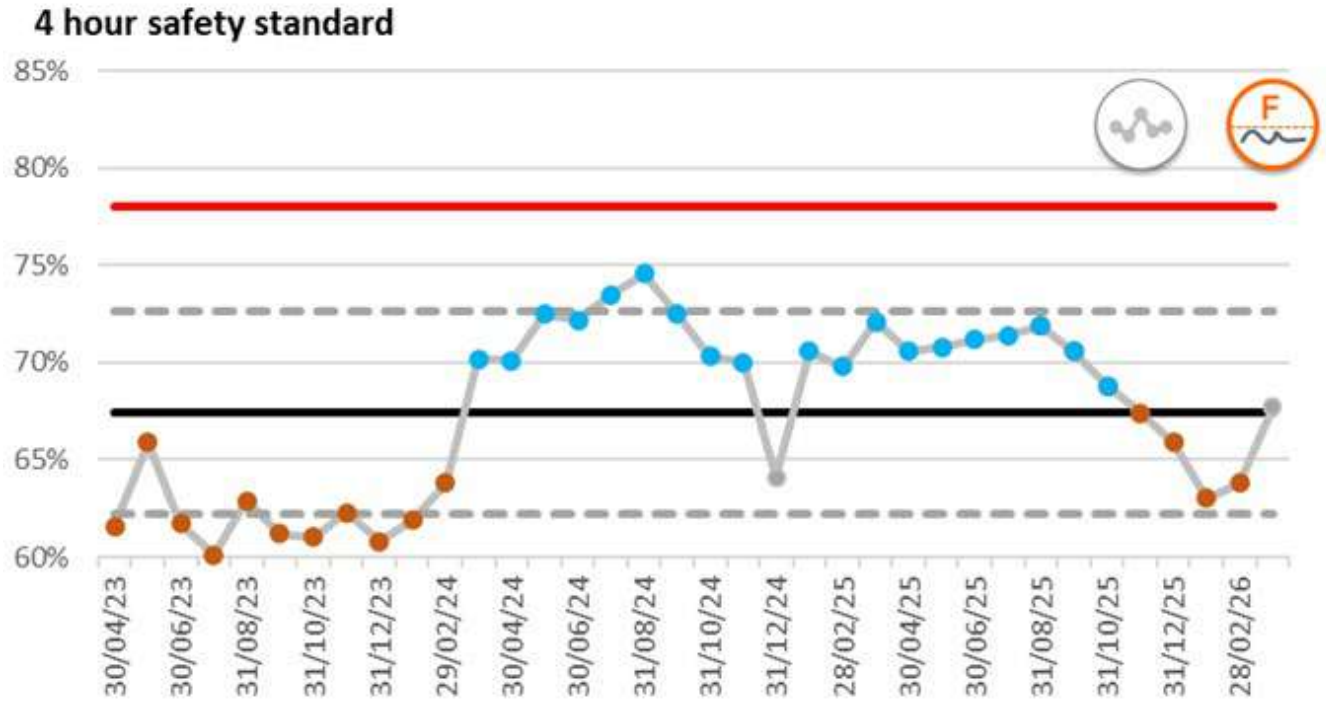
The Trust has also been an early adopter of a national digital platform that helps direct patients to the most appropriate care setting. This supports better patient flow, reduces unnecessary ED attendances, and ensures capacity is prioritised for those with the greatest need. Work is ongoing to fully embed this technology.

UEC performance

The Trust did not achieve the 78% four-hour ED standard this year. However, performance was delivered against a backdrop of sustained operational pressure and rising demand.

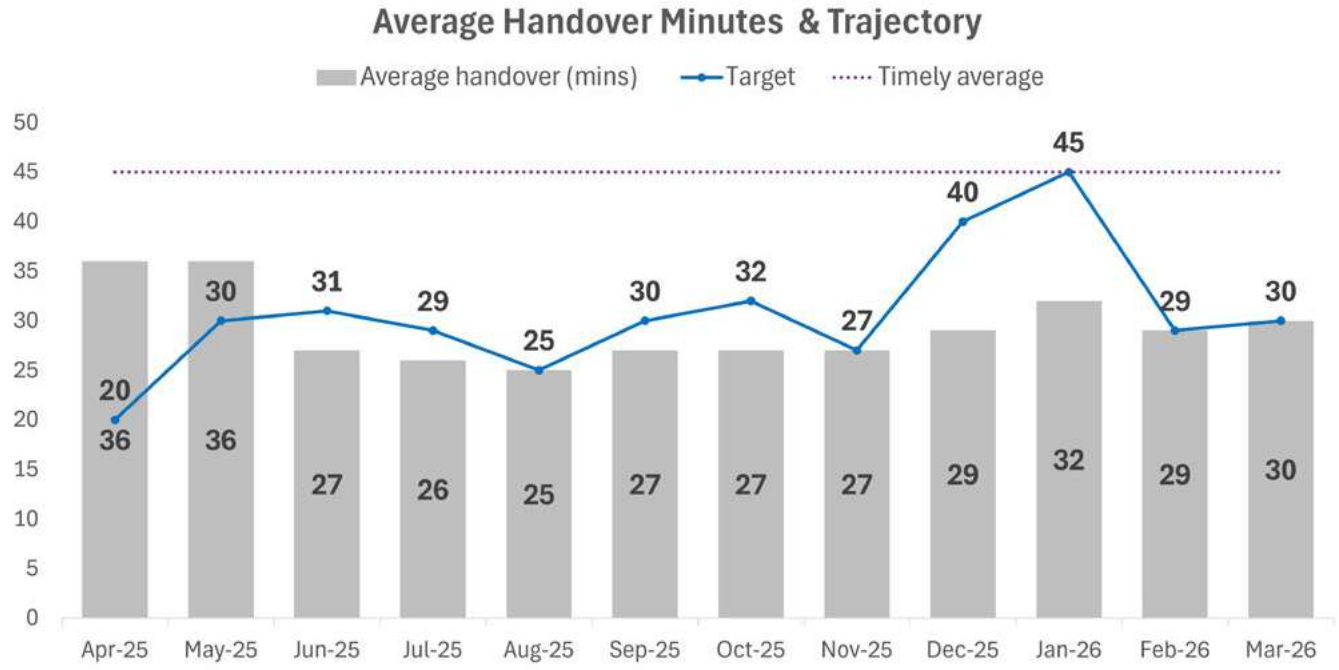
Bed occupancy remained consistently high, largely due to delays in discharging patients who were medically ready to leave but were unable to do so because of limited community and social care capacity. This, alongside increased demand and the need to further strengthen internal processes, impacted patient flow through the hospital.

In response, focused work is underway both internally and with system partners to improve discharge pathways and patient flow. Our internal flow programme is targeting key constraints, with the aim of improving performance against the four-hour standard and ensuring patients receive timely care.



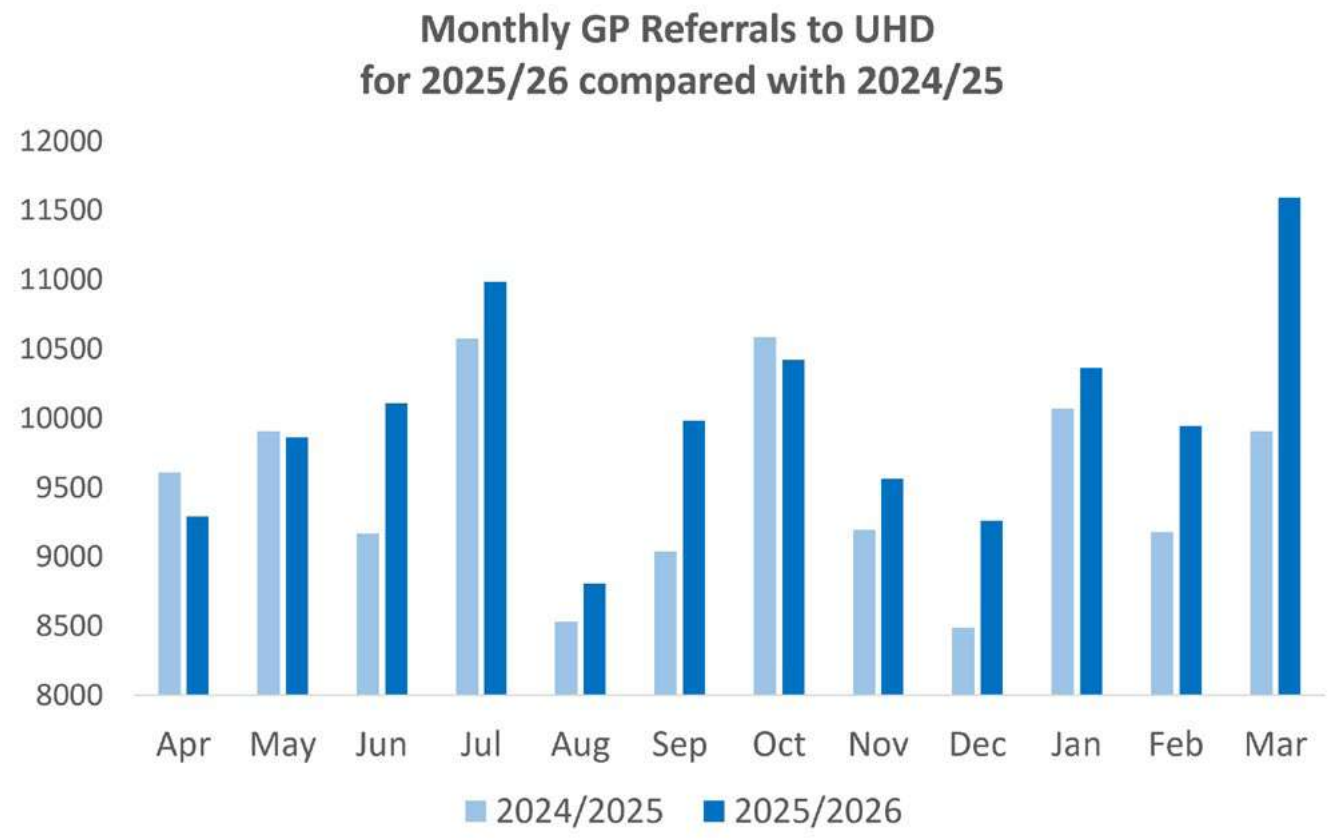
Ambulance handover delays

Strong partnership working with ambulance providers resulted in fewer ambulance delays, following the implementation of improvement work in June 2025. This enables patients to be handed over to EDs in a timelier manner and in turn ensures that ambulances can respond to the emergency needs of our local population.



Elective demand

GP referrals have increased 5.2% (by 5,942, to 120,189 for 2025/26).



Elective demand management

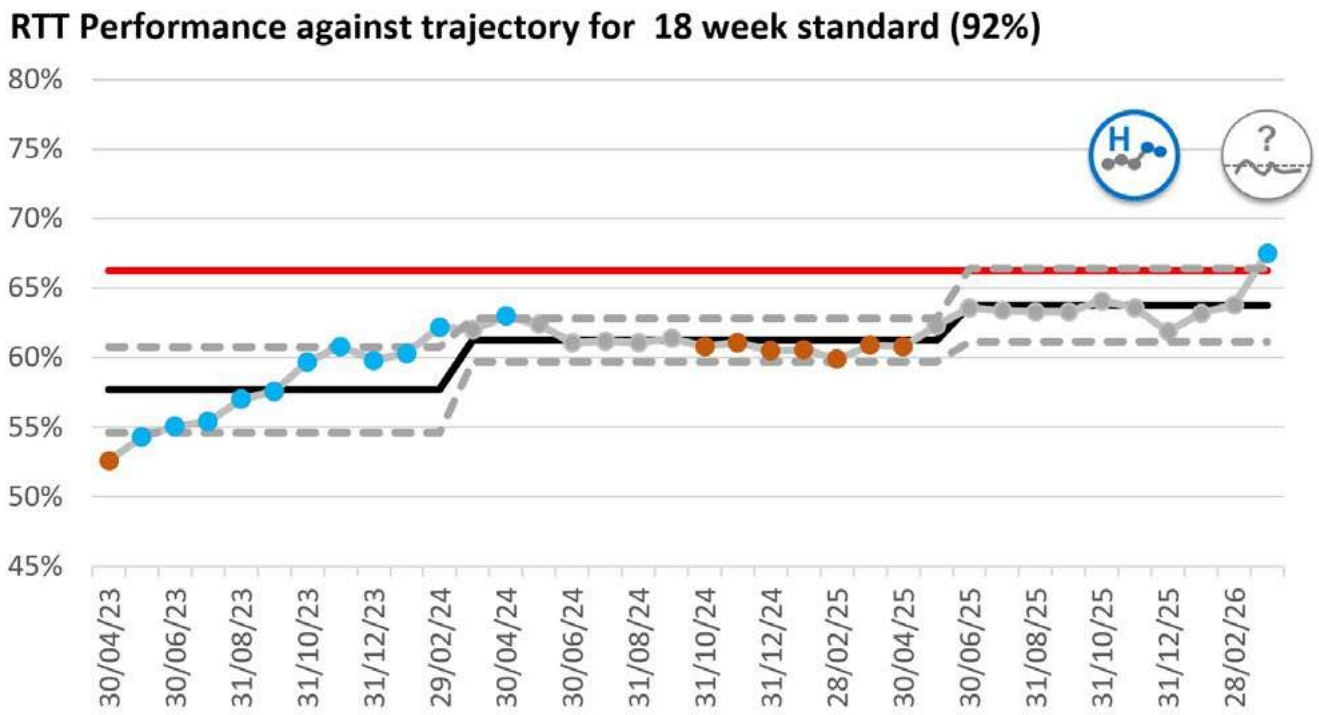
The work on devising alternative pathways and managing demand started in 2025/26. Through a programme management approach and collaboration across ICB and providers, the work has progressed in the following areas:

- dermatology skin analytics
- gynaecology women's hub
- evidence based interventions
- advice and guidance
- straight to test pathways

Further acceleration of this work is planned for 2026/27.

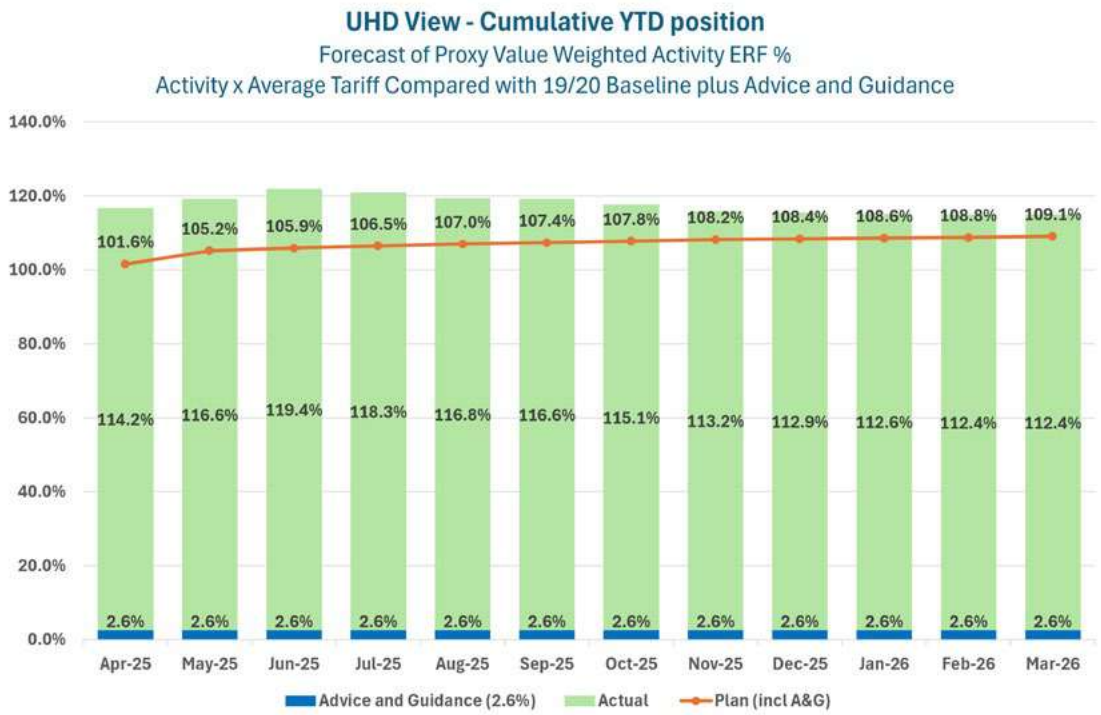
Referral to Treatment (RTT)

In 2025/26, we were able to make significant strides ahead in access to services for our longest waiting patients. We eliminated our elective (RTT) waits which exceeded 65 weeks and reduced waits over 52 weeks to less than 1% of patients on a referral to treatment waiting list. Our total elective waiting list reduced to just over 66,500, despite experiencing an increase in GP referrals of 5.2%. When patients were referred on an elective pathway almost 80% had a first attendance (outpatient or diagnostic appointment) within 18 weeks and over two thirds of patients were either discharged or started treatment within the same time period.



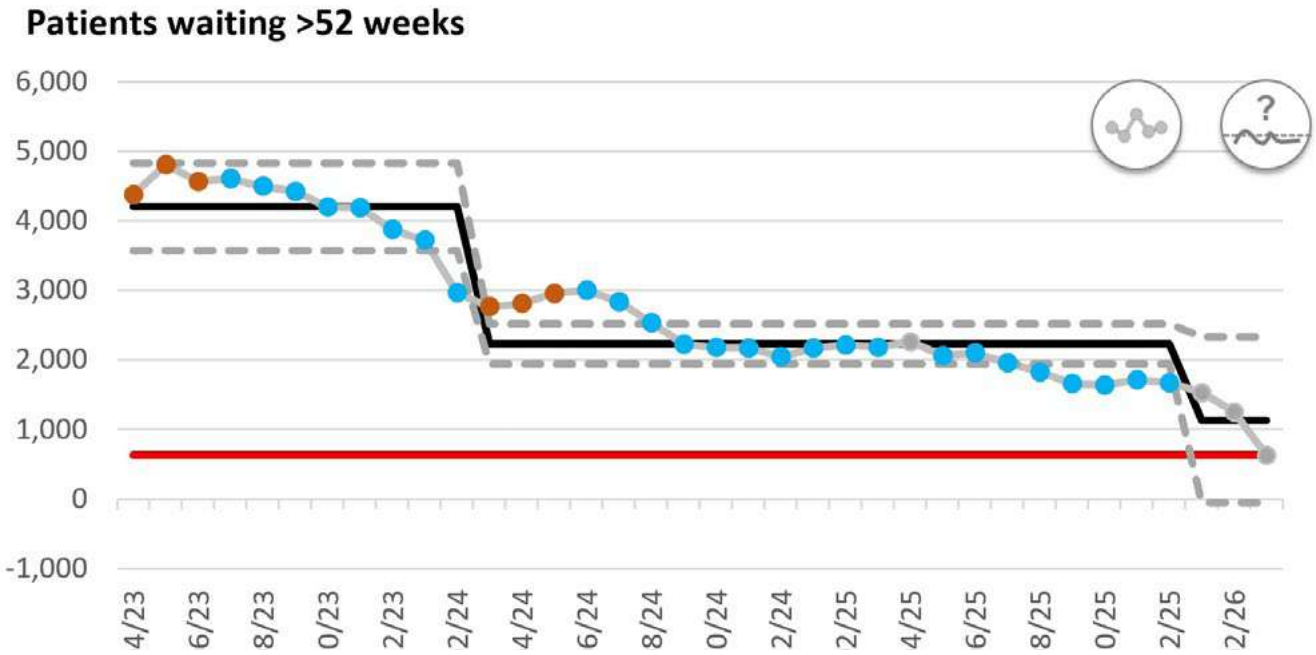
Despite industrial action at varying points during the year, challenges in capacity, workforce availability, and estate limitations, the Trust has continued its elective recovery plans to deliver against the constitutional targets.

We have delivered an increase in the number of hospital appointments, diagnostic tests and elective admissions during the year, achieving a 115% increase in our elective activity when compared to 2019/20. This was nearly 6% above our operational plan target of 109.1%.



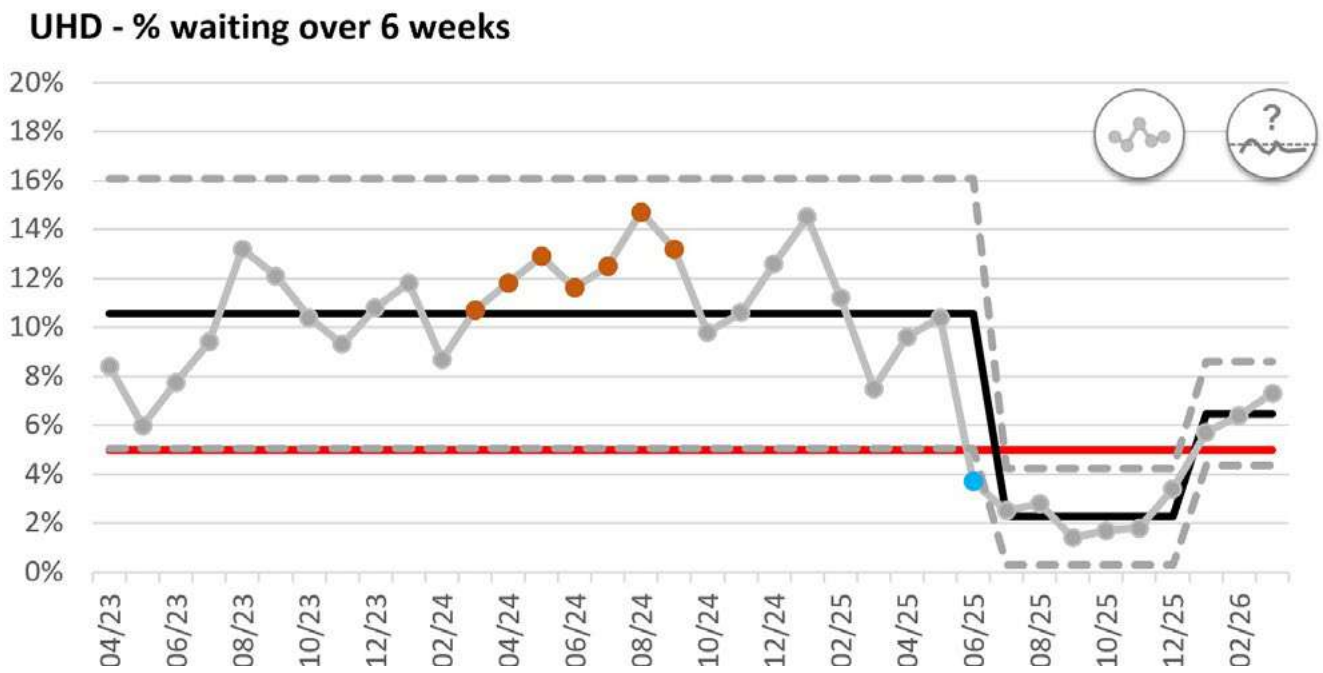
As a result of increasing activity, we were able to reduce the number of patients who experienced a wait longer than 52 weeks for treatment from 2,184 in March 2025 to 631 in March 2026. We aim to eliminate waits over 52 weeks in 2026/27.

Number of patients waiting more than 52 weeks between referral and commencement of a treatment for their condition or discharge.



Diagnostics

Performance against the six-week diagnostic standard remains strong. In March 2026, only 7.3% of patients were waiting over six weeks, with several months during the year achieving rates below 2%. This has been achieved despite rising demand, which increased by 6.8% over the same period. The Trust delivered 19,672 additional diagnostic tests compared to 2024/25 maintaining its position as one of the top-performing trusts in the south west.

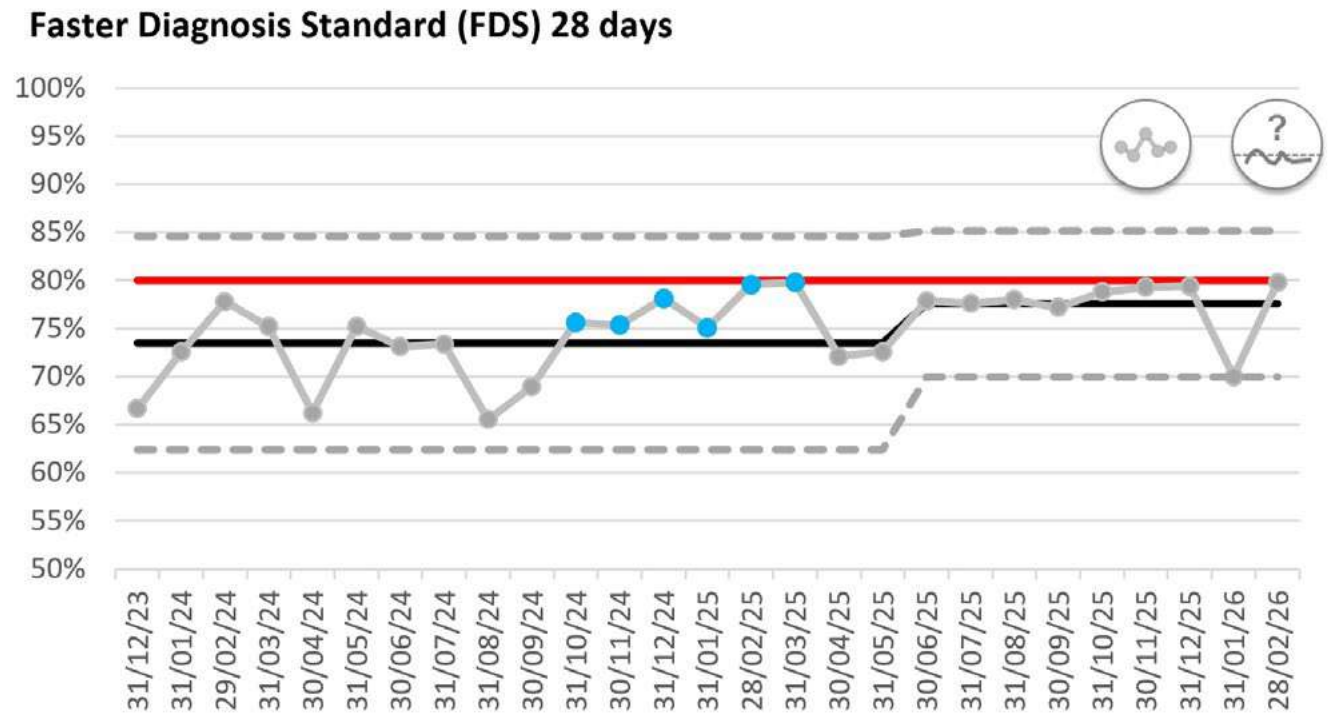


Cancer

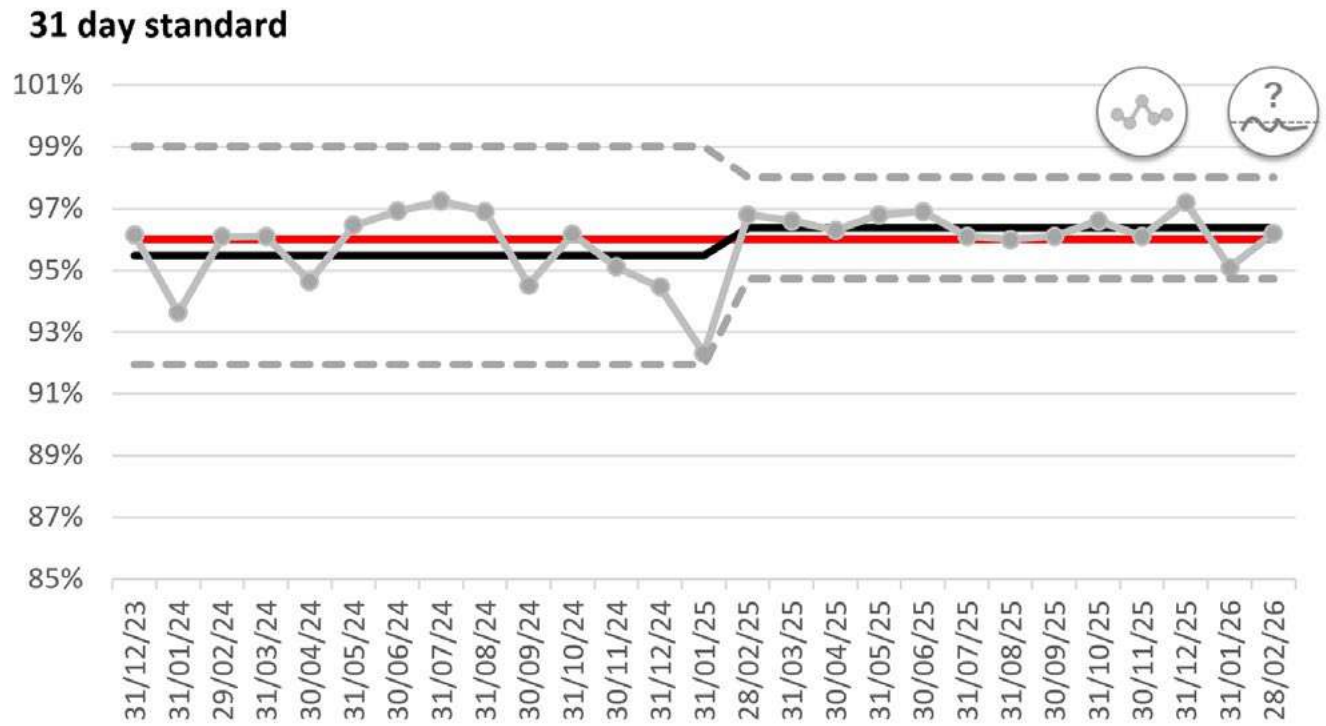
Over the past 12 months, the Trust has improved performance against the 28-day Faster Diagnosis Standard and is now delivering consistently against the 31-day standard. While the 62-day pathway remains a national challenge, a comprehensive improvement plan across all tumour sites is in place for 2026/27.

The Trust continues to work closely with the Wessex Cancer Alliance in delivering the Dorset Cancer Plan. The publication of the National Cancer Plan in February 2026 has also led to the establishment of a new UHD Cancer Board and strengthened governance arrangements.

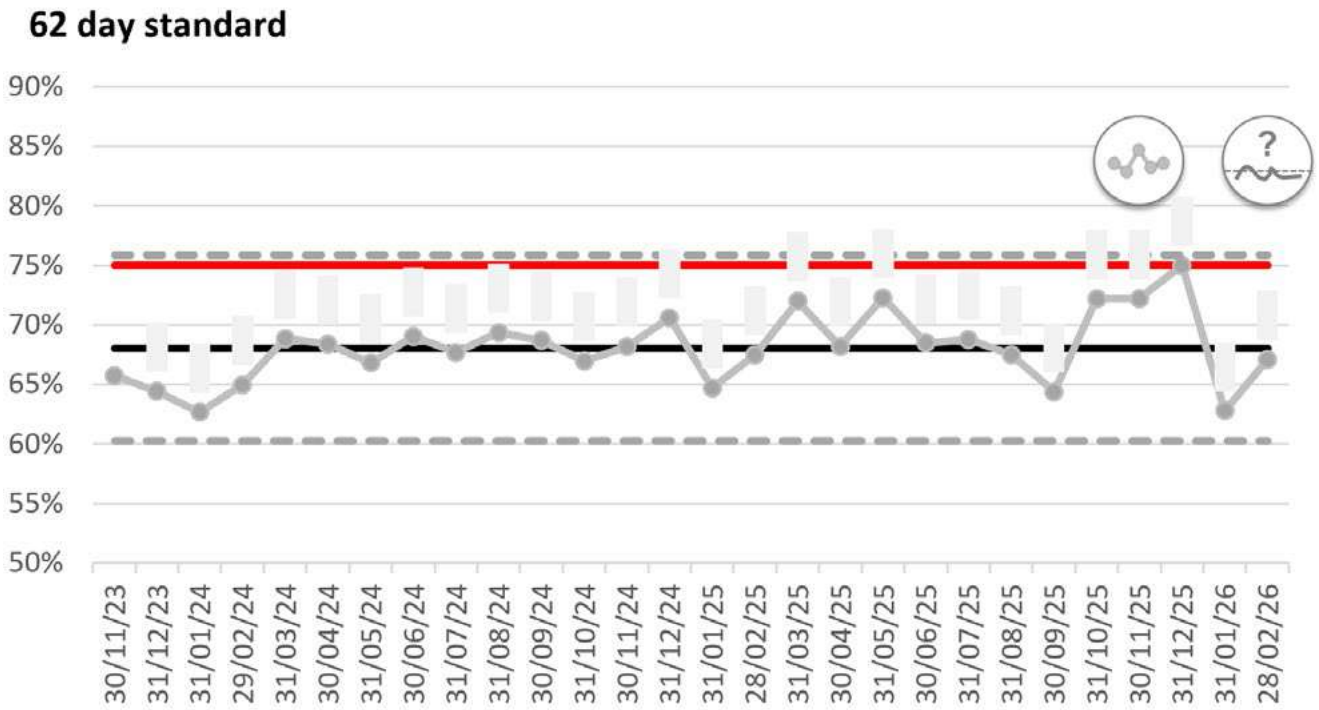
28 Day Faster Diagnosis Standard (80% by March 26):



31 Day Standard (96%):



62 Day D Referral to Treatment Standard (75% stretch target by March 26):



Quality performance

During 2025/26, the Trust monitored and improved the quality of care through established quality assurance and patient safety frameworks, supported by routine monitoring of key quality indicators and structured clinical oversight. Performance analysis focused on patient safety, infection prevention and control, and harm reduction, combining quantitative data with narrative explanation.

Infection prevention and control remained a priority. The Trust implemented a comprehensive programme of prevention measures and antibiotic stewardship, supported through the Patient Safety Incident Response Framework and the Patient First approach. A zero-tolerance approach to MRSA bacteraemia was maintained, with all cases reviewed and subject to multidisciplinary after-action review. MRSA cases reduced by more than 50% compared with the previous year. Learning identified through post-infection reviews informed improvements in early skin assessment and timely referral to specialist services, supported by the introduction of the SKIIN bundle. Hand hygiene compliance was monitored through monthly ward assurance audits, with learning informing further action in 2026/27.

Performance against Clostridioides difficile trajectories was monitored throughout the year. A total of 113 community-onset and hospital-onset healthcare associated cases were reported against a nationally set threshold of 100. In response, the Trust strengthened its focus on antibiotic stewardship and worked collaboratively with system partners to reduce unwarranted antibiotic use. Total antibiotic use at UHD is approximately 4,200 Defined Daily Doses per 1,000 admissions, placing the Trust as the 39th lowest user out of 135 NHS Trusts. Use of broad-spectrum antibiotics is lower still, at 1,382 Defined Daily Doses per 1,000 admissions, ranking the Trust 15th out of 135. Effective control of these agents is essential due to their association with antimicrobial resistance and Clostridioides difficile infection.

During the year, 63% of antibiotic prescribing was from the Access (non-broad-spectrum) category, meeting the forthcoming national target. An audit of intravenous-to-oral antibiotic switching showed that only 7.5% of patients remained on intravenous therapy where an oral switch was clinically appropriate. **This is very positive, as it is against a target of less than 15%, with performance improving over the year**. Quarterly point prevalence audits were also undertaken to support ongoing antimicrobial stewardship.

The Trust also monitored wider quality and safety indicators including patient falls and pressure ulcers. **Fall rates reduced** by 8% from previous year, while falls resulting in moderate harm or above reduced compared with 2024/25. An increase in category 3 and 4 pressure ulcers was observed, and targeted actions were implemented, including the development of the aSSKINg bundle and associated staff training, focusing on personalised care planning and harm prevention.

Quality assurance was further strengthened through quality peer reviews, including matron walkabouts aligned to Care Quality Commission quality statements. **In addition, a Clinical Quality Accreditation Scheme was introduced in 2025, combining ward self-assessments with formal review visits and the involvement of Patient Safety Partners**. By year end, three wards had achieved Gold accreditation, providing additional assurance on the quality of care delivered.

For further details, please see our Quality Account on the Trust website.

Financial performance

This section summarises the Trust's financial results for the 2025/26 financial year. This provides a 12-month reflection of the Trust financial performance from 1 April 2025 to 31 March 2026.

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 2025/26 financial year. At 31 March 2026 the Trust delivered a full year surplus of £4.948m against its break-even budget. This represents a £33,000 Trust underspend, together with an additional bonus payment from NHS England of £4.915m, being a national redistribution of Deficit Support Funding.

2025/26 Control total	25/26
	£'000
Deficit for the year	**(27,276)**
Add back impairment	32,237
Add donated capital/fixed asset disposal adjustment	(13)
Control total surplus	**4,948**
Agreed control total surplus	0
Performance against control total	**4,948**

Income

Trust income during the 12 months to 31 March 2026 was £980m. Of this, £916m related to income for patient care activities with £799m received from Integrated Care Boards. Dorset Integrated Care Board income received in 2025/26 was £662m representing 68% of total Trust income. Other Trust operating income was £65m for the period.

Operating income	12 months to 31 March 2026
	£'000
Foundation Trusts and NHS Trusts	4,081
Integrated Care Board	798,930
NHS England	106,738
Non-NHS patient income	6,456
Total income from patient related activities	**916,205**
Other operating income	**64,613**
Operating income from continuing operations TOTAL:	**980,818**

Expenditure

Operating expenses on continuing operations during 12 months to 31 March 2026 equated to £1.007bn. Of this, employee costs were £648m, representing 64% of total expenditure.

Cash

As at 31 March 2026 the Trust was holding a cash balance of £133m, 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 across estates, digital and equipment. This has required very careful management, and as at 31 March 2026 full-year capital expenditure amounted to £189m against a plan of £189m. The Acute Reconfiguration Programme and associated works accounted for £106m of the 2025/26 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 £55m, representing 6.3% of planned turnover, were achieved for the financial year ending 31 March 2025; together with additional income to off-set the savings shortfall of £14.6m relating to the cessation of the planned wholly owned subsidiary.

Modern slavery and human trafficking statement

Modern slavery involves the recruitment, movement or harbouring of individuals through the use of coercion, deception or abuse for the purpose of exploitation. This can include sexual exploitation, forced labour, domestic servitude or organ harvesting, and may occur within, into or out of the UK.

The Trust is committed to preventing modern slavery and human trafficking within all aspects of its operations and supply chains, in line with the requirements of the Modern Slavery Act 2015. It expects its suppliers to demonstrate a similarly robust approach.

Modern slavery considerations are incorporated into procurement processes, with the Trust applying NHS Terms and Conditions for Goods and Services, which require compliance with all relevant legislation and guidance, including modern slavery requirements.

The Trust ensures that procurement staff receive appropriate training and legal updates to maintain awareness of their responsibilities in this area. In addition, modern slavery awareness is included within mandatory safeguarding training for all staff. Any concerns identified by staff are managed by the safeguarding team and, where appropriate, referred through the National Referral Mechanism in accordance with statutory requirements.

Anti Bribery and Corruption

Our Anti-Crime Team works to investigate and prevent fraud and bribery, ensuring that appropriate procedures are in place. The team provides advice and guidance to staff on recognising potential fraud and the actions to take where concerns arise. A robust Counter Fraud Policy is in place, which aligns closely with the Managing Conflicts of Interest Policy. Those policies are regularly reviewed with support of our local Anti-Crime team.

The Trust also maintains up-to-date registers of interests, gifts, hospitality and sponsorship received and staff are made aware of the need to declare any potential conflict of interest.

Significant events since the end of the last financial year affecting the Trust

There are no events after year end to report.

Overseas operations

The Trust does not have any overseas operations.

Dorset System Financial Overview

NHS Dorset delivered a breakeven position across the 2025/26 financial year, with the assistance of £13.9m planned NHS England national deficit support funding. This means that our expenditure was in line with our overall funding. Across the Dorset NHS Integrated Care System, an in year breakeven position was planned. However, a system surplus position of £13.2m was achieved due to year-end National redistribution of unachieved deficit support funding of £13.2m.

During the year the system received several significant additional funding allocations for Elective Sprint as part of the National

Elective Care Programme (£2.8m) covering Outpatient, 52 week wait and Validation sprint programmes for the ICS, as well as £7.2m funding support for in year industrial action costs.

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

The Dorset NHS Integrated Care System comprises:

- NHS Dorset Integrated Care Board
- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust

These five NHS bodies received an initial allocation of £2.05bn for 2025/26 and were required to collectively plan within this envelope. NHS bodies in the Dorset Integrated Care System initially planned a £13.9m deficit across the year with £13.9m held at Dorset ICB and £9.8m at Dorset County Hospital with an offsetting surplus of £9.8m at Dorset HealthCare NHS Foundation Trust. This was adjusted to a breakeven plan for the system following receipt of £13.9m of non-recurrent deficit support funding from NHS England in year.

NHS Integrated Care System partners have successfully planned and delivered capital investment projects totalling £327m. This is higher than the planned spend of £307.8m due to the in-year approval of additional capital.

The Integrated Care System also encompasses local authority partners, Dorset Council and Bournemouth, Christchurch and Poole Council, plus other partners such as those in the voluntary sector.

Our Dorset Provider Collaborative (ODPC)

Provider collaboratives are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations.

In Dorset we have established the Our Dorset Provider Collaborative formed of UHD, Dorset Health Care University Foundation Trust, Dorset County Hospital NHS Foundation Trust, and the Dorset General Practice Alliance (whose membership includes all GP practices in Dorset).

The goals of the ODPC are:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development

There are monthly executive-led Board meetings of the ODPC. The role of the Chair has been held by the UHD CEO during 2025/26 and will be reviewed as per the Terms of Reference for 2026/27. The agenda is set collaboratively and supported by the Delivery Director whose role is jointly funded for independence. 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 each of the Boards of the member organisations. During 2025/26 the Chairs and Non-Executives Oversight Group was formalised within the terms of reference. There have been two multi-board development sessions including the non-executive teams focusing on the future of collaboration in Dorset in line with ICB changes and the publication of the NHS 10-Year Plan.

During 2025/26 the ODPC has overseen a number of programmes of work in line with the agreed objectives below.

Programme	Purpose	Achievements 2025/26
Shared Corporate Services	Efficiencies and economies of scale for the system in shared support functions such as procurement and estates/facilities services.	Board agreements across the three provider trusts to establish a single procurement service hosted by UHD, overseen by a joint procurement board to be established later in 2026. Plans for a single Estates and Facilities services were not progressed following a national policy directive.
Workforce	Better recruitment, retention and deployment of staff.	Maintained consistency across nursing bank and agency rates of pay and usage, reducing reliance on temporary staffing improving quality of care for patients.
Single services modelling	Reductions in unwarranted variations for patients and greater resilience across the Dorset system.	Joint recruitment to hard-to recruit to consultant posts in some services, working across clinical networks to align best practice.
Vertical integration and Integrated Neighbourhood Team work	Reductions in health inequalities and supporting greater efficiency of services for patients.	Neighbourhood teams established across Dorset, prioritising patients with most need. Developing access to diagnostics closer to people's homes for respiratory services, improved diagnostic tools for gastroenterology patients and collaborating for best practice in hospital at home services.
Integrated Digital Services	Economies of scale, improved patient care and reductions in health inequalities.	Agreed funding for the development of a single electronic health record.
Shared Operational Services Oversight	Economies of scale, improved patient care.	Overseen the work of the One Dorset Pathology and Community Diagnostic programmes.

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 the corporate risks which impact upon the achievement of our strategic priorities.

Strategic objective	BAF Risk controls and assurances	Linked corporate risks
All patients in UHD receive quality care which results in a positive experience for their families and carers.	• Patient Experience Strategy • People and Culture Strategy • Quality Committee oversight • Complaints and PALS Policy and processes • Patient champions, patient safety partners, patient engagement • National and local patient surveys and feedback • Healthwatch engagement and feedback • PLACE Audit	• Meeting the 4-hour urgent and emergency care standard • Macular injection treatment delays • Glaucoma service provision • Availability of breast radiologists • Care of patients in non-clinical areas • Obstetric ultrasound scanning service
We consistently deliver timely, appropriate, accessible care as part of a wider integrated care system for our patients.	• Patient Access Policy • UHD Interprofessional Standards • Discharge policies and procedures • Internal flow and Future Care programmes • RTT pathways and processes • Transfer policies • Planned Care Improvement Programme • Dorset ICB Working better Together Strategy • Community Diagnostic Centre Programme • Accountability Framework	• Meeting the 4-hour urgent and emergency care standard • Celluar pathology capacity • School age neurodevelopmental service capacity

Strategic objective	BAF Risk controls and assurances	Linked corporate risks
To be rated the safest Trust in the country as seen by our staff, as an outstanding organisation for effectiveness and patient safety.	• Risk Management Strategy • Annual Clinical Audit Plan • Clinical Strategy • Fundamentals of Care standards • Interprofessional standards • Clinical accreditation standards • NICE Policy • GIRFT Programme • Digital Strategy • Quality Governance Framework • Quality metrics • Internal and externals reviews and inspections • Learning from incidents - PSIRF Plan and Policy	• Macular injection treatment delays • Glaucoma service provision • Availability of breast radiologists • Care of patients in non-clinical areas • Obstetric ultrasound scanning service • Point of care testing • Results acknowledgement • 24/7 transfusion laboratory services • Access to a second obstetric theatre in an emergency
To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patient and the working lives of our staff.	• Budgetary controls • Scheme of delegations, Standing Financial Instructions, finance policies and procedures • Cost Improvement Programme • Equality Impact Assessments • Efficiency Improvement Programme • Vacancy controls • Financial planning with system partners • Sustainable services groups	• Medium term financial stability risk

Equality of service delivery

This section outlines how UHD ensures our services are fair and easy to access for everyone, as required by our public duties. We focus on people with protected characteristics, such as age, disability, and ethnicity, to understand how different groups use our care.

UHD primarily serves residents in the Bournemouth, Christchurch, and Poole Council and Dorset Council areas, though we also care for many people from nearby counties like Hampshire and Wiltshire, as well as tourists and visitors. Our approach to fairness is built on working closely with partners across the Dorset Integrated Care System (ICS). This collaboration is guided by the Dorset ICS shared health inequalities plan and its governance framework.

Progress in 2025/26

Building on work that began in early 2024, we have used a shared 'logic model' to identify the best way to reach our goals. This work is now moving forward through five broad workstreams and three major partnership projects:

- **Prevention**: Stopping health problems before they start.
- **Data and insight**: Using the Dorset Intelligence and Insight Service (DiiS). They provide real-time data dashboards and analytics, so we can make better, proactive decisions for patients.
- **Reducing Unwanted Variation**: Making sure care is consistent for everyone.

The Dorset Health Inequalities Framework and Plan brings together and organises all the work needed to meet several major goals.

It directly delivers the ambitions of the Joint Forward Plan, following national planning guidance, and supports the broader NHS Long Term Plan. Central to this work is a focus on NHS England's Information Standard for Health Inequalities. The specific metrics allow us to monitor progress in reducing gaps in how patients access care, the experience they have during treatment and their health outcomes - especially Core 20% most deprived populations and inclusion groups, ensuring that progress is tracked and realised for those that need it most.

Dorset-wide oversight is provided from the Health Inequalities Group and the Strategic Outcomes Committee, which includes representation from UHD.

At UHD, this is becoming part of our 'business as usual', with regular oversight from existing governance frameworks.

Reviewing the data on equality of service delivery

Our analysis shows that peoples experience with healthcare in Dorset can vary depending on their age, where they live, their ethnicity, their gender and their deprivation levels.

To ensure our findings are reprehensive, we have 'age-adjusted' the data. This ensures that we aren't misinterpreting high usage in certain groups just because they happen to be, for example older. We also use statistical 'confidence intervals' to check if differences are significant or happened by chance.

Elective and Emergency Admissions	Outpatient and Virtual Attendences	Emergency Attendences	Elective Activity Pre and Post Pandemic (0-17)	Elective Activity Pre and Post Pandemic (18+)

As an acute NHS Trust, we have a focus on the impact of inequalities on:

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

2025 data shows that Dorset residents in the most deprived areas are affected much more than others when it comes to hospital use. They have a higher rate of Emergency Department visits and are more likely to be admitted to the hospital as an emergency.

However, when it comes to planned elective care (appointments or surgeries scheduled in advance), there can be differences in how easily people can access these services.

For many other factors, the differences we see are 'within the expected range'. This means that when we look at the confidence intervals, the variation isn't unusual.

Elective admissions and waiting lists

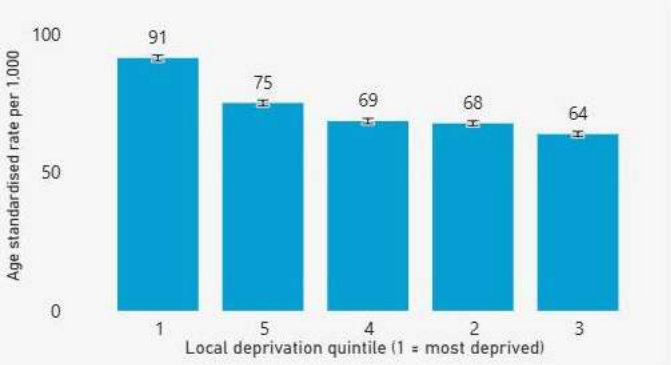
Planned care (elective) activity for all groups is currently at or above levels seen before the Covid-19 pandemic. The exceptions to this are patients with an unknown ethnicity, who have lower rates, and Black ethnic groups, who have higher rates.

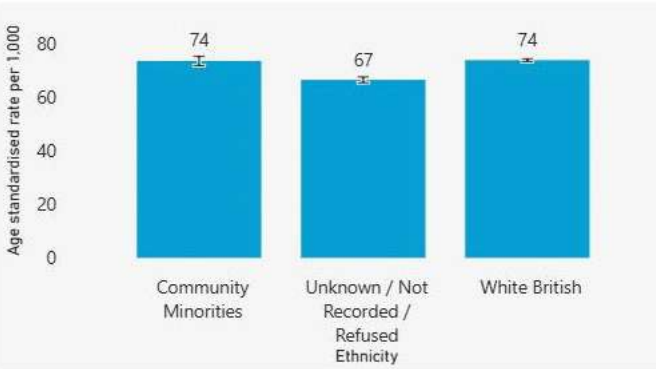
National data from 2025, which applies to UHD, indicates disparities in waiting lists. Patients from deprived communities and certain minority ethnic backgrounds are more likely to wait longer than 18 weeks for elective treatment.

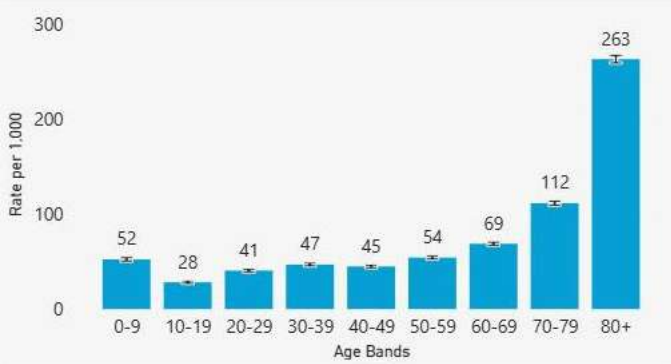
Elective admissions

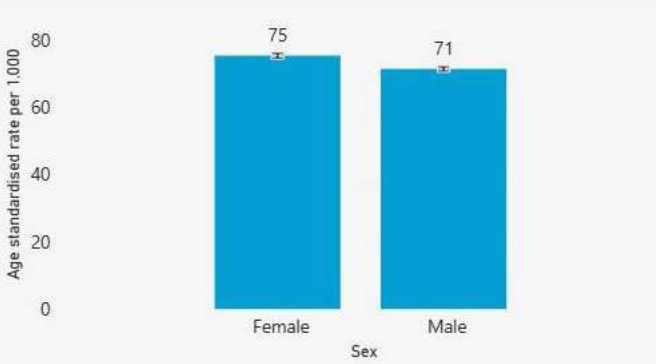
- Admissions increase with age up to the 70-79 bracket.
- While women appear more likely to be admitted, this difference disappears once the data is adjusted for age.
- When adjusted for age, those from the least deprived areas have higher rates of elective admission.

Age standardised and crude rates of Emergency admissions per 1,000 population in UHD









Waiting lists:

- Patients on the waiting list are predominantly female, White British and less likely to come from the most deprived areas.
- Numbers on the list increase with age until the 70-79 bracket, then decrease slightly for those aged 80 and over.
- While average waits are similar across genders and deprivation groups, women with learning disabilities may wait three or more weeks longer than the general population.

Outpatients attendances

In person (face to face) outpatient appointments are more common in older age groups and among women, even after age adjustment.

Gypsy, Irish Traveller, and White English ethnicities have higher rates of face-to-face appointments, while other ethnic groups have lower rates.

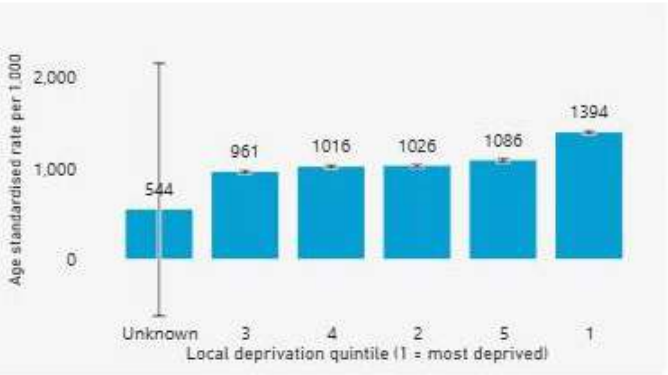
Virtual outpatient attendance rates increase with age up to the 70-79 bracket and are higher in women.

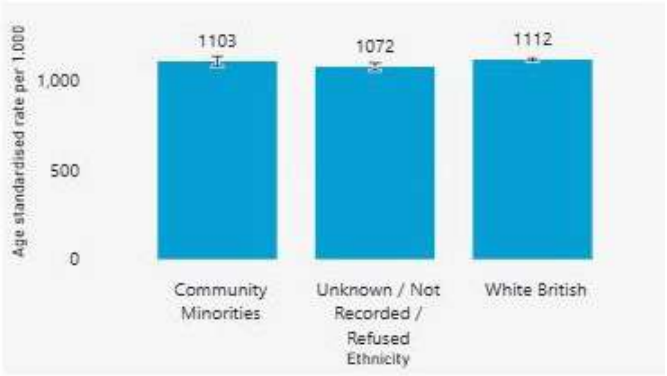
Gypsy and Irish Traveller ethnicities have notably higher rates of virtual attendance, followed by White Irish and Black/Black British ethnicities.

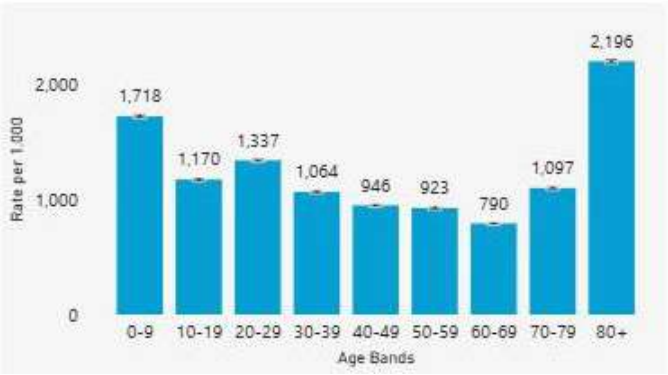
Emergency attendances

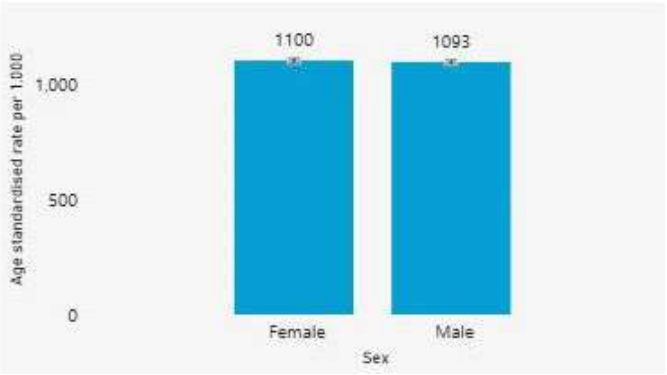
Higher rates of attendance are observed in more deprived areas. Attendance rates are highest in the over 80s, followed by the 0-9 age group. After age adjustment, rates for women are similar to those for men.

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









Emergency admissions

People from the most deprived areas are more likely to have emergency admissions.

Rates are highest in those aged 80 and over, followed by the 0-9 age group. After age adjustment, rates for women are similar to those for men.

Under 18s: Children aged 0-4 are much more likely to have emergency admissions than older children. These rates are higher in deprived areas, with no significant differences found between genders or ethnic groups except for those with an unknown ethnicity, which has lower rates.

Areas of focus within the 24 key NHS Inequalities Indicators

The Dorset Intelligence and Insight Service (DiiS) provides a digital data dashboard to track health inequalities. This dashboard currently looks at inequalities indicators across 11 domains and continues to build on these key indicators.

Early cancer diagnosis: Women are more likely than men to be diagnosed with cancer at an early stage. This becomes less common as people get older. There are no differences based on deprivation or a person's ethnic background.

Cardiovascular disease (CVD): A 2025 Cardiac Health Needs Assessment for Dorset found significant inequalities in heart disease. It showed that outcomes and access to treatment are not the same for everyone.

Stroke admissions: Age is a major factor for hospital visits. People aged 80 and over are four times more likely to be admitted for a stroke. Men also have higher rates than women. While rates seem higher in more deprived areas, this might just be by chance.

Heart attack (myocardial infarction) admissions: Hospital rates go up as people get older. Those aged 80 and over are almost twice as likely to be admitted. Men are more likely to be admitted than women. People living in the most deprived areas are also more likely to go to the hospital for a heart attack.

Diabetes care processes:

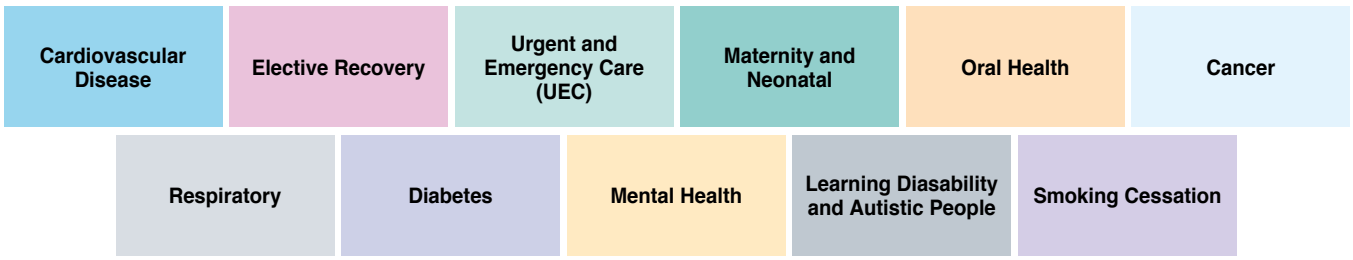
- **Type 2 diabetes**: Most people get all eight care checks as they get older, but this drops after age 85. Men and people in wealthier areas are more likely to get all eight checks.
- **Type 1 diabetes**: People with Type 1 are less likely to get all eight care checks than those with Type 2.

Oral health:

Tooth extractions for children under 10: The number of children getting teeth pulled is very small. The data only covers a few age groups and one ethnic group. There is a slight link to poverty, but the differences are very small.

Learning disabled and people with autism :

Annual health checks: People with a learning disability and people with autism often have poorer physical and mental health than others.

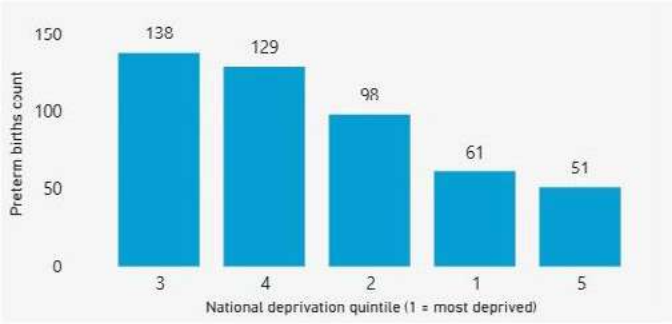


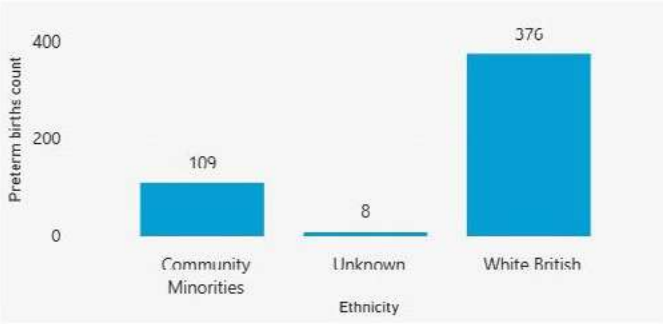
The Diis Learning Disability report for 2025-2026 is being reviewed. The 2024 report shows no differences in annual health check uptake in Dorset by sex, ethnicity, or deprivation level. Uptake is lower in younger adults than in older adults.

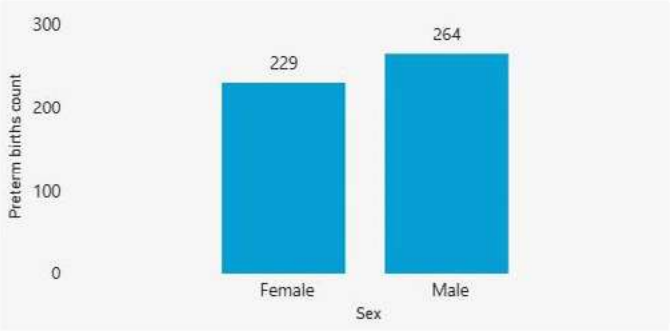
Maternity and Neonatal

Preterm births: The local numbers for early births are very low. Because the numbers are so small, it is hard to see any clear patterns between different groups.

Count of preterm births from 02/04/2023 to 31/10/2024 for Dorset ICB





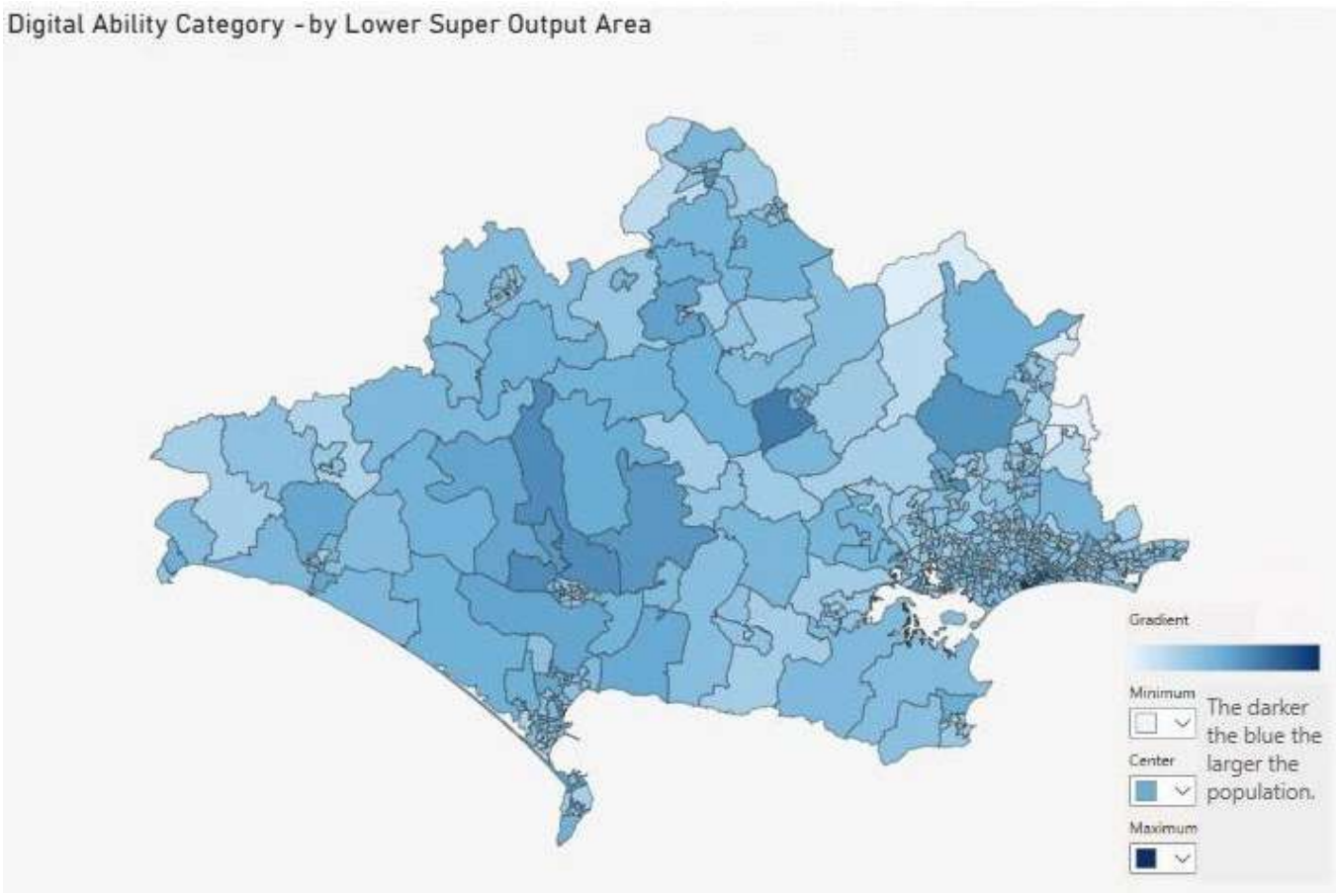


Actions taken on improving service equity

Data and monitoring: DiiS has developed a suite of indicators built upon 24 key measures across 11 healthcare domains. This information can be drilled down to the level of individual trusts within Dorset, allowing staff to use this data to inform their daily operational and improvement work. These 24 key indicators are also being applied to a wider range of other digital dashboards.

System collaboration: We are working collaboratively with system partners to review 37 new indicators, 27 of which are already available to be delivered. Work is currently underway to create a timeline for the further building and development of these dashboards.

Governance and review: Equality indicators are regularly reviewed through specific oversight groups and reports, including those focused on unwarranted variation, planned care, elective recovery, and urgent and emergency care.



Targeted analysis: Rates for elective 'did not attend' appointments have been specifically analysed through the planned care inequalities group to identify and address barriers to access.

Digital inclusion: A new Dorset Digital Strategy seeks to address health inequalities by improving digital inclusion. This ensures that as we adopt new technology, we do not disadvantage vulnerable groups who may have less access to digital tools.

During 2025/26, progress was made on the actions (which were defined in 2024/25) as following:

1. Maternity Services

Data quality:
In line with the Ethnicity Recording Improvement Plan, UHD's Maternity Services are focused on improving the quality and completeness of ethnicity data. This is essential for better understanding and addressing health inequalities.

Monitoring and reporting:
Ethnicity information from the Badgernet system is regularly reviewed through Trust reporting systems. This data contributes to key maternity measures within the Dorset Local Maternity and Neonatal System (LMNS) Dashboard.

Staff support and communication:
Staff receive support to record this information accurately during booking and antenatal appointments. This is done using sensitive and respectful communication, ensuring that the importance of the data and its confidentiality are clearly explained to patients.

Patient feedback:
Maternity teams continue to encourage participation in feedback surveys, such as the national Maternity Survey. There is a specific focus on reaching groups that are often underrepresented in health data.

National insights:
NHS England has introduced a new maternity and neonatal equalities dashboard, which provides Trust-level insights to further support this improvement work.

2. Lung Cancer Screening Programme

Expanding access:
Plans are being explored to extend screening services into secure facilities starting in 2026.

Improving participation:
The programme is continuing to develop its approach to reach more people and improve participation rates.

Addressing low engagement:
Analysis shows that uptake is lower among those who do not engage initially. To address this, the programme is focusing on broader advertising and offering telephone appointments, which can be more convenient for participants.

Support for quitting smoking:
The programme is working closely with stop-smoking services to improve data sharing. This work aims to understand how direct referrals from screening can better support people in their efforts to quit smoking.

Patient feedback and improvement:
Dorset County Hospital, as the lead provider, has successfully introduced 'Friends and Family' feedback for those participating in screening. The service now offers several ways for people to share their views, ensuring that patient experiences directly shape ongoing improvements.

3. Digital Home Blood Pressure Monitoring

Scale and access:
Across Dorset, we delivered a digital home blood pressure monitoring service at scale. We used clinically validated risk criteria to ensure fair access. This included prioritising groups at higher risk of high blood pressure, such as some ethnic minority communities.

Eligibility and reach:
Using these criteria, 368,631 adults were identified as eligible. This represents around 59% of the Dorset population. Data was available for over 90% of residents. The programme covered every Primary Care Network.

Uptake and demographics:
Uptake was strong. Between 2021 and 2025, 17,166 people chose to use the service. Participants represented a wide range of ages. There was an equal balance of men and women.

Clinical outcomes:
Early results show that many participants moved from higher-risk to lower-risk categories. This demonstrates improved blood pressure management. It also shows reduced clinical risk.

Patient experience and inclusion:
Patient feedback showed positive experiences. Many valued the convenience and control of monitoring at home. We gathered feedback from people across a broad range of protected characteristics. This helped ensure the service was inclusive and responsive.

Programme summary:
Overall, the programme reflects a wide reach and equitable design. It provides early evidence of improved health outcomes for the population.

4. Hospital at Home

Scale and access:
The Hospital at Home service is for all patients. We built equality into every stage of its development. An equality impact assessment was carried out. It confirmed that people with protected characteristics should not face barriers to using the service.

Monitoring and data:
We routinely collect patient information to help monitor fairness. This includes data on age, sex, ethnicity, and disability. This data helps us improve access for everyone. Work is also underway to improve how we record gender and other characteristics. The data shows that ethnicity is not captured for 18% of the patients who are cared for under Hospital at Home. There are plans within the project to improve this.

Clinical delivery:
Patients receive care plans based on their individual needs. The service works closely with partners across the Dorset ICS. This ensures our care meets national best practice standards. It also helps support people safely in their own homes.

Patient experience and safety:
We use the Friends and Family Test to get regular feedback. This helps us shape ongoing improvements. Safety processes are also in place. We monitor patient incidents by protected characteristics to ensure care is fair.

Programme summary:
Some of our data systems are still being developed. However, we are committed to improving our equality information. This will help us monitor access, experience, and outcomes more effectively for all patient groups.

5. Fit Notes and Employment

Scale and access:

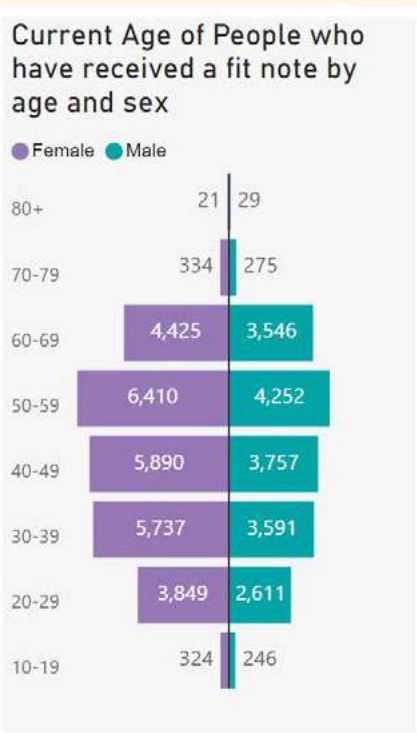
Work is currently happening within UHD and the Dorset ICS. We are working to improve Fit Notes and employment. We also want to widen participation in our workforce.

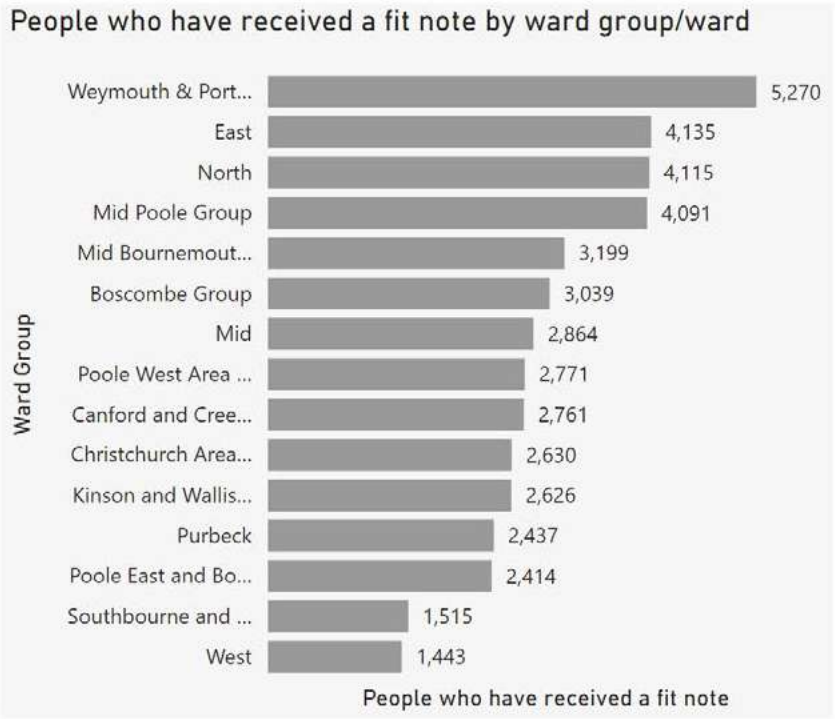
Monitoring progress:

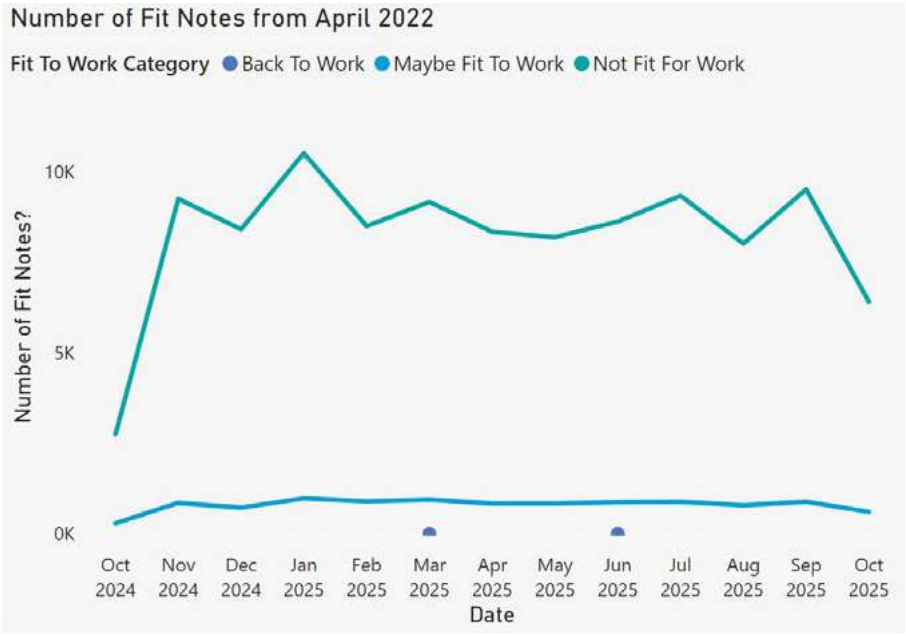
We view Fit Notes as an important indicator. They help us see if we are moving things in the right direction. They show us if our plans are reaching the goals we want.

Programme summary:

We know that progress may not go in the best direction at first. However, tracking this data is a key part of our long-term plan.







6. Health Literacy

Communication and access:
The way services communicate with users is very important. It affects a person's ability to access care. It also impacts how they make choices about their health based on the information they receive.

Training and support:
UHD Knowledge and Library Services provides training for all staff. This includes 'Health Literacy Awareness' and 'Writing in Plain English' sessions. These training opportunities are also offered to partners within the Dorset ICS. The service also regularly reviews patient information leaflets. This ensures they are easy to read for people of all ages. It also helps make sure they are suitable for all literacy levels.

Data and insights:
The DiiS dashboard now includes static health literacy data to help staff understand local needs. This information is based on the Health Literacy Geo-Data tool. This provides insights into the health literacy levels of different communities across the region. Staff can use this data to tailor their communications and improve patient support.

Health inequalities national indicators

Through continued monitoring, partnership working and targeted improvement activity, the Trust sought to ensure that services were accessible, fair and responsive to the needs of the diverse communities it serves.

Sustainability

Under the Health Act 2022 it is explicit that the NHS must, in the course of its activities, respect both the Climate Change Act 2008 and the Environment Act 2021. As an NHS Trust, and as a spender of public funds, UHD has an obligation to work in a way that has a positive effect on the communities we serve and the environment which sustains them.

2025 saw the publication of the Green UHD Plan revised edition.

Our Green UHD 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.

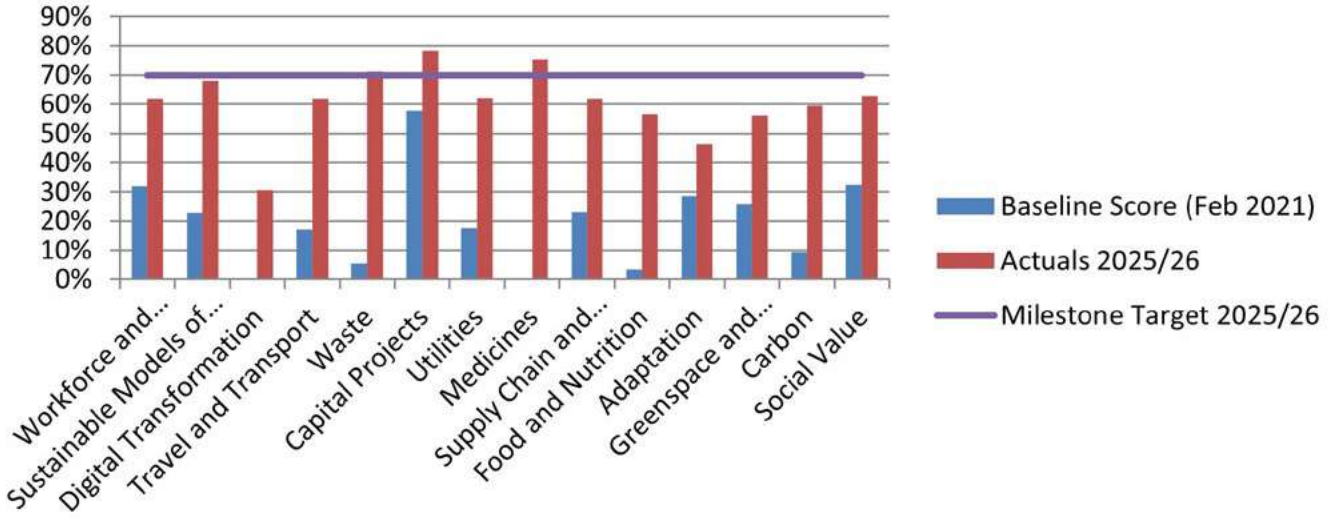
UHD Green Plan

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

Cornerstone Area	Target	Outcome	Comment
Carbon	Carbon Footprint: 80% target reduction by 2032 - Net Zero Carbon by 2040.	Work in progress	2025-26 has been a year of important progress to lay the foundations for our decarbonisation journey. Heat decarbonisation is the largest component of the wider estate decarbonisation challenge. The Trust has partnered with CF to help procure decarbonisation solutions for the Royal Bournemouth and Poole Hospital sites. Whilst technology agnostic in approach, we are activity exploring geothermal solutions coupled with a local area heat network. We aim to award contracts to successful bidders Q4 2026/27. Building energy related carbon emissions through 2025/26 fell circa 1200 tCO2e over the previous year. This is a considerable achievement given the backdrop of estate expansion. These reductions are a combination of factors including UHD carbon reduction measures, UK grid decarbonisations and a mild winter resulting in lower heating demand.
Our People	All Executives and Senior Leaders have actions from Green Plan within their annual objectives.	Achieved	Executive and Senior Leaders are appraised on their delivery of the Trust annual objectives.
Our People	All staff to have access to online training. 90% staff trained by 2027.	Work in progress	Online training available to all staff re Sustainable Healthcare and Healthcare Waste. Uptake to be monitored.
Air Quality	Clean Air Hospital Framework implemented by 2026.	Work in progress	Key targets have been set for the year and will be regularly reported against.
SDAT	100% score for each area of activity by 2030, in year target 70%.	Mixed 3 or 12	UHD has now achieved 70% for 3 out of 12 activity areas and averages 61%..
Climate Resilience	Comprehensive Climate Adaption Risk Assessment	Work in progress	Project kicked off and Q4 2025/26 for delivery Q3 2026/27.
Climate Resilience	Climate Adaption Governance Processes in Place by 2027.	Work in progress	Project kicked off and Q4 2025/26 for delivery Q3 2026/27.

Much progress has been made against core 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. As can be seen from the bar chart below, significant progress has been achieved since our baseline exercise in 2021.



UHD had a stretch target of 70% for 2025/26 and achieved or exceeded this for three of 14 activity areas resulting in an average of 62%. This progress has been against a backdrop of considerable workload for departments as the organisation continues to go through major transformation.

Net zero progress

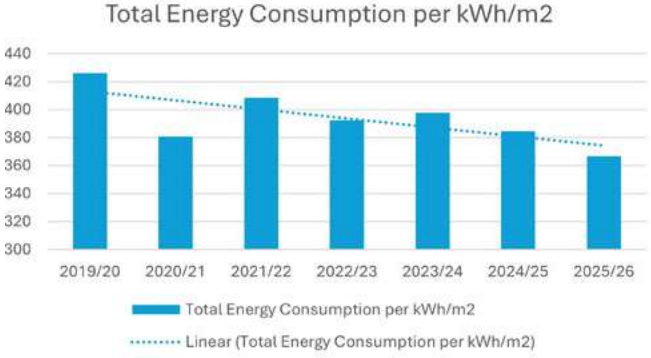
2025/26 has been an important year for UHD in the quest for Net Zero carbon emissions. Our Annual Report captures a fraction of our work and the metrics that we use for management and reporting. The NHS Annual Report and Accounts details carbon emissions for the entire NHS. Detailed Trust level data can also be accessed via the ERIC returns database.

Energy:

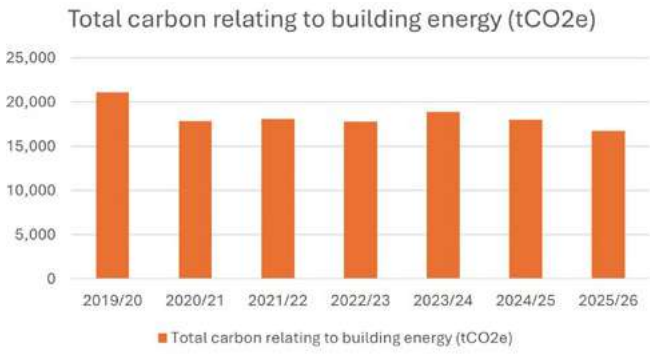
UHD continuous to go through a number of major changes to our estate. This reporting year saw service moves into our new BEACH Building. Construction of the new Endoscopy and Coast Buildings are also well underway. These new buildings are constructed to high-efficiency standards, however they represent large increases to our overall estate, all of which requires heating and lighting.

It is important to monitor both energy consumed by floor area and overall energy consumption when managing our energy spend and carbon emissions.

This year we are pleased to be able to report improvements to the energy consumption, both overall and per m2.



We are also happy to be able to report an overall reduction of building energy consumed and a corresponding reduction of over 1,200 tCO2e.



Once again, this puts the Trust among the best performing in the UK when benchmarking against other NHS Trusts.

In-year energy projects:

The Trust has been successful with three separate funding awards this year with a total value of over £3m. This has enabled us to bring forward plans for large investments into solar arrays on our buildings and car parks.

The solar arrays, are set to be completed in summer 2026 and will generate around 1,600,000 kWh of energy each year. At current prices, this will save the Trust circa £400,000 per year and reduce carbon emissions by around 440 tCO2 p.a.

We have also been busy delivering the final phase of LED lighting upgrades for our main sites which we estimate are now saving £340,000 in energy and 260 tonnes of co2e each year.

The Trust delivered a large part of the Building Management System upgrade project. This is a multi-year upgrade programme that is helping to deliver the efficiency savings observed in our consumption performance above and when finished will save 3-5% of our total energy consumption.

Efficiency savings and solar PV generation are an important part of our decarbonisation journey, however they can not deliver Net Zero alone. For this we need to heat our sites without the need for fossil fuels. We have entered into partnership with the Carbon and Energy Fund (CEF) to procure and manage a decarbonisation programme. Over the course of 2026-27 the Trust plans to award contracts for projects for heat networks on our major sites and low carbon heat source solutions, including geothermal energy.

Waste:

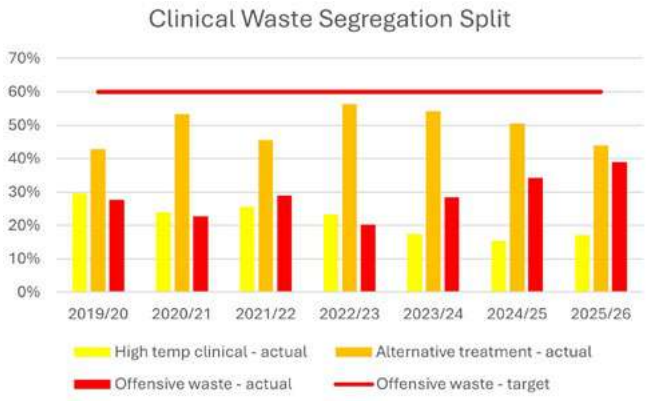
During 2025/26, we have continued our programme to minimise waste where possible.

- We continue to sell retired IT and communications equipment to raise funds for the Trust and our UHD Charity and to minimise disposal.
- The Trust carefully monitors food plate waste from each ward allowing trials of measures to reduce waste. Plate waste management is also an important tool for ensuring patient satisfaction, correct portion sizing and patient nutrition.
- We have also been supporting a trial of an innovative circular solution for hand towels. We have been segregating hand towel waste from Christchurch Hospital and sending them back for processing to be made into new hand towels.

Waste segregation is an important part of our strategy and we are constantly improving the infrastructure to support efficient and effective waste segregation and handling. We take education very seriously and are always exploring novel ways to train our staff. The image below shows the waste segregation game played during the Trust Sustainability Fair in June 2025.

Clinical waste requires special treatment often involving high temperature and high carbon emissions relative to other waste streams. Careful segregation is an important carbon reduction measure and helps to reduce the costs of waste processing. UHD has again this year kept high temperature waste well within the NHS target of 20% or less. The graph below shows the progress towards our target to segregate 60% of clinical waste into offensive waste (the least carbon intensive waste stream), although we recognise there is more work to do.

We have made good progress this year and aim to build on this success.



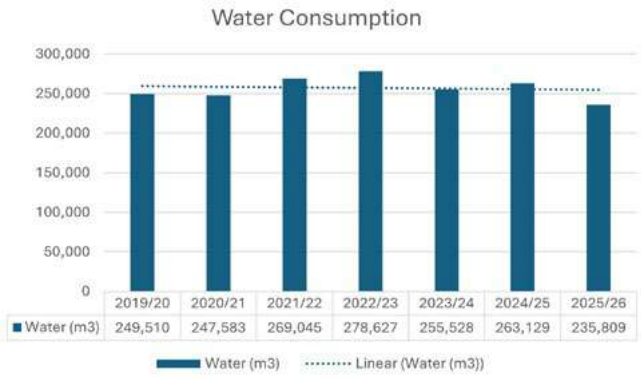
Travel:

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 and 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). UHD participates in Dorset NHS Liftshare - a platform to assist staff to find matches for shared car commutes thereby reducing costs, emissions, and congestion.

Our dedicated inter-site bus continues to provide staff with fast, free transport between the Poole and RBH sites. The initiative has proven very popular with over 8,000 staff bookings a month. The first year was treated as a proof of concept and will now help shape the tender for a longer-term service provision.

Water:

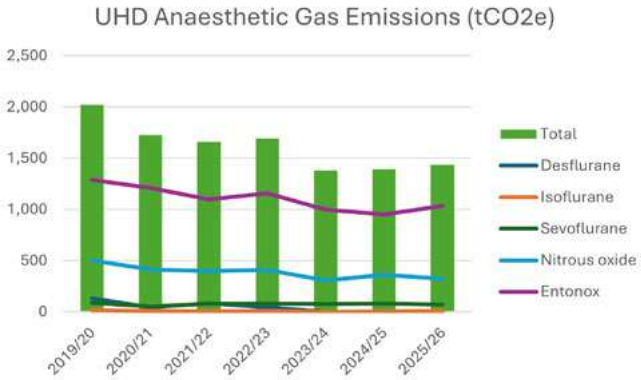
The Trust estate expansion and growth in clinical activity drives higher water demand. However, we have successfully mitigated these impacts through leak detection and remedial action as well as the selection of water efficient equipment. We have delivered a 10% reduction in water consumption over 2025/26.



Medicines:

Medicines and chemicals account for approximately 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 have also decommissioned all nitrous oxide manifolds across the Trust in favour of more efficient delivery systems.

Annual data shown below includes estimates for Q4 and a one time spike in emissions relating to the decommissioning of the nitrous manifolds. We will see the benefit from this in next years' data.



UHD is also working hard to optimise medicines use to avoid waste and associated carbon emissions, this includes a shift from liquid to tablet paracetamol where clinically appropriate.

Partnership work for sustainability

We recognise sustainability requires deep organisation change and partnership work. Sustainability managers for all Dorset NHS trusts meet regularly to further develop strategy and progress joint initiatives.

Examples include the successful joint bid for a Dorset based 'Nature Ranger'. The ranger is now based in Dorset County Hospital and developing sustainable healthcare through nature projects that are being piloted in Dorchester and are a template for work in UHD, with work planned for 2026.

The trusts have also jointly commissioned a climate adaptation risk assessment and action plan programme.

Partnership work also extends to regular sustainability themed meetings and coordination efforts with BCP Council, Dorset County Council, Bournemouth University, Health Sciences University, and with local MPs.

Task force on Climate-related Financial Disclosures (TCFD)

NHS England's NHS Foundation Trust Annual Reporting Manual adopted a phased approach to incorporate 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 are as interpreted and adapted for the public sector by HM Treasury. 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.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications. Where measures have been deferred due to operational pressures during a period of major transformation, details are provided as to what actions are planned and when.

Governance pillar

The UHD Chief Strategy and Transformation Officer (CSTO) is the Board-level Senior Responsible Owner for sustainability. The Trust has a full-time Sustainability and Carbon Manager who reports to the Associate Director of Estates, who in turn reports to the CSTO. In relation to climate adaptation, the Sustainability and Carbon Manager works closely with the Head of Emergency Preparedness, Resilience and Response.

The Trust has established the Green UHD Steering Group, which meets quarterly to review progress across all activity areas set out in the Trust's Green Plan. The Steering Group reports quarterly to the Sustainable Services Group and subsequently to the Trust Management Group, providing a clear escalation route and an opportunity to keep the Board appropriately sighted.

At present, business cases and programmes are not automatically considered by the UHD Green Steering Group; however, this arrangement is under review. The Board is updated at least biannually on progress against the Green Plan and considers significant proposals as required. The Board-approved Trust Green Plan covers the period from 2021 to 2026 and has been updated three times during that period.

Currently, there is no formal sustainability oversight requirement for all Board committees. All sustainability updates provided to the Board are captured within meeting papers and minutes.

Staff

Staff have access to the Trust Green Plan, as well as eLearning courses covering NET Zero healthcare and healthcare waste. The Trust also has a well-developed risk management process in place.

Together with Dorset Healthcare and Dorset County Hospital, UHD has jointly commissioned Sustainability West Midlands to support delivery against a Climate Adaptation Framework (CAF) for NHS organisations in England. The full scope of the project is set out in the table on page 54 and is mapped against all tasks within the CAF. The project is scheduled to take place over the first three quarters of 2026-27 and will feed into UHD and wider system risk processes, including those of the Local Resilience Forum.

It is anticipated that this project will support the Trust to fully meet the requirements of the Task Force on Climate-related Financial Disclosures (TCFD).

Task No.	Climate Adaptation Framework Task	Stakeholder mapping and strategic alignment	Climate adaptation workshop	Climate projections and risk mapping	Climate change risk assessment	Adaptation Plan	Setting up a Working Group
Understanding the Challenge							
UC1A	Learn about England's Changing Climate			Y	Y		
UC1B	Learn about climate impacts affecting health and healthcare	Y		Y	Y		
UC1C	Key staff undergo basic training on climate change risk and adaptation.		Y		Starts		
UC2A	Develop understanding of climate risk and vulnerability	Y		Y	Y		
UC2B	Record the impact of recent weather events on your organisation		Y		Starts		
UC2C	Consider how your organisation's functions (or service areas) might be affected by climate change		Y		Y		
UC3A	Integrate climate risk into corporate risk register						
UC3B	Undertake detailed climate change risk assessment			Starts	Y		
UC3C	Identify knowledge gaps, seek expertise and foster links with research and innovation				Y		
UC4A	Undertake project-level risk assessment						

Task No.	Climate Adaptation Framework Task	Stakeholder mapping and strategic alignment	Climate adaptation workshop	Climate projections and risk mapping	Climate change risk assessment	Adaptation Plan	Setting up a Working Group
UC4B	Integrate climate adaptation into internal systems and procedures						
UC4C	Actively engage in sharing, learning, research and innovation						
Organisational Culture and Resources							
OC1A	Consider how adaptation fits with your organisation and its objectives	Y			Y		
OC1B	Identify resources available for adaptation		Y				
OC2A	Secure resources to plan and deliver adaptation						
OC2B	Engage with colleagues to identify adaptation opportunities across functions		Y				
OC2C	Establish governance arrangements for adaptation						Y
OC3A	Identify opportunities to include adaptation and resilience in plans, policies and procedures	Y				Y	
OC3B	Put governance arrangements for adaptation into operation						Y
OC3C	Appoint named leads within functions for specific adaptation actions or responsibilities						Y
OC3D	Mainstream adaptation into your organisation's plans, policies and procedures						Y
OC4A	Establish communication and reporting processes for adaptation across functions/ service areas						Y
OC4B	Review and update governance arrangements for adaptation						
Planning and Implementation							
PI1A	Define a strategic vision and outcomes for adaptation		Y			Y	

Task No.	Climate Adaptation Framework Task	Stakeholder mapping and strategic alignment	Climate adaptation workshop	Climate projections and risk mapping	Climate change risk assessment	Adaptation Plan	Setting up a Working Group
PI1B	Identify a range of existing and potential adaptation actions		Y			Y	
PI1C	Identify relevant NHS internal structures and requirements for adaptation	Y			Y	Y	
PI2A	Develop an initial adaptation strategy and action plan					Y	
PI2B	Take action to deliver initial adaptation					Y	
PI2C	Engage with relevant NHS internal structures and processes to plan for adaptation		Y			Y	
PI3A	Develop an appraisal process for selecting adaptation actions					Y	
PI3B	Develop a comprehensive adaptation strategy and action plan					Y	
PI3C	Implement a programme of adaptation actions					Y	
PI4A	Adopt an ongoing adaptive management cycle for adaptation planning						Y
PI4B	Taking action on adaptation is mainstreamed into your organisation's functions						
PI4C	Develop a strategic change process for achieving adaptation outcomes						
	Working Together						
WT1A	Join and participate in relevant professional and/or adaptation networks						
WT1B	Identify and engage a wide range of internal and external stakeholders	Y			Y		
WT2A	Develop key partnerships and opportunities		Y		Y		
WT2B	Coordinate with partners to identify initial actions		Y		Y		
WT3A	Formalise partnership working						
WT3B	Develop communication and engagement activities with partners						

Strategy pillar

The Climate Adaptation Project being undertaken in the 2026/27 financial year will comprehensively identify the current and future climate related risks to and opportunities for the Trust and identify actions that help build capacity for adapting to climate change in line with the Climate Adaptation Framework for NHS organisations in England.

This project will capture the impact of climate related risks and opportunities on the organisation's operations, strategy and financial planning, taking into consideration climate and impact projections at various Global Warming Levels (with a focus on 2°C), historic impacts and stakeholder input to assess how these risks may materialise or change over time.

The Trust has been incorporating climate change projections into the designs for our new builds and refurbishments projects as is now a requirement under the UHD Capital Estates Sustainable Construction Policy and design guides.

Risk Management pillar

To support the identification and assessment of climate-related risks, the Climate Adaptation Project is using a suite of NHS-developed tools collectively known as Adapt to Survive. The project is being led by Sustainability West Midlands, the team that helped to develop the Adapt to Survive toolkit, and is supported by the Trust's Sustainability and Carbon Manager and the Emergency Preparedness, Resilience and Response (EPRR) Manager. This approach ensures close integration with existing Trust risk management processes and the EPRR Core Standards.

The Climate Adaptation Project is collating a comprehensive set of climate-related risks and opportunities, which will be used to update the Trust Risk Register where they will be automatically flagged for review. All identified risks will be managed through appropriate mechanisms, including relevant action plans and ownership by responsible departments.

The Trust also participates in Local Resilience Forum (LRF) activities, such as wildfire response planning, and the LRF has been identified as a key stakeholder in the Climate Adaptation Project. In addition, the project includes awareness training for staff involved in identifying and assessing climate-related risks.

The Trust has a number of core climate-related emergency plans in place, including a heatwave plan, cold weather plan, adverse weather plan and specific business continuity action cards, such as those relating to flash flooding. These plans are subject to a minimum of annual review and will also be considered as part of the Climate Adaptation Project.

Climate-related risks identified and assessed through the Climate Adaptation Project will be integrated into the Trust Risk Register as appropriate. There are established criteria in place for prioritising risks for escalation, based on their risk rating and potential impact, and all risks recorded on the Trust Risk Register have assigned risk owners.

The Trust participates in NHS Emergency Preparedness, Resilience and Response assurance exercises as they take place throughout the year. In addition, the Trust receives warning alerts from the Met Office, the UK Health Security Agency and the Environment Agency in relation to weather-related events such as heatwaves, flooding and extreme cold. These alerts trigger the activation of the relevant Trust response plans as required.

Metrics and target pillar

The Trust has a range of metrics that we employ to monitor and manage the drivers of carbon emissions. As shown in the sustainability section of the Annual Report (page 48), the Trust monitors gas, electricity, oil and water consumption as part of our performance management. We also track and manage other key drivers of carbon emissions including: anaesthetic gas consumption by gas type, refrigerant gas use by gas type, all waste tonnage by waste stream, and fleet and grey fleet travel miles by vehicle fuel type.

Overheating, low temperature and flooding incidents are captured via manual staff reports into the Datix system and collated periodically for and monitoring purposes. The Trust is improving building management systems that will aid better automated monitoring.

Siobhan Harrington
Chief Executive
17 June 2026

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 routine activity across the Trust is carried out by the executive directors, who work closely with the medical, nursing and operational leads of the three clinical care groups, as well as with clinical directors, senior nurses, clinical leads and other leaders throughout the organisation. The Board sets out the Trust's financial, quality and operational ambitions through its strategic objectives and quality priorities.

The Board normally meets 11 times a year. Its annual business cycle ensures effective oversight of the systems and processes used to measure and monitor the Trust's performance, including its effectiveness, efficiency, use of resources and the quality of care provided. A suite of relevant metrics has been established to assess progress and delivery against these expectations.

All non-executive directors are regarded by the Board as independent. The balance, completeness and suitability of the Board's composition are reviewed regularly, and a statement reflecting this is published on our website.

Board engagement

During the year, the Board maintained a strong focus on direct engagement with colleagues and services, carrying out more than 30 visits across the Trust's three hospital sites. These visits provided Board members with valuable first-hand insight into the delivery of care, staff experience and the operational challenges and achievements in these areas. Information gathered was used alongside formal performance reporting, quality metrics, patient feedback and regulatory information to support effective triangulation of quality and assurance and celebrating key areas if improvement.
This approach strengthened the Board's understanding of risks and mitigations at ward and service level, informed constructive challenge and assurance, and supported confident, well-evidenced oversight of quality and patient safety across the Trust.

Our Board of Directors 1 April 2025 to 31 March 2026

Non-executive directors - as at 31 March 2026:

Judy Gillow MBE
Interim Trust Chair, Chair of the Transforming Care Together Steering Group, and Chair of the Appointments and Remuneration Committee

Date of appointment: 1 May 2025

End of term: 30 April 2027

Judy Gillow 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 clinically and managerially in a range of settings in acute, community, primary care and education as well as undertaking voluntary work overseas.

Previous NHS roles have included Director of Nursing and Organisational Development at University Hospital Southampton NHS Foundation Trust, and she has been a non-executive director at Dorset County Hospital.

Judy also has previous experience of being a specialist professional advisor for the Care Quality Commission (CQC), supporting hospital well led inspections and has worked at Health Education England.

She was awarded an MBE for services to healthcare in 2012 and in addition awarded an honorary Doctor of Science at Southampton University, for her contribution to healthcare research and education in 2016.

Her priority in the Trust will continue to be a focus on, providing excellent safe efficient care and the best patient and staff experience.

Dr Michael Marsh MBE
Interim Vice Chair and Chair of the Quality Committee

Date of appointment:
1 September 2025

End of term:
31 August 2028

Dr Michael Marsh joined the Board as a non-executive director in September 2025, bringing with him a wealth of experience in the healthcare sector. Michael qualified at Guy's Hospital Medical School. Most of his paediatric training was at the Evelina Children's Hospital, at Guy's Hospital where he was appointed as a consultant in 1995. In 1998 he was appointed Director of Paediatric Intensive Care in University Hospital Southampton NHS Foundation Trust before becoming Clinical Director of Paediatrics and then Divisional Director of Women and Children's Services. He was Executive Medical Director in Southampton from 2009-2016.

Michael was Medical Director for specialised commissioning for NHS England in the London region from 2015-2019. In 2016 he was appointed as a non-executive director at Salisbury NHS Foundation Trust, a post he held until 2019 when he joined the Council of the General Medical Council. In 2019 he took up the post of Regional Medical director and Chief Clinical Information Officer for NHS England in the South West region.

Tracie Langley
Chair of the Audit Committee

Date of appointment:
6 January 2025

End of term:
5 January 2028

Tracie Langley has had a distinguished career as a senior strategic executive across both public and private sectors and has held a number of director and non-executive director roles across a variety of organisations and industries. Tracie is a qualified accountant and is recognised nationally for her strategic commercial and financial advice.

Tracie has a deep understanding of how organisations function 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.

Femi Macaulay
Chair of the Charitable Funds Committee

Date of appointment:
16 December 2024

End of term:
15 December 2027

Femi Macaulay has over 35 years' experience at senior levels in banking, insurance, health, education, and management consulting. He was 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 he UK. He started his career with PricewaterhouseCoopers in London in 1985.

Currently, Femi is Chairman 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 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.

Alastair Matthews
Chair of the Finance and Performance Committee

Date of appointment:
20 October 2025

End of term:
19 October 2028

Alastair Matthews brings extensive senior strategic, financial, and commercial experience from across the NHS, higher education, and the wider public and private sectors. Before joining UHD, Alastair served as a non-executive director at the Royal Devon University Healthcare NHS Foundation Trust, where he had chaired the Finance, Audit and Charity Committees and the Integration Programme Board. His earlier executive roles include Finance Director and Deputy Chief Executive at University Hospital Southampton NHS Foundation Trust, Chief Financial Officer at the University of Plymouth, Finance Director at Ordnance Survey and Chief Financial Officer at Computer Sciences Corporation. He worked as a senior manager with PricewaterhouseCoopers having qualified with them as a Chartered Accountant.

At UHD, Alastair chairs the Finance and Performance Committee and contributes to a range of assurance and oversight activities across the Trust. He is committed to strengthening financial governance, supporting operational excellence, and ensuring the delivery of high-quality, sustainable care for the communities served by UHD.

Helena McKeown

Date of appointment:
1 October 2023

End of term:
30 September 2029

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:
31 March 2029

Born in Bangalore, India, Sharath Ranjan 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 and Isle of Wight 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. 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 Southampton Solent University, Southampton since 2020 and is a member of the University's governance committee and Chair of People and Culture Committee. He mentors students at the university and is passionate about making a difference to people at pace.

Claire Whitaker CBE
Senior Independent Director

Date of appointment:
1 October 2023

End of term:
30 September 2029

Claire Whitaker 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 successful 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, Chair of Aster's Customer and Community Network Committee and has just joined the Board of Hampshire and Isle of Wight Healthcare NHS Foundation Trust as the Lead Non-Executive Director for Engagement.

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 2025 to 31 March 2026

Professor Cliff Shearman OBE
Vice Chair and Chair of the Quality Committee

Date of appointment:
1 October 2020

End of term:
30 September 2025

John Lelliott OBE
Chair of the Finance and Performance Committee

Date of appointment:
1 October 2020

End of term:
31 October 2025

In addition, **Professor Alison Honour**, Vice Chancellor of Bournemouth University, and **Andrew Doe** hold the position of Associate Non-Executive Directors of the Trust

Executive directors - as at 31 March 2026:

Siobhan Harrington
Chief Executive Officer

Date of appointment:
1 June 2022

Siobhan Harrington has been Chief Executive of UHD since June 2022. She has overseen the £500m transformation of services that will see the Royal Bournemouth Hospital become the major emergency hospital for east Dorset and Poole Hospital become the largest planned care hospital in the country. With 10,000 staff, UHD is the largest employer in Dorset. She is also Chair of the NHS Dorset Provider Collaborative which is bringing together services across the county, as well as the Southwest Elective Learning and Improvement Network and the Dorset Planned Care Group.

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 Bryant 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 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 University Hospital Southampton NHS Foundation Trust medical division through Covid before becoming the Deputy Chief Nurse there in 2021.

Sarah holds a 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 Mould is the first Chief Operating Officer for UHD. 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 Papworth 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 UHD 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 Renaut 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.

Melanie Whitfield
Chief People Officer

Date of appointment:
18 August 2025

Melanie Whitfield is an accomplished HR leader and coach with many years of experience leading on significant programmes of change and people strategy in both the private and public sector. Melanie joined the national team at NHS England and Improvement becoming one of the founding authors of the NHS People Plan and the People Promise. Melanie began her career in retail working for some of the best-known brands on the high street including The John Lewis Partnership, Sainsbury's and Boots. She has continued both her formal academic studies and professional development and has a particular interest in the value and impact of team coaching. In joining the Trust. Melanie has an ambition to continue her work to support all staff to be the best they can be, helping create the kind of environment where everyone can thrive and in doing so, provide the best possible care to the communities we serve.

Within the UHD Executive Team, she is the responsible leader for our Operational HR Services, Resourcing, Organisation Design and Development, Education and Communication strategies alongside our Health and Safety and Occupational Health services.

Dr Peter Wilson
Chief Medical Officer

Date of appointment:
1 April 2023

Dr Peter Wilson 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 2025 to 31 March 2026

Tina Ricketts
Chief People Officer

Date of appointment:
26 February 2024

End of term:
30 April 2025

Irene Mardon
Acting Chief People Officer

Date of appointment:
1 May 2025

Date of appointment:
17 August 2025

Declarations of interest

The Trust holds a register of directors' interests which is made publicly available on our website.

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 2025/26 we delivered performance of 96% against the national standard of 95%.

Better Payment Practice Code Non-NHS invoices	2025/26	
	No.	£'000
Total bills paid	105,375	493,366
Total bills paid within target	101,711	475,356
Percentage of bills paid within target	96.5%	96.3%
NHS invoices		
Total bills paid	3,118	85,613
Total bills paid within target	2,915	80,436
Percentage of bills paid within target	93.5%	94.0%
Total		
Total bills paid	108,493	578,979
Total bills paid within target	104,626	555,792
Percentage of bills paid within target	96.4%	96.0%

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.

The Board currently has seven committees: the Appointment and Remuneration Committee, Audit Committee, Charitable Funds Committee, Finance and Performance Committee, Quality Committee, People and Culture 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[1].

[1] The Population Health and System Committee had been dissolved as a Board Committee of UHD, with its functions moving to a system-level committee instead.

Appointments and Remunerations Committee

A summary of the work of our Appointments and Remuneration Committee during the year is set out on page 88 of the Annual Report.

Audit Committee

The Audit Committee meets at least four times in each financial year and representatives from internal audit, and the anti-crime 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:

- Providing independent assurance on the adequacy of the Trust's governance, risk management and internal control systems. It reviews the effectiveness of the Board Assurance Framework, the quality of risk information, and the Trust's response to significant control issues or emerging risks.
- Overseeing internal audit by approving the annual plan, monitoring delivery against key risk areas, assessing independence and performance, and ensuring that audit recommendations are implemented promptly. It also oversees external audit, reviewing the audit strategy and findings, meeting privately with auditors, and advising the Board on the external audit opinion for the Annual Report and Accounts.
- Maintaining oversight of anti-crime arrangements, including investigations, thematic risks and the development of a strong anti-fraud culture. It reviews the integrity of the financial reporting process, including major judgements, estimates and compliance with statutory and NHS requirements.
- Considering wider assurance functions such as quality governance, information governance, cyber security, workforce and estates, ensuring that assurance sources collectively provide a coherent view of control. This includes oversight of Freedom to Speak Up arrangements, information governance compliance, cyber-security risks, and adherence to regulatory and statutory requirements, including Standing Orders and guidance on exit-related payments.

The terms of reference can be found on our website.

During the year, the Audit Committee paid particular attention to the following areas: ward identity checks, critical IT applications, consultant job planning, speaking up, fire safety, salary errors, DSP toolkit and cyber security, governance of major clinical and operational moves, Maternity Incentive Scheme (MIS) Year 7, Care Group financial governance and commercial compliance and single tender waivers benchmarking.

Internal Audit

Internal Audit supports the Audit Committee by providing independent assurance on the design and effectiveness of internal control arrangements. The Chief Finance Officer holds professional responsibility for the implementation of systems of internal financial control and is able to advise the Audit Committee on these matters.

The internal audit function is provided by BDO and has reported:

Internal Audit is required to provide an opinion to the Trust 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. Our opinion is as follows: ***Generally satisfactory with improvements required in some areas****.*

Overall, the controls in the areas reviewed were generally appropriately designed, supported by established governance frameworks and structured reporting arrangements. However, the effectiveness of these controls in practice was variable, with identified weaknesses in implementation, monitoring and follow-through which, if not addressed, may impact the achievement of organisational objectives.

External Audit

The Trust's external auditors for the year ended 31 March 2026 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 on 1 April 2023, with an option to extend for up to two further 12-month periods. In light of the quality of service received, the Audit Committee approved the exercise of these extension options, extending KPMG's appointment by a further 24 months to 31 March 2028.

The role of the external auditors is to provide an independent audit opinion on the Trust's Annual Report and Accounts. The effectiveness of the external audit process is assessed through a framework that includes consideration of performance against the contracted service specification, the standard of audit work undertaken, the timeliness of reporting, the availability of the auditors for discussion, and the value for money provided by the audit service. Using this framework, the Audit Committee and the Council of Governors were satisfied with the effectiveness of the external audit process.

As part of the overall audit, significant audit risks were identified in relation to the valuation of land and buildings, the risk of fraud associated with expenditure recognition (understatement) and the risk of management override of controls. These risks were discussed with the Audit Committee during the audit planning process, and KPMG reported on these areas in their year-end audit report. No significant issues were identified.

The Board has approved a policy governing the provision of non audit services by the Trust's external auditors. The policy avoids unnecessary restrictions on the purchase of such services while ensuring that any non audit work undertaken does not, and is not perceived to, compromise the auditors' independence or objectivity in forming their opinion on the Trust's financial statements.

The Trust reviews and formally assesses the effectiveness of its external auditors on an annual basis.

Anti-Crime

The Audit Committee is responsible for the appointment of the Anti-Crime (Counter Fraud) Service and for ensuring that it is appropriately supported within the Trust to fulfil its responsibilities. The Committee reviews the annual counter fraud programme, together with the outcomes of proactive monitoring and awareness raising activities, and considers the key findings arising from investigative work, including managements' response to recommendations. Any significant issues are escalated to the Board where necessary. The Counter Fraud Service is accredited by the NHS Counter Fraud Authority and works in partnership with the Trust to ensure compliance with Government Functional Standard 013 (Counter Fraud) and the requirements set by the NHS Counter Fraud Authority, in line with the NHS Counter Fraud Authority Strategy 2023-26.

Charitable Funds Committee

The Charitable Funds Committee is a formally established committee of the Trust, acting in its capacity as corporate Trustee of the University Hospitals Dorset NHS Foundation Trust Charity. The Board of the Trust acts as the Board of the Trustee and holds overall responsibility for the charity. The Committee provides the Board assurance that the charity is properly governed, managed, and compliant with relevant legislation and regulatory requirements. The charity publishes 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 supports the Board by providing input and recommendations on the development of key strategic plans, including the Annual Operating Plan, Productivity and Efficiency Plan, Estates Strategy, Sustainability Strategy and Digital Strategy. The Committee's responsibilities also include reviewing and commenting to the Board on the Trust's annual revenue and capital budgets, and overseeing operational performance against key national performance standards, including access times.

People and Culture Committee

The People and Culture Committee provides input and makes recommendations to the Board on the development of the People Strategy and the Equality, Diversity and Inclusion Strategy. It also seeks assurance on the effective implementation of these strategies.

The Committee further sought assurance on the Trust's culture, supported by a Chair's report presented to the Board. This included reviewing reports from the Guardian of Safe Working Hours and the Freedom to Speak Up Guardian. The Committee ensured that appropriate feedback mechanisms were in place for individuals who raised incidents and that a culture of openness and transparency was promoted, actively supporting the speaking-up agenda.

Standing items within the Board's programme included the gender pay gap, Freedom to Speak Up, equality and diversity, and workforce indicators such as WRES and WDES.

Quality Committee

The Quality Committee is responsible for overseeing robust management systems and processes to ensure high standards of quality of care across the Trust. The Committee provides assurance that the Trust has an effective framework in place to deliver safe, high-quality care and a positive patient experience, through continuous improvement and assurance of the quality and safety of services across a range of areas. It also provides internal assurance of compliance with the Care Quality Commission's regulatory and inspection framework. The extensive work of the Committee, and the processes 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 established to provide input and recommendations to the Board and relevant Committees to support the delivery of the Trust's Service Ready, Build Ready and People Ready programmes. Collectively, these programmes deliver the Clinical Services Review, supporting the development of planned and emergency hospital services for Dorset. In support of system-wide working, representatives of the Integrated Care Board are periodically invited to attend meetings of this and other relevant committees.

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	Quality Committee meetings	Transforming Care Together Group
Beverley Bryant	6(7)	11(13) *				10(14) *	1 (1)			
Judy Gillow	7(7)	13(13)	1(1)	1(1)				1(1)	0(1)	5(6)
Siobhan Harrington	7(7)	13(13)								6(6)
Sarah Herbert	7(7)	13(13)							10(12)	
Tracie Langley	6(7)	11(13)	1(1)	3(5)		13(14)	1(1)			2(6)
John Lelliott (Until 31 October 2025)	3(4)	5(6)	0(0)	4(4)		6(7)				3(4)
Femi Macaulay	6(7)	12(13)	1(1)		4(4)			6(6)	12(12)	
Michael Marsh	4(4)	8(9)		2(2)	2(2)				6(6)	3(3)
Alastair Matthews	3(3)	7(7)	0(0)	1(1)		7(7)				2(2)
Dr Helena McKeown	5(7)	10(13) *	1(1)		4(4)			4(6)	11(12)	3(3)
Mark Mould	6(7)	10(13)				11(14) *	1(1)	4(6)	10(12)	6(6)
Pete Papworth	7(7)	13(13)			4(4)	14(14)	1(1)			5(6)
Sharath Ranjan	7(7)	10(13) *				11(14) *	1(1)	5(6)		4(6)
Richard Renaut	7(7)	13(13)				13(14)	1(1)			5(6)
Cliff Shearman (Until 30 September 2025)	5(5)	5(6)	0(0)	3(3)			1(1)		6(6)	1(3)
Claire Whitaker	7(7)	11(13) *	1(1)	5(5)	1(2)	12(14) *	1(1)			
Melanie Whitfield	4(4)	8(9) *			2(2)			2(3)		4(4)
Dr Peter Wilson	6(7)	13(13)							10(12)	
Quorate	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*One/two of the meetings not attended was an extraordinary meeting

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 to ensure that the views of the local community are represented. Governors held listening and engagement events to gather feedback from members and the public. This feedback was shared with the Board through several routes, including questions raised by governors at Board meetings held in public, a bi-annual update from the Lead Governor on behalf of the Council of Governors highlighting key engagement themes, and feedback provided at Council of Governors' meetings with escalation where appropriate.

Views and comments on the Annual Plan were sought from a cross section of the Trust's members. This feedback, together with input from governors, staff and commissioners, informed the development of the Plan.

Council of Governors' development sessions held during 2025/26 covered a range of topics, including the Trust's strategic priorities, accountability and assurance arrangements, and equality, diversity and inclusion. This programme supported governors to remain informed and effective in fulfilling their role.

In addition to its statutory Nominations, Remuneration and Evaluation Committee, the Council of Governors was supported by three informal working groups: the Effectiveness Group, the Membership Engagement Group, and the Quality Group. These groups supported the Council's work by enabling more detailed consideration of key issues and by strengthening the effectiveness of governor contributions.

Our members

Our 13,000 members over three constituencies; Christchurch, Bournemouth and Poole, play an important role in helping UHD grow and improve. As a Foundation Trust, we have greater freedom to make local decisions, and member involvement helps ensure our services reflect the needs of the communities we serve.

We stay connected with our members through regular updates and newsletters, and we invite them to share their views on key issues and service developments. This feedback helps shape our plans and supports improvements to patient care and services.

Members can take part by raising concerns, celebrating good practice and sharing ideas through their elected representatives. Members are welcome to attend Trust meetings and events free of charge, helping to promote openness, transparency and meaningful engagement.

The members of our Council of Governors as at 31 March 2026 were:

Name	Constituency/organisation represented	Attendance at meetings of the Council of Governors	
		Part 1	Part 2
Benjamin Ango	Staff: Clinical	1(1)	1(1)
Colin Blebta	Bournemouth	5(5)	5(7) *
Dr Deniz Cetinkaya	Bournemouth	3(5)	3(7) *
Marie Cleary	Poole and Rest of Dorset	0(1)	0(1)
Sharon Collett	Bournemouth	5(5)	7(7)
Sue Comrie	Appointed Governor: Volunteers	5(5)	7(7)
Steve Dickens	Christchurch, East Dorset and Rest of England	3(5)	4(7)
Peter Fitzmaurice	Poole and Rest of Dorset	1(1)	1(1)
Rob Flux	Staff: Non-Clinical	2(5)	2(7) *
Colin Hamilton-Welsh	Staff: Non-Clinical	5(5)	5(7) *
Cllr Paul Hilliard	Appointed: Bournemouth, Christchurch and Poole Council	5(5)	6(7) *
Malcom Keith	Staff: Non-Clinical	1(1)	1(1)
Rosie Martin	Christchurch, East Dorset and Rest of England	1(1)	1(1)
Elizabeth McDermott	Bournemouth	5(5)	5(7) *
Andrew McLeod	Poole and Rest of Dorset	3(5)	4(7) *
Keith Mitchell	Bournemouth	5(5)	7(7)
Jeremy Scrivens	Christchurch, East Dorset and Rest of England	4(5)	6(7)
Diane Smelt	Bournemouth	5(5)	7(7)
Carrie Stone	Poole and Rest of Dorset	4(5)	6(7)
Kani Trehorn	Staff: Clinical	4(5)	5(7) *
Dr Shelley Thompson	Appointed Governor: Bournemouth University	3(5)	5(7) *
Michele Whitehurst	Poole and Rest of Dorset	5(5)	6(7) *
Nicholas Williams	Christchurch, East Dorset and Rest of England	1(1)	1(1)

* * One of the meetings not attended was an extraordinary meeting; all governors were elected, except where noted above as appointed.

The terms for which each governor was elected or appointed were three years. The Trust recorded its thanks to Richard Ferns, whose tenure as governor came to an end during 2025/26, for his valuable contribution to the work of the Council of Governors.

The register of governors' interests was maintained in accordance with statutory requirements and was available on the Trust's website.

Directors and governors could be contacted by emailing: **uhd.ftmembers@nhs.net**

The Trust has formal arrangements in place for the resolution of any disagreements between the Board of Directors and the Council of Governors, should these arise. These arrangements included the involvement of the Senior Independent Director and the Lead Governor. A formal policy for the resolution of disputes was available at: UHD Board policy for Engagement with the Council of Governors.

Care Quality Commission (CQC) and NHS England Well-led Framework

The Trust's approach to ensuring that services are well led is also described in the Performance Report and the Annual Governance Statement. The Board has approved an Accountability Framework that supports the delivery of the Trust's vision and strategic objectives, underpinning its role as a well led organisation that delivers safe, high quality patient care in a clinically and financially sustainable way. Through this framework, the Board oversees the development of the leadership capabilities and culture required to achieve the Trust's vision. The leadership model supporting culture change is based on collective, clinically led leadership, with the Board actively promoting inclusive leadership and management behaviours. The Accountability Framework also sets out the Trust's performance management arrangements.

Leadership capacity and capability are supported through the Trust's management structures. A Care Group model has been established to strengthen clinical leadership and embed the triumvirate and quadrumvirate approach across care groups. The triumvirate model comprises a partnership between the Care Group 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 Midwifery forms an integral part of a quadrumvirate at Care Group level. These leadership teams hold collective responsibility for the delivery of services within their respective areas, an approach which is replicated across all leadership levels within the Trust.

The Trust has established a range of management and leadership development programmes to support the delivery of its mission and strategic objectives, and to promote an inclusive and well led organisation that delivers safe, high quality patient care in a clinically and financially sustainable way. Further detail is provided in the Staff Report.

In addition to routine visits to services undertaken by executive directors, the Trust also operates a programme of visits for non executive directors. Alongside the appointed Maternity Board Safety Champion, Wellbeing Guardian, Freedom to Speak Up Champion and Security Management Non Executive Director Champion, the Trust has also designated a Non Executive Director Engagement Lead.

The Council of Governors plays a key role in engaging with the Trust's members and the wider community, supporting the Trust's communications strategy. Regular, externally facilitated developmental reviews of leadership and governance are recognised as good practice and are used to identify areas where further targeted development would support the Trust in securing and sustaining future performance. NHS England

requires all Trusts to undertake externally facilitated, developmental reviews of their leadership and governance arrangements using the Well led Framework.

In September 2025, the Board appointed the Good Governance Institute (GGI) to undertake a developmental well-led review of leadership and governance at the Trust, accompanied by a CQC preparation programme. **The review concluded that the Trust was progressing towards a 'Good' rating, with many recommendations already completed or underway**. The Board agreed that oversight of the resulting action plan would be embedded within established business-as-usual governance arrangements.

The Board participates in an ongoing Board development programme, with development sessions during the year covering a range of well led related topics.

The Trust is required to be registered with the CQC, and its current registration status is unconditional. This confirms that the Trust has no restrictions on its services or practice.

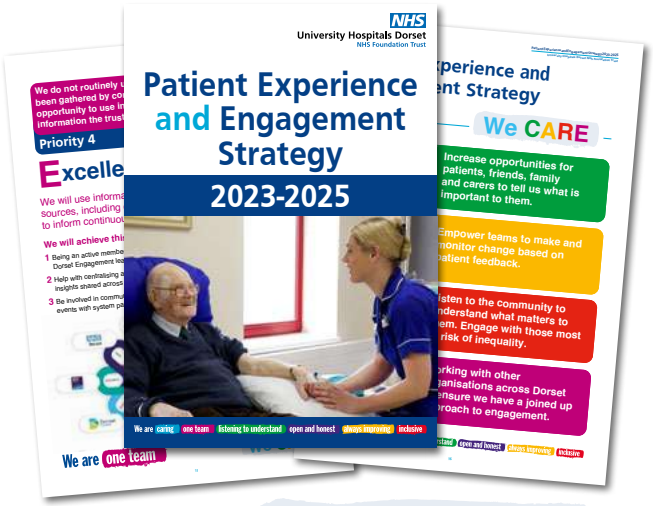
In September 2025, the CQC inspected Maternity and Neonatal services at the Royal Bournemouth Hospital, with the final report published in March 2026 and the maternity service rated as Requires Improvement. The inspection identified areas for improvement relating to aspects of staffing, timeliness within the induction pathway and capacity pressures affecting some elective procedures. The Trust has accepted the findings and implemented improvement actions with clear ownership and oversight through established quality governance arrangements.

The inspection also identified areas of good practice, including strong compliance with standards for monitoring babies during labour, early booking rates exceeding national expectations, and positive, person-centred feedback from women. Progress against the CQC action plan is monitored through executive and Board-level governance to ensure continued focus on safe, effective and compassionate maternity care.

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.

Our 2023-2025 Patient Experience Strategy



Our **CARE** priorities focused the Trust's work to improve our patient's experience. 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 experiencess.

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 2026-2027 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.

We increased opportunities for people to share feedback, used that feedback to make improvements, ensured patient and community voices were heard, and strengthened partnerships across health, social care and the voluntary sector to solve issues together. The priorities supported delivery of the Trust's Patient First objectives and were set out in the Patient Experience and Engagement Strategy 2023-2025.

We introduced new systems and significantly increased the ways patients could share feedback. This included volunteer-supported feedback, QR codes, SMS text messaging, kiosks, and more traditional paper methods. Additionally, we launched a staff dashboard to bring together feedback from different sources, helping teams understand what patients say about their care.

Shared Decision Making

Shared Decision Making remains a core principle of our approach to delivering high-quality, person-centred care. We are committed to ensuring that patients and, where appropriate, their families and carers, are fully involved in decisions about their care and treatment. By providing clear information on available options, including the benefits and potential risks, and by creating space for questions and discussion about individual preferences and priorities, we work in partnership with patients to agree the most appropriate plan of care.

Feedback gathered with the support of our volunteers indicates that patients feel well informed and actively involved in these conversations. Across a sample of 455 respondents, patients overwhelmingly rated

their discussions with clinicians highly, with an average score of 9 out of 10, reflecting strong levels of confidence in the quality of communication and engagement.

Our 2026 Patient Experience Strategy will build on this strong foundation, with a focus on embedding shared decision-making consistently across all care pathways, including both inpatient and outpatient settings, to further strengthen patient experience and outcomes.

National surveys

National surveys remain an important source of insight into patient experience, enabling us to benchmark our performance against other trusts and identify priority areas for improvement.

In September 2025, the CQC published the results of the 2024 National Adult Inpatient Survey. Patients reported a range of positive experiences, including respect for cultural needs, effective communication, including around ward moves during the night, timely access to wards and beds following admission, and appropriate support for communication and language needs. Many patients also reported feeling actively included in conversations with doctors, reinforcing the findings from our Shared Decision Making work. **Overall, the Trust's performance was above the national average, with six domains scoring higher than the national benchmark**.

The CQC National Survey programme reported improved results for maternity services in 2025. Feedback indicated that people felt confident in the advice provided through the Maternity Assessment Line (MAL) and reassured that concerns about labour were taken seriously, with patients reporting that they were not sent home when worried they might be in labour. Patients also described positive experiences when attending triage, noting that they felt listened to by both doctors and midwives. Overall, our maternity services compared favourably with trusts nationally.

We also continue to use Patient-Led Assessments of the Care Environment (PLACE) to review those aspects of the hospital environment that matter most to patients, including cleanliness, food and drink, privacy and dignity, and accessibility for people living with dementia or disabilities. These assessments are undertaken jointly by staff and members of the public, providing an important external perspective on the quality of our care environments. **In the 2025 PLACE assessment, UHD scored above the national average for both cleanliness and the condition of our facilities**.

Learning from complaints and concerns

In accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the Trust is required to produce an Annual Complaints Report. This report sets out the number of complaints received; the number deemed to be well founded and provides a summary of their subject matter. It also highlights any issues of general significance arising from complaints, how these have been managed, and the actions taken or planned to improve services as a result.

Complaints are managed in line with the Trust's Complaints Procedure and the relevant national NHS complaints regulations. The primary objective is to achieve resolution with complainants through timely explanation, engagement, and discussion wherever possible. The number of formal complaints received and investigated during the reporting period is set out below:

	2025/26	2024/25	2023/24	2022/23	2021/22
Formal complaints received	**UHD**	**UHD**	**UHD**	**UHD**	**UHD**
	881	803	800	984	491

The Trust introduced an early resolution complaints process, which forms part of the formal Complaints Procedure and is reported accordingly. Early resolution is designed to provide a timely response, typically within 10 working days, where appropriate.

Our Patient Advice and Liaison Service (PALS) continues to focus on the informal resolution of concerns in collaboration with frontline staff. The table below demonstrates a further increase in the number of concerns raised through informal channels over the past year, reflecting continued engagement with the service and use of early resolution routes.

	2025/26	2024/25	2023/24	2022/23	2021/22
PALS concerns	**7,041**	**6,624**	**5,982**	**5,530**	**5,200**

Subjects of complaints

Each complaint is reviewed at the outset, and key themes are identified and recorded. The table below presents these themes, based on the Department of Health submission dataset, shown by number and percentage of total complaints.

Complaint themes	2025/26	2024/25	2023/24	2022/23
Clinical treatment	313 (34.4%)	131 (15.9%)	505 (33.7%)	664 (35%)
Access to treatment	112 (12.31%)	6 (0.7%)	64 (4.3%)	94 (4.9%)
Admission, discharge, transfers	43 (4.73%)	90 (10.9%)	101 (6.7%)	97 (5.1%)
Delays and cancelled appointments	34 (3.74%)	36 (4.3%)	38 (2.5%)	153 (8%)
Communication	143 (15.71%)	208 (25.3%)	272 (18.1%)	435 (22.9%)
Consent	6 (0.66%)	9 (1.1%)	7 (0.5%)	27 (1.4%)
End of life care	5 (0.55%)	0 (0.0%)	14 (0.9%)	21 (1.1%)
Facilities	5 (0.55%)	8 (0.9%)	6 (0.4%)	0 (0%)
Integrated care	2 (0.22%)	0 (0.0%)	3 (0.2%)	0 (0.0%)
Patient care	42 (4.62%)	0 (0.0%)	72 (4.8%)	90 (4.7%)
Mortuary	0 (0.0%)	0 (0.0%)	2 (0.1%)	0 (0.0%)
Prescribing	17 (1.87%)	0 (0.0%)	37 (2.5%)	43 (2.2%)
Privacy, dignity and wellbeing	23 (2.53%)	154 (18.7%)	41 (2.7%)	22 (1.1%)

Complaint themes	2025/26	2024/25	2023/24	2022/23
Staffing numbers	1 (0.11%)	1 (0.1%)	1 (0.1%)	9 (0.5%)
Administration	46 (5.05%)	82 (9.9%)	48 (3.2%)	0 (0%)
Values and behaviours	92 (10.11%)	46 (506%)	264 (17.6%)	146 (7.7%)
Waiting times	26 (2.86%)	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.

Changes resulting from complaints

You said
Concerns raised about lack of lighting in patient and visitors car park.

We did
This was due to the lights not working and our Maintenance Team rectified this. The team will also be auditing the lighting provision during the darker months to ensure there are safe, well-lit paths to and from the car park.

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

We did
Additional signage was arranged.

You said
Concerns were raised by a patient's family that their relative was not being assisted out of bed as frequently as they would like.

We did
A tally chart has been introduced to encourage patients to sit out of bed and to mobilise on the ward.

You said
Concerns raised that there was a delay in patient receiving therapy input over the weekend.

We did
Our Therapy Department completed an audit to analyse frequency and quality of therapy input for this particular patient group which has informed workforce planning and further recommendations to improve care. Recruitment continued to be prioritised with new members of staff starting within the team.

You said
Patient did not receive information regarding stopping certain medications prior to surgery in writing.

We did
Processes changed so that this information can be provided via email to patients.

You said

Concerns regarding storage of medicines in the locked storage in patients' rooms.

We did

New practices have been introduced including the change of codes every 29 days or immediately following any potential security breach. Compliance will be audited annually and shared via our eLearning medication management package as well as Trustwide via senior leadership teams.

You said

Concerns raised regarding congestion in the car park and feedback regarding the speed humps on the Royal Bournemouth Hospital site.

We did

Our external car park company has increased staffing at the exit barriers during peak periods. The speed bumps have been reviewed and will be replaced with ones at a lower height.

You said

Concerns raised about queues to get into the visitors car park, causing anxiety around getting to appointments in time.

We did

A new automatic number plate recognition system has been introduced, reducing the time vehicles spend queuing at the car park entrance. We have also added blue badge scanners at all our payment terminals and exit barriers. This allows blue badge holders to validate their parking session without needing to visit our parking kiosk.

Action plan for 2025/26

- 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.

Stakeholder relations

Engagement with different stakeholder groups and our community has continued over the last year ensuring news and updates about the changes happening across UHD are communicated.

Regular attendance at in person events organised by partner organisations like the Primary Care Network (PCN), has led to hundreds of residents hearing directly from staff about the changes and many concerns eased through these face-to-face contacts.

These qualitative interactions have been a fantastic way to hear in detail the specific aspects of the changes that are concerning communities. In turn this has helped guide different engagement activity and messaging.

As well as public events, we've also attended closed meetings, a number of business groups, residents' association meetings, patient groups and partner organisation staff groups. We also visited libraries and shopping centres and organised a UHD marketplace at Poole Dolphin Centre, where members of the public could come along and see a host of partner organisations, like Dorset Police and the fire service, as well as speak to staff from UHD.

In addition to our engagement events and opportunities, our governors have been hosting listening events throughout Dorset - sharing and promoting the surveys, events, and key messages about the changes. Governors help build and maintain strong links into our communities and their time and efforts are incredibly valuable.

A well-attended transformation update was held in St Lukes Church in Parkstone following a request from a parish member and enabled different questions from the congregation being raised and answered.

Through strong relationships with the PCN, multiple opportunities have arisen for UHD to link with different groups, including attending a Purbeck PCN staff meeting and then holding an information stand in Wareham Hospital and attending a public Integrated Neighbourhood Team update in Corfe Castle Village Hall. Some residents in the west of Dorset are concerned about the upcoming changes and so these face-to-face meetings proved invaluable in being able to clarify some of the changes that will take place. Updates about any service changes or news about the transformation plans are communicated through established communication channels and the UHD/PCN monthly meeting.

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

Two editions of *Together Magazine* (a printed newsletter for members) were also published in Spring and Summer 2025. This contained important updates and details of our future development plans.

In October 2025, the monthly newsletter and Together merged to create '*Together online*' which is published electronically on a monthly basis.

Our UHD update newsletter continues to be circulated to stakeholders and partners to inform them of any upcoming changes, including those such as members of Health Overview and Scrutiny Committee (HOSC), the council, MPs and neighbouring health care providers.

We held our Annual Members' Meeting (AMM) in person at the Lecture Theatre of Poole Hospital on Thursday 18 September 2025.

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 2024/25 Annual Report and Accounts and forward planning for 2025/26.

Michele Whitehurst, Lead Governor, also gave a presentation on the Council of Governors.

Following the AMM, Dr Tom Bartlett, Consultant Geriatrician and Clinical Lead for Hospital at Home, and his teams gave an informative health talk on 'Transforming care for older people across Dorset'.

Bournemouth University

The Bournemouth University and UHD partnership continued to thrive with staff from both organisations benefiting from the joint working. Research projects, educational courses, placements, and events are just some of the ways the partnership is going from strength to strength. Over 160 delegates attended the 2025 research event arranged in collaboration with Bournemouth University, Dorset Healthcare NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust. The event included presentations, workshops, digital posters, and showcasing some of the research/QI/audit underway across the Dorset area.

Patient engagement

The Patient Experience Team further strengthened patient involvement through collaboration with community partners, including Healthwatch Dorset and other local community groups over 2025/26.

Work with individuals with hearing impairments helped to identify communication barriers and informed the development of an upcoming regional interpreting solution.

Opportunities for involvement were expanded through the recruitment of additional Volunteer Patient Safety Partners, alongside support for clinical services in meeting their 'Duty to Involve' responsibilities. This was achieved through tailored advisory support, co-designed surveys, and clearer articulation of patient roles in service improvement activity.

Patient feedback, including patient stories and emerging themes, was routinely shared with clinical leaders and the Board. This was supported by the introduction of a new dashboard, enabling teams to access and triangulate multiple sources of patient experience data more effectively.

Spiritual Care Centre

The Chaplaincy Service provided support to patients, families, and staff at particularly sensitive times, including at the end-of-life care and during bereavement. The team also facilitated collective moments of reflection across the Trust, including memorial events and services for families and staff.

The service continued to benchmark its provision against NHS England chaplaincy guidelines and met all key standards. Capacity was further strengthened through the recruitment of additional volunteer, honorary, and student chaplains, enabling the team to extend its reach across the organisation.

The chaplaincy service also enhanced its links with local partners and inclusion programmes and continued to develop its multi-faith provision through community engagement and an increasingly diverse chaplaincy workforce.

Over the year, the team delivered more than 12,000 hours of support to patients and families, provided by a combination of employed chaplains, honorary staff, students, and volunteers. Looking ahead to 2026/27, the service will continue to co-design improvements with patients and communities, with a focus on increasing awareness of spiritual care services and improving access to reflection spaces, particularly for individuals who do not identify with a specific faith tradition.

Peer support volunteers - providing valuable support to our patients

Volunteers contributed 89,207 hours in support of patients, carers, and staff. Volunteers played a vital role across a wide range of services, including ward and welcome support, End of Life Companion volunteering in collaboration with palliative care teams, and Patient Safety Partner roles, which bring the patient perspective into governance and service improvement activity.

Volunteer engagement was strengthened through regular communication and structured feedback opportunities, including newsletters, quarterly engagement sessions, and Volunteers' Week celebrations across all three sites. The Voluntary Services Policy was reviewed during the year, and role descriptions were refreshed to ensure they remain meaningful, safe, and compliant. Progress was also made to increase the visibility of volunteering opportunities nationally through the NHS England Volunteering website.

The volunteer workforce continues to reflect the communities served by the Trust. During the year, 25% of volunteers identified as being from global majority ethnic backgrounds, 15% were aged 25 or under (with volunteers aged over 92 also contributing), and 10% reported a disability.

Volunteer recruitment activity was targeted to align with patient need, and patient feedback was used to inform the development and expansion of roles where volunteers add most value to the patient experience. During periods of estate development and ward reconfiguration at RBH, volunteers provided wayfinding and navigation support for patients and visitors, including assistance in attending appointments and delivery of the volunteer buggy service.

Looking ahead to 2026/27, the Trust will broaden the scope of volunteer roles during periods of increased operational pressure and continue to embed volunteer involvement in Trust decision making, including participation in meetings and committee structures where appropriate.

Partnership working with unpaid carers

The Carer Support service provides support to unpaid carers, ensuring they feel recognised, informed, and appropriately involved in the care of their relatives or loved ones. Where additional support is required beyond the hospital setting, the service works in partnership with external organisations to signpost carers to appropriate community-based support, including the Community Discharge Support Scheme delivered by Prama.

Partnership working across the local system was strengthened during the year through representation at carers' forums across Dorset Council areas and ongoing engagement with internal programmes, including the Dementia and Delirium Group.

Further collaboration was established with Liaison Psychiatry and specialist teams to enhance support for carers of people with mental health needs and to improve early identification and signposting of carers at the

point of care. The service also participated in community events and carer support groups to raise awareness, gather feedback, and inform service development. In addition, 'carer walkabouts' were undertaken to identify opportunities for improvement within the care environment. Carer experiences, including case studies relating to supporting individuals living with dementia, were shared with senior leaders and the Trust Board.

Training and awareness sessions for staff and volunteers continued throughout the year, with plans in development for a broader programme in 2026/27, delivered in collaboration with people with lived experience.

Our UHD Charity has funded an additional fixed-term post for 2026/27 to support the Carer Support Lead in implementing practical improvements for carers. This role will focus on reducing carer fatigue and improving discharge pathways, strengthening the transition between home, hospital, and community services through closer working with NHS and partner organisations.

2026/27 priorities for patient experience

The Trust will use insight gathered from patients, alongside engagement with community partners, to inform its priorities for 2026/27. This work has strengthened understanding of the issues that matter most to people and the factors influencing their experience of care.

Through the development of a new Patient Experience Strategy in 2026, the Trust will focus on improving access to services, strengthening communication with patients, and further embedding Shared Decision Making in care and treatment planning. Continued improvement of the care environment will also remain a key priority.

In addition, the Trust will continue to explore opportunities presented by emerging technologies, including the use of artificial intelligence (AI), to enhance patient experience. This will include consideration of how digital solutions can improve access to information and support more effective patient engagement with services.

Staff Engagement

Staff engagement remains a major priority at UHD. We have worked through another year of significant change and continue to plan for the next phase of transformation. Making sure that our staff feel involved, informed and valued is a key part of this planning.

Our senior leadership team host regular events which are an opportunity for staff to ask questions and share feedback about what matters most to them. These events include a monthly face-to-face all staff briefing across sites and in public areas at which our Chief Executive, Siobhan Harrington, gives an update on operational pressures, our elective recovery, our redevelopment, staff success and any major campaigns. The event is also streamed live via Microsoft Teams and the recording is shared so staff can catch up afterwards. Alongside the briefing, we publish *The Brief*, our monthly magazine which managers are encouraged to use to share information with their teams. 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 *The Brief*.

Another event is our monthly Ask Me sessions, led by Chief Medical Officer, Dr Peter Wilson, and Deputy Chief Medical Officer, Dr Becky Jupp. Staff are invited to join online for an open and honest conversation about any topic they feel is important to discuss. We also host special versions of 'Ask Me' to cover questions around our transformation programme, and to mark key staff network events.

Ad hoc informal meetings are also held to mark dates in our awareness calendar and address issues faced by colleagues. These events are organised by our staff networks and supported by the Communications Team. We also hold listening events which focus in on particular subjects, allowing staff voices to be heard. Autumn 2025 listening events focused on discussions about creating an NHS owned subsidiary company for clinical engineering, estates, facilities, procurement and sterile services. Colleagues who attended talked about the impact this proposal would have on them and asked questions about their roles.

Colleagues can also book stands in our main hospital entrances to promote awareness events, gather feedback, or to celebrate the work of their departments.

Using engagement surveys to gather feedback is a vital way for us to make sure all colleagues have a voice that counts. In a large organisation with over 10,000 staff, surveys are the best way to hear from colleagues across job roles, departments and sites. The results of our 2025 NHS Staff Survey were released in March 2026. 55% of staff shared their experience to help make UHD a better place to work and receive care. This shows despite the challenges we faced at the time the survey was open in autumn 2025, such as winter pressures, financial constraints, and huge transformation to our services, we are continuing to create a positive culture where staff feel empowered to share their experiences, thoughts and ideas on what matters most to them. We also promote quarterly NHS People Pulse surveys which help us get up to date insight in to how our staff are feeling.

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. 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 May 2025, we held our third UHD staff awards, with over 950 nominations from staff and patients across 14 categories. Shortlisted nominees were celebrated with a ceremony at the Pavilion in Bournemouth. 360 staff members are invited to the ceremony to celebrate together and reflect on the incredible work they do every day. The event is funded by our UHD Charity and external sponsors.

Our UHD staff app continues to thrive, giving all staff access to Trust news, updates, eRoster, staff networks and our education platform on the go. The app also includes links to our staff wellbeing pages 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.

Siobhan Harrington
Chief Executive
17 June 2026

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, were made by the Trust's Appointments and Remuneration Committee. For the financial year, a summary of these was set out below, including the context in which the changes occurred, and the decisions taken.

Annual Report on Remuneration

Appointments and Remuneration Committee membership

Members of our Appointments and Remuneration Committee were:

Judy Gillow
Interim Trust Chair

Femi Macaulay
Chair of the Charitable Funds Committee

Alastair Matthews
Chair of the Finance and Performance Committee

Helena McKeown
Non-Executive Director

Dr Michael Marsh MBE
Interim Vice Chair and Chair of the Quality Committee

Tracie Langley
Chair of the Audit Committee

Sharath Ranjan
Chair of the People and Culture Committee

Claire Whitaker CBE
Senior Independent Director

The Chief People Officer attended the Appointments and Remuneration Committee, except when her own performance and/or salary were discussed, and acted as an expert adviser on personnel and remuneration policy. The Chief Executive attended to provide advice on issues concerning the performance of directors and salary ranges, except when her own appointment, removal, or remuneration were discussed.

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

- overseeing and taking forward the process for the appointment and 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 reviewed information on remuneration for executive directors at other trusts of a similar size and nature, with the aim of ensuring that the remuneration of executive directors was fair and appropriate.

Work of the Appointments and Remuneration Committee

During 2025/26, the Committee met once with all members present and considered proposed redundancy and settlement payments, which were approved by the Committee.

The Committee's terms of reference are available here: Appointments and Remuneration Committee.

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 the Nominations, Remuneration and Evaluation Committee were:

Judy Gillow
Interim Trust Chair

Michele Whitehurst
Public Governor: Poole and Rest of Dorset, Lead Governor

Carrie Stone
Public Governor, Poole and Rest of Dorset

Shelley Thompson
Appointed Governor, Bournemouth University

Rob Flux
Staff Governor, Non-Clinical

Sharon Collett
Public Governor, Bournemouth

Please note, there was a vacancy for the Christchurch, East Dorset and Rest of England constituency in 2025/26.

The Committee met five times during the period, with meetings quorate on each occasion.

In addition, Irene Mardon, Acting 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-executive and associate non-executive directors.

Meeting date	Committee business considered (✔ = recommendations approved by the Council of Governors)
30 May 2025	The Committee considered the following: • ✔ Non-executive director recruitment process: clinical • ✔ Non-executive director recruitment: audit and finance
23 June 2025	The Committee considered the following: • ✔ Non-executive director (clinical): recommendation for appointment • ✔ Outcome of the Chair's and non-executive directors' annual performance evaluation; Fit and Proper Persons Test • ✔ Nominations, Remuneration and Evaluation Committee Terms of Reference • Governors' attendance at the Council of Governors meetings
25 July 2025	The Committee considered the following: • ✔ Non-executive director (audit and finance): recommendation for appointment • Governors' attendance at the Council of Governors meetings
24 September 2025	The Committee considered the following: • ✔ Composition of Board of Directors: Amendment to Trust's Constitution • Review the balance of skills, knowledge, experience and diversity on the Board and in light of this evaluation, describe the role and capabilities required for the appointment of non-executive directors, including the Trust Chair. • Nominations Remuneration and Evaluation Committee's Governance Cycle • Governors' attendance at the Council of Governors meetings
7-Jan-2026	The Committee considered the following: • ✔ Reappointment of non-executive directors • ✔ Interim Chair and Interim SID tenure extension • ✔ Appointment of Interim Vice Chair of the Board • ✔ Trust Chair and non-executive directors' 2025/26 performance evaluation (previously agreed) • NREC membership

The Committee's terms of reference are available here: Nominations, Remuneration and Evaluation Committee Terms of Reference.

Senior Managers' Remuneration Policy

The Trust's Senior Managers' Remuneration Policy sets out arrangements relating to contract duration, notice periods and termination payments. Executive directors are required to provide six months' written notice, although this may be varied by mutual agreement in appropriate circumstances. There are no payments for loss of office other than those provided for under standard NHS redundancy arrangements.

Board vacancies are advertised nationally, with a targeted approach to attract a diverse range of candidates that reflects the composition of the Trust's workforce and local community. The Trust also operates a reverse mentoring programme to support the development of a diverse pipeline of future leaders. The effectiveness of the Board is evaluated annually through self assessment, and equality, diversity and inclusion are embedded as a core component of the Trust's culture, supported by the Trust value of 'we are inclusive'. Further detail on diversity and inclusion is set out in the Staff Report. In addition, a skills assessment is undertaken to inform Board succession planning.

Disclosures relating to specific pay and remuneration matters

Remuneration for senior managers is set out on page 96. The majority of Trust staff are employed under Agenda for Change national terms and conditions, which operate as the single pay system across the NHS. Doctors, dentists, very senior managers and directors are employed under separate national terms and conditions, with pay circulars used to implement changes to pay and conditions for medical and dental staff, doctors in public health medicine, community health service doctors and staff covered by Agenda for Change.

The expenses of directors and staff governors are reimbursed in accordance with the Trust's Expenses Policy applicable to all staff. Travel and other expenses incurred by public governors are reimbursed in line with a separate policy. Governors are volunteers and do not receive any remuneration in respect of their roles.

Future policy table

The Trust's remuneration policy in respect of each of the above is outlined in the tables below:

	Salary - (Fees and Salary)	Pension and benefits
Purpose and link to Strategy	• Helps to recruit, reward and retain • Reflects competitive market level, role, skills, experience and individual contribution	• Help to recruit and retain • NHS Pension Scheme arrangements provide a competitive level of retirement income
Operation	Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions. The Remuneration Committee considers the following parameters when reviewing base salary levels: • pay increases for other employees across the Trust • economic conditions and governance trends • the individual's performance, skill and responsibilities through appraisals • base salaries at NHS organisations of similar size are benchmarked against Dorset County Hospital NHS Foundation Trust • base salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll • the executive directors do not receive performance related pay	Executive directors are eligible to receive pension and benefits in line with the policy for other employees. Executive directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme. Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, they retain the benefits accrued from these schemes. The principal features and benefits of the NHS Pension Scheme are set out in a table in the Remuneration Report. Pension related benefit is the annual increase in pension entitlement accrued during the current financial year from total NHS career service.

	Salary - (Fees and Salary)	Pension and benefits
Opportunity	The Remuneration Committee ensures levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but avoid paying more than is necessary though using benchmarking. National and local benchmarking data was reviewed by the Remuneration Committee who reviewed the relative position of each executive.	The maximum employers' contribution to NHS Pension Scheme is 23.78% (14.38% paid by the Trust and 9.4% is paid by NHS England) of base salary for all employees including executive directors.
Performance Conditions	None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual receives an annual appraisal to review performance and set objectives.	None
Performance Period	Annual appraisal covers a 12-month period.	None

Differences in remuneration for other employees

The remuneration approach for executive directors is consistent with the UK Corporate Governance Code, Code of Governance for NHS Provider Trusts and NHS Policy. This guidance requires that remuneration committees ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully.

The structure of the reward package for the wider employee population is based on the national NHS remuneration frameworks for Medical, Dental and Non-Medical Staff. Non Medical Staff remuneration is in line with the Agenda for Change Framework, which assesses remuneration in line with the framework for Medical and Dental Staff remuneration. All staff are eligible to join and participate in the NHS Pension Scheme.

Where one or more senior managers are paid more than £150,000, the committee is required to ensure this remuneration is reasonable. The Trust has seven senior managers paid more than £150,000. The committee is satisfied the salary of the individual is reasonable when compared to the benchmarking provided in setting the senior managers' salaries.

The Trust's policy for equality, diversity and inclusion defines the approach that will be taken to promoting and championing a culture of diversity and equality of opportunity, access, dignity, respect, and fairness in the services the Trust provides and in employment practices.

The activities and decisions of the Remuneration and Terms of Service Committee are in accordance with the Trust's Equality, Diversity, and Inclusion Policy.

Policy on remuneration of non-executive directors

	Fees	Appointment
Purpose and link to Strategy	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity.	
Overview	The remuneration and expenses for the Trust Chair and non-executives are determined by the Council of Governors.	The Council of Governors appoint the non-executive directors in accordance with the Trust's constitution which allows them to serve two three-year terms. Any term beyond six years is subject to rigorous review and takes into account the need for progressive refreshing of the Board and their independence. This is subject to annual re-appointment approved by the Council of Governors.

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
Irene Mardon	Acting Chief People Officer	1 May 2025	17 August 2025	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	N/A
Melanie Whitfield	Chief People Officer	18 April 2025	Current	6 months
Dr Peter Wilson	Chief Medical Officer	1 April 2023	Current	6 months
Judy Gillow	Interim Trust Chair	1 May 2025	30 April 2027	1 month
Tracie Langley	Non-executive director	6 January 2025	5 January 2028	1 month
John Lelliott	Non-executive director	1 October 2023	30 October 2025	N/A
Femi Macaulay	Non-executive director	16 December 2024	15 December 2027	1 month
Dr Michael Marsh	Vice-Chair; Non-executive director	1 September 2025	31 August 2028	1 month
Alastair Matthews	Non-executive director	20 October 2025	19 October 2028	1 month
Helena McKeown	Non-executive director	1 October 2023	30 September 2029	1 month
Sharath Ranjan	Non-executive director	3 April 2023	2 April 2029	1 month
Cliff Shearman	Non-executive director	1 October 2023	30 September 2025	N/A
Claire Whitaker	Senior Independent Director and non-executive director	1 October 2023	30 September 2029	1 month

Disclosures relating to specific pay and remuneration matters

Senior manager remuneration

Senior manager remuneration														
Name	**Title (as at 31 March 2026 unless stated)**		**Twelve months ended 31 March 2026**						**Twelve months ended 31 March 2025**					
			Salary and fees	Expense payments	Other remu-neration	Total salary and fees	Pension related benefits	Total	Salary and fees	Expense payments	Other remu-neration	Total salary and fees	Pension related benefits	Total
			(bands of £5000)	(taxable) To nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(taxable) To nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
		Note(s)	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Executive members														
Siobhan Harrington	Chief Executive Officer	1	240-245		-	240-245	0.0	240-245	235-240		-	235-240	0.0	235-240
Dr Peter Wilson	Chief Medical Officer		235-240		-	235-240	102.5-105.0	340-345	230-235		-	230-235	62.5-65.0	290-295
Pete Papworth	Chief Finance Officer		180-185		-	180-185	57.5-60.0	240-245	175-180		-	175-180	32.5-35.0	210-215
Sarah Herbert	Chief Nursing Officer		150-155		-	150-155	82.5-85.0	235-240	125-130		-	125-130	175.0-177.5	300-305
Mark Mould	Chief Operating Officer		175-180	100	-	175-180	70.0-72.5	245-250	170-175	100	-	170-175	105.0-107.5	275-280
Richard Renaut	Chief Strategy and Transformation Officer		170-175		-	170-175	60.0-62.5	230-235	160-165		-	160-165	10.0-12.5	175-180
Beverley Bryant	Chief Digital Officer		195-200	200	-	195-200	330.0-332.5	525-530	80-85	100	-	80-85	17.5-20.0	100-105
Melanie Whitfield	Chief People Officer (from 18/08/25)		90-95		-	90-95	30.0-32.5	125-130	N/A		N/A	N/A	N/A	N/A
Irene Mardon	Acting Chief People Officer (01/05/25 - 17/08/25)		40-45		-	40-45	45.0-47.5	85-90	N/A		N/A	N/A	N/A	N/A
Tina Ricketts	Chief People Officer (01/04/25 - 30/04/25)	2,3	10-15		-5-0	5-10	0.0	5-10	160-165		5-10	170-175	215.0-217.5	385-390
Non-executive members														
Judy Gillow MBE	Interim Chairperson		50-55		-	50-55	N/A	50-55	15-20		-	15-20	N/A	15-20
Cliff Shearman OBE	Non Executive Director	4	5-10	200	-	5-10	N/A	5-10	15-20	200	-	15-20	N/A	15-20
Helena McKeown	Non Executive Director		15-20	300	-	15-20	N/A	15-20	15-20	200	-	15-20	N/A	15-20
Sharath Ranjan	Non Executive Director		15-20	200	-	15-20	N/A	15-20	15-20	200	-	15-20	N/A	15-20
Claire Whitaker CBE	Non Executive Director		15-20		-	15-20	N/A	15-20	15-20		-	15-20	N/A	15-20
John Lelliott OBE	Non Executive Director	5	5-10		-	5-10	N/A	5-10	15-20		-	15-20	N/A	15-20
Femi Macaulay	Non Executive Director		15-20		-	15-20	N/A	15-20	0-5		-	0-5	N/A	0-5
Tracie Langley	Non Executive Director		15-20		-	15-20	N/A	15-20	0-5		-	0-5	N/A	0-5
Dr Michael Marsh	Non Executive Director	6	5-10	100	-	5-10	N/A	5-10	N/A		N/A	N/A	N/A	N/A
Alastair Matthews	Non Executive Director	7	5-10		-	5-10	N/A	5-10	N/A		N/A	N/A	N/A	N/A

Notes:

1 Siobhan Harrington increased her hours from 0.9 WTE to 1.0 WTE on 1 November 2025.

2 Tina Ricketts resigned from her post as Chief People Officer with effect from 30 April 2025.

3 Consistent with Trust policy, having resigned within one year of appointment, Tina Ricketts repaid in full her previously claimed relocation and removal expenses.

4 Cliff Shearman concluded his post as a non-executive director on 30 September 2025.

5 John Lelliott concluded his post as a non-executive director on 30 September 2025.

6 Dr Michael Marsh commenced as non-executive director on 1 September 2025.

7 Alastair Matthews commenced as non-executive director on 20 October 2025.

8 Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employee Pension Notices and replicated in the HM Treasury Financial reporting Manual.

9 There are 23 governors (including staff governors) at the end of March 2026, no expenses were claimed during the period.

10 Senior management remuneration does not include any annual related bonus or long term related bonuses for the period.

11 No senior managers received any significant benefits in kind for the period.

12 No other categories in the proforma single table are relevant to the Trust for the period.

13 Of the 20 senior managers in the table above, there were £8,013 expenses claimed for the period.

Summary of policy in relation to duration of contracts, notice periods and termination payments:

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

Total 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 2025-26 was £255-£260k (2024-25, £245-£250k). This is a change between years of 4.0% (2024-25, 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 2025-26 was from £20-£25k to £255-£260k (2024-25, £20-£25k to £24k-£250k). 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 3.6% (2024-25, 6.2%). No employees received remuneration in excess of the highest-paid director in 2025/26.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Table illustrating pay ratio disclosure and derivations

	25th Percentile		Median		75th Percentile	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Salary component of pay	29,865	29,114	38,800	37,479	50,470	49,889
Salary component: pay ration for highest paid director	8.6	8.5	6.6	6.6	5.1	5.0
Total pay and benefits excluding pension benefits	29,865	29,114	38,800	37,479	50,470	49,889
Total pay and benefits excluding pension: pay ratio for highest paid director	8.6	8.5	6.6	6.6	5.1	5.0

Note: The prior year disclosures included the NED Chairperson.

Senior manager pension entitlements

Senior manager pension entitlements

Name	Title (as at 31 March 2026 unless stated)	Note(s)	Real increase in pension at retirement age (Bands of £2,500)	Real increase in pension lump sum at retirement age (Bands of £2,500)	Total accrued pension at retirement age at 31 March 2026 (Bands of £5,000)	Lump sum at retirement age at 31 March 2026 (Bands of £5,000)	Cash equivalent transfer Value at 1 April 2025 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31 March 2026 £'000	Employer's contribution to stakeholder pension £'000
Siobhan Harrington	Chief Executive Officer	1, 2	-	-	15-20	-	237	54	326	N/A
Dr Peter Wilson	Chief Medical Officer		5.0-7.5	5.0-7.5	95-100	240-245	2,117	121	2,303	N/A
Pete Papworth	Chief Finance Officer		2.5-5.0	0.0-2.5	45-50	100-105	768	44	848	N/A
Sarah Herbert	Chief Nursing Officer		2.5-5.0	5.0-7.5	40-45	90-95	745	82	857	N/A
Mark Mould	Chief Operating Officer		2.5-5.0	2.5-5.0	75-80	210-215	1,773	89	1,914	N/A
Richard Renaut	Chief Strategy and Transformation Officer		2.5-5.0	2.5-5.0	60-65	145-150	1,207	65	1,313	N/A
Beverley Bryant	Chief Digital Officer		17.5-20.0	-	65-70	-	817	294	1,150	N/A
Melanie Whitfield	Chief People Officer (from 18/08/25)		0.0-2.5	-	20-25	-	342	24	405	N/A
Irene Mardon	Acting Chief People Officer (01/05/25 - 17/08/25)		0.0-2.5	2.5-5.0	50-55	135-140	1,117	43	1,311	N/A
Tina Ricketts	Chief People Officer (01/04/25 - 30/04/25)	3, 4	-	-	0-5	115-120	1,073	-	67	N/A

Notes:

1. Siobhan Harrington drew her 1995 NHS pension on 31 October 2024.
2. Siobhan Harrington increased her hours from 0.9wte to 1.0wte on 1 November 2025.
3. Tina Ricketts drew her pension on 31 January 2025.
4. Tina Ricketts left the organisation on 30 April 2025.
5. Individuals would not receive any additional pension benefits on early retirement. Additional benefits would only become payable in the event of ill health retirement or where a redundancy pension is awarded, in accordance with the relevant pension scheme rules.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (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
17 June 2026

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 are refreshing the 5-year People Strategy at UHD to include the actions that will continue the delivery of the four core pillars of The NHS People Plan, and build a UHD workforce fit for the future as referenced in The 10-year Health Plan for England, published in July 2025. We anticipate the NHS 10-year Workforce Plan will be published in Spring 2026, and our work may need to be refreshed accordingly.

The four core pillars of The NHS People Plan are: Looking after our People, Improve Belonging in the NHS, Delivering New Ways of Working and Care, and Growing for the Future, each of which are guided by the seven elements of Our People Promise. **We will work towards our strategic objectives to improve our people retention and increasing their availability and capability**.

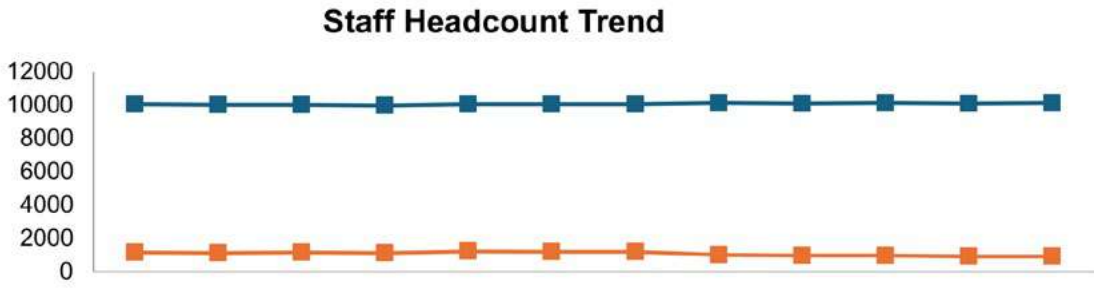
Our work aligns with national and local aspirations and we are committed to ensuring staff have the skills they need in a digitally enabled NHS, improving our training and development for nurses, midwives and doctors, increasing our skills in research, innovation and system change, improving flexible working and putting great leadership at the heart of our plans. The Government wishes to introduce a new set of employment standards. These will support us in our ambition to enhance our position as a modern employer increasing local social prosperity.

Our People Strategy drives the actions required to keep our people safe, healthy and well, both physically and psychologically. It 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.

Staff numbers

The headcount of substantive staff employed in April 2025 was 10,052 and this figure increased to 10,141 by March 2026. Over the same, active bank staff reduced steadily from 1,154 to 914, reflecting a decreasing reliance on temporary staffing. This trend is consistent with a focus on strengthening substantive workforce capacity and improving workforce efficiency.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Substantive	10052	10014	10014	9986	10065	10052	10083	10125	10099	10128	10121	10141
Active Bank	1154	1142	1145	1131	1222	1220	1208	1016	979	955	914	914

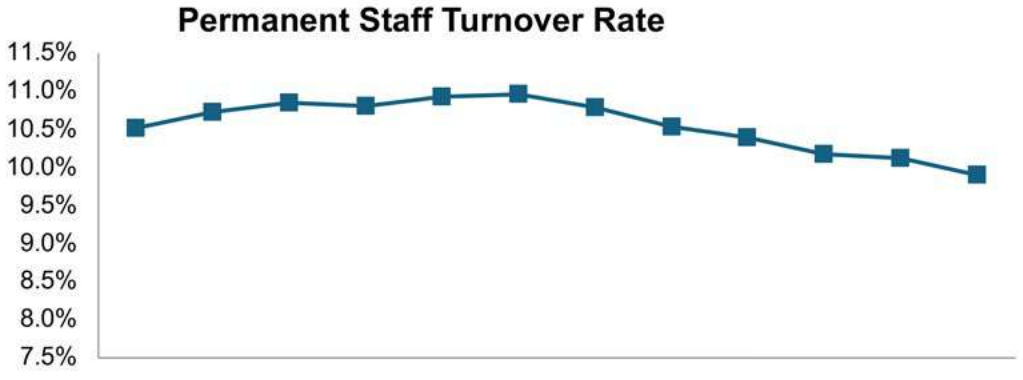
Average number of employees (WTE basis)

	Total 2025/26 No.	Permanent 2025/26 No.	Other 2025/26 No.
Medical and dental	**1,398**	1,314	84
Ambulance staff	**1**	1	0
Administration and estates	**1,398**	1,282	80
Healthcare assistants and other support staff	**1,509**	1,318	336
Nursing, midwifery and health visiting staff	**2,845**	2,561	284
Nursing, midwifery and health visiting learners	**0**		
Scientific, therapeutic and technical staff	**2,428**	2,349	79
Healthcare science staff	**238**	235	3
Social care staff	**0**		
Other	**0**	0	0
Total average numbers	**9,817**	8,951	866
Of which:			
Number of employees (WTE) engaged on capital projects	**110**	110	1

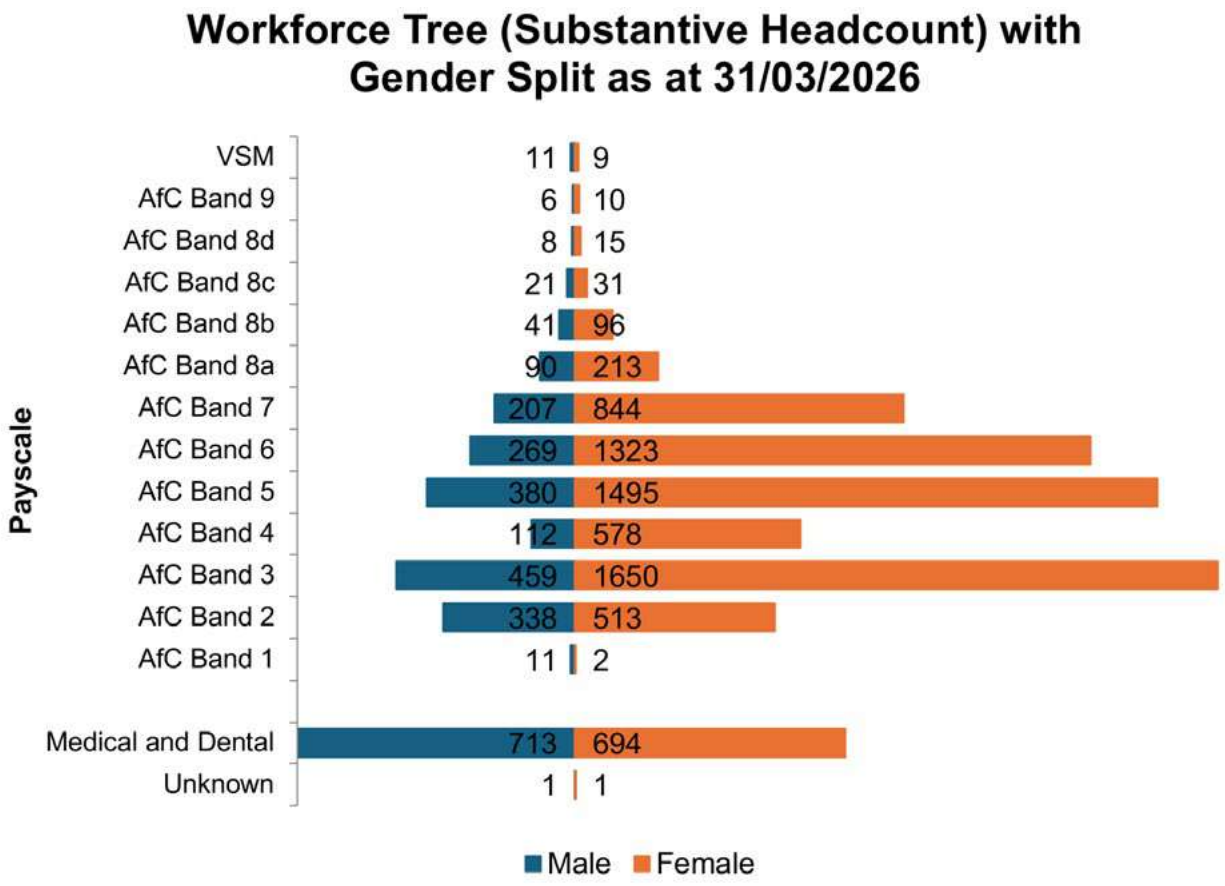
Staff costs (audited)

Note 5.1 Employee expenses (Group before consolidation of charity)		Expected sign	**A09CY01** Total 2025/26 **£'000**
Salaries and wages	i	+	**488,616**
Social security costs	i	+	**61,246**
Apprenticeship levy	i	+	**2,393**
Pension cost - employer contributions to NHS pension scheme	i	+	**57,280**
Pension cost - employer contributions paid by NHSE on provider's behalf (9.4%) - month 12 only	i	+	**37,519**
Pension cost - other*	i	+	**51**
Other post-employment benefits		+	**0**
Other employment benefits		+	**0**
Termination benefits	i	+	**0**
Temporary staff - external bank	i	+	**0**
Temporary staff - agency/contract staff		+	**5,780**
Total gross staff costs	i	-	**652,885**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure		-	**0**
Recoveries from other bodies in respect of staff cost netted off expenditure		+	**0**
Total staff costs			**652,885**
Included within:			
Costs capitalised as part of assets		+	**5,537**

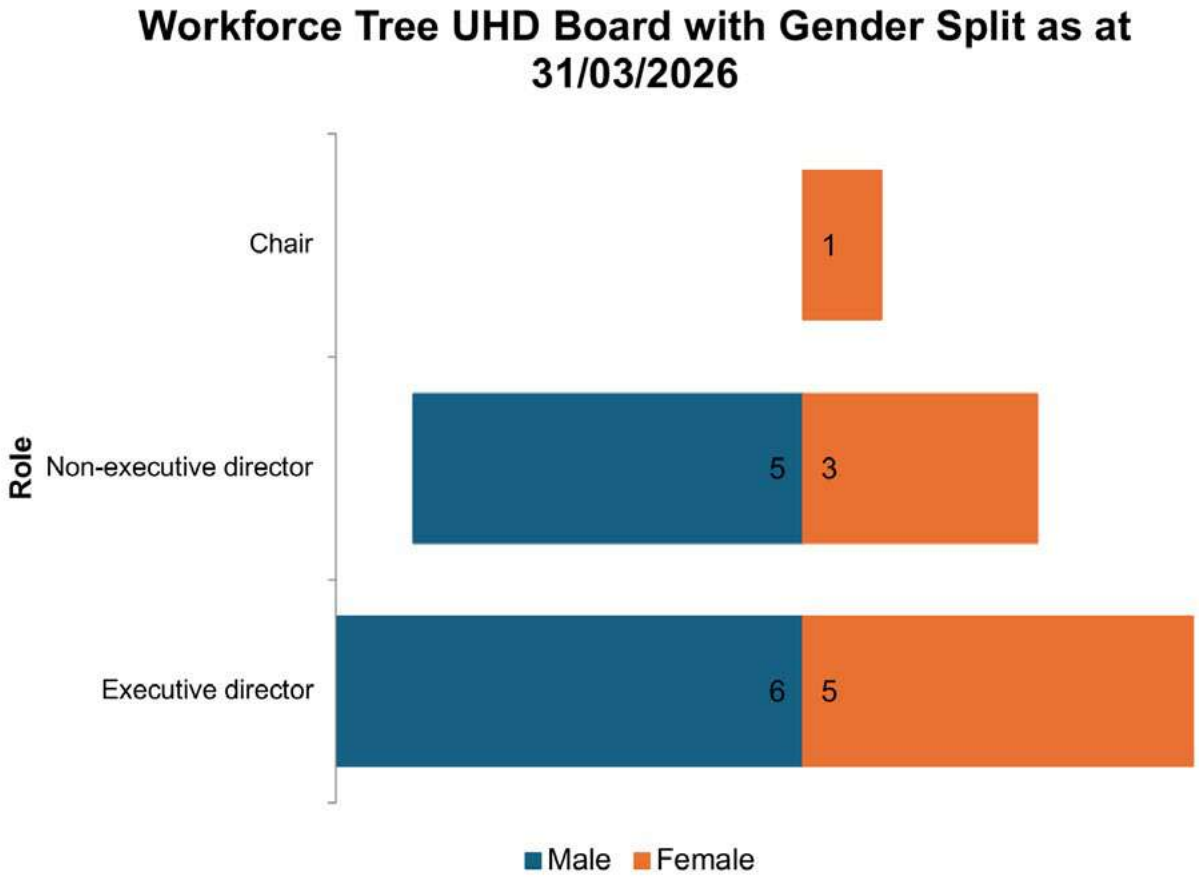
Permanent staff turnover remained relatively stable in the first half of the year, peaking at 11% in September 2025, before demonstrating a sustained downward trend in the latter months. Turnover reduced progressively to 9.9% in March 2026, representing an overall improvement across the year.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Permanent Only	10.5%	10.7%	10.8%	10.8%	10.9%	11.0%	10.8%	10.5%	10.4%	10.2%	10.1%	9.9%

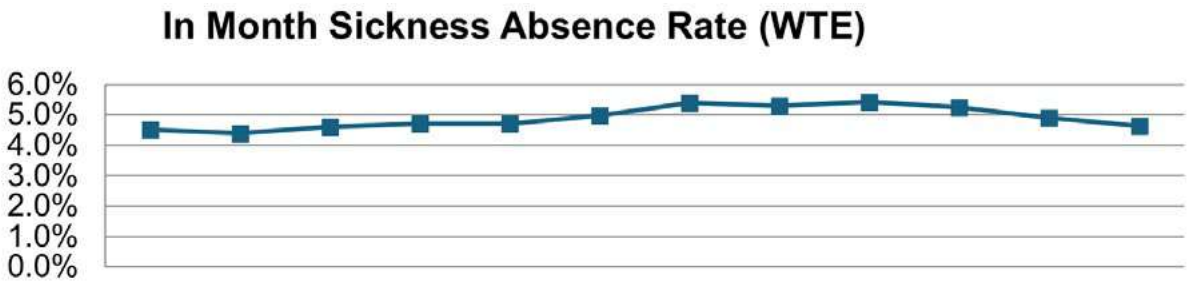


Information on gender pay gap can be found at: **https://gender-pay-gap.service.gov.uk**



Sickness absence data

Sickness absence rates remained relatively stable in the first half of the year, before increasing through the autumn and winter months, peaking at 5.4% in October and December 2025. This pattern is consistent with seasonal pressures typically experienced across the NHS. From January 2026, absence rates showed a sustained improvement, reducing to 4.6% by March 2026. This downward trend reflects the continued focus on proactive absence management, early intervention and targeted support to improve staff wellbeing and attendance.



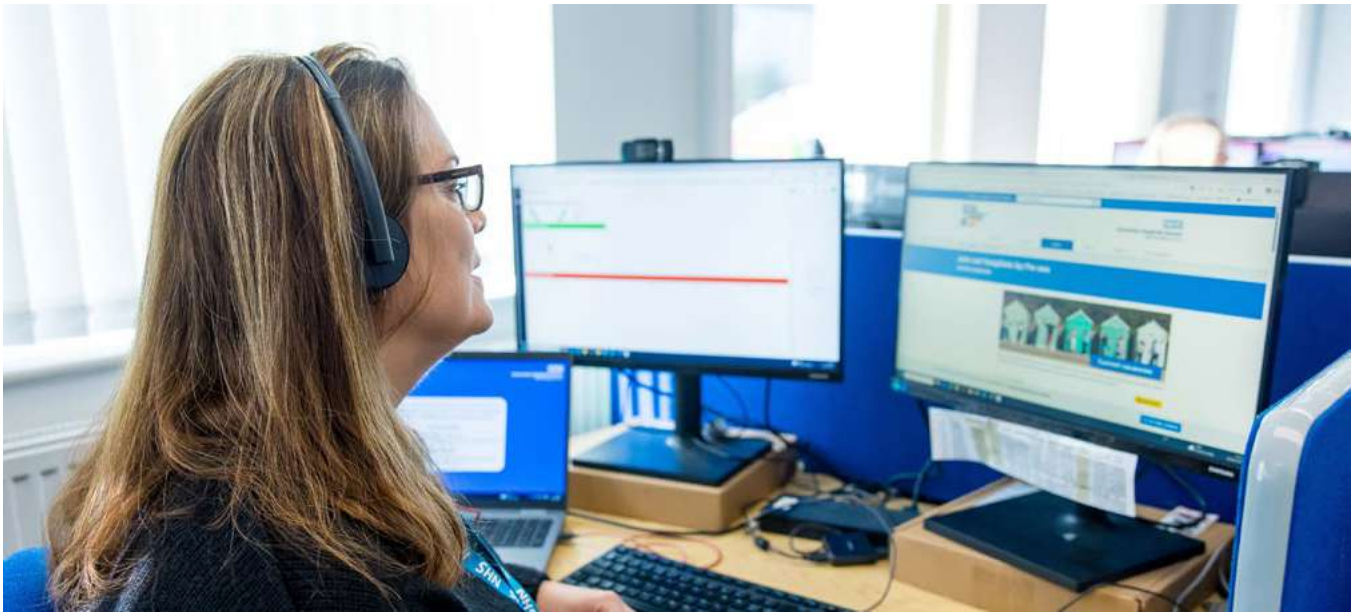
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
In Month Rate	4.5%	4.4%	4.6%	4.7%	4.7%	5.0%	5.4%	5.3%	5.4%	5.3%	4.9%	4.6%

Information on counter fraud

The Trust has an Anti-Fraud, Bribery and Corruption Policy in place, endorsed by senior management and overseen by the Audit Committee. The People Directorate works closely with the Counter Fraud Team to support the Trust's counter fraud arrangements.

Exit packages/settlement agreements

The Trust has established processes to prevent and manage workplace disputes, including mediation and formal employee relations procedures. In a small number of cases, where resolution is not achievable, settlement agreements may be used. These are made on a commercial basis without admission of liability. There was one special severance payment made within this reporting period.



Reporting of compensation schemes - exit packages 2025/26

In 2025/26 there were no compulsory redundancies (none in 2024/25) and a total of 47 agreed departures (45 in 2024/25 at a cost of £495,000), of these agreed departures none related to a senior manager of the Trust (none in 2024/25). A breakdown of the different price ranges and types of agreed departures are identified in the two tables below:

Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**
< £10,000	0	42	42
£10,000 - £25,000	0	4	4
£25,001 - 50,000	0	2	2
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total	**0**	**48**	**48**
Total cost (£)	£0	£257,000	£257,000

Exit packages: other (non-compulsory) departure payment	**Number of agreements**	**Total value of agreements**
		£'000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	46	232
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT / DHSC approval (special severance payments)	2	25
Total	**48**	**257**
Of which: non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary*	0	0

*Includes a £6,000 payment where the Trust is awaiting the outcome of a retrospective approval application to HM Treasury, made in December 2025 following a DHSC request for approval to be sought. Legal advice at the time of the payment confirmed HMT / DHSC approval was not required.

Risk management

Quality and Safety are embedded within the Trust's induction and mandatory training programmes for all staff, providing a consistent foundation for safe practice. This is complemented by targeted development sessions for clinical leaders, heads of department and ward leaders, focusing on risk assessment, working safely, patient and family engagement (including Duty of Candour), and effective incident reporting, review and investigation (Patient Safety Incident Response Framework, PSIRF).

Staff policies

Policies provide a clear and consistent framework to support staff, ensure fair practice and maintain compliance with employment standards. Policies are developed and reviewed in partnership between trade unions and management, with ratification through the Staff Partnership Forum (SPF) for general staff policies and the Joint Local Negotiating Committee (JLNC) for medical and dental staff specific policies. Final approval is provided by the people and culture committee. Between April 2025 and March 2026, a total of 15 new and revised staff policies were agreed.

Occupational Health

Thrive wellbeing

The Thrive Health and Wellbeing Services comprise Occupational Health, the Staff Musculoskeletal (MSK) Service, the Psychological Support and Counselling Service (PSC), and the Health and Wellbeing Development Lead. Collectively, these services directly support the NHS People Promise commitment that 'We are Safe and Healthy', ensuring every member of staff has access to the support they need to stay well, remain in work, and feel genuinely valued.

For UHD staff, this commitment is a funded, staffed, and accessible reality. Looking after the people who care for our patients is a core organisational priority. Our focus is on enabling staff to be well in both body and mind, supporting safe and effective working, and strengthening organisational capability.

The Occupational Health Service (OH) is a multidisciplinary service comprising specialist nurses, specialist physiotherapists, a doctor, and administrative staff. It provides expert advice on the interaction between work and health, ensuring staff are fit to undertake their roles both physically and emotionally. The service delivers health assessments for new starters and existing staff, advises on work-related illness and injury, supports preventive approaches, plays a key role in managing short and long-term absence and facilitating safe, sustainable return to work.

The Staff Musculoskeletal (MSK) Service provides specialist, evidence-based assessment, treatment, and advice for staff with musculoskeletal conditions. A core feature is specialist functional assessment, which takes a holistic view of the physical demands of roles and the impact of injury on work ability. The service supports staff to adapt and manage their condition through targeted rehabilitation, workplace-focused advice, and return-to-work planning aligned to functional capacity and safety. This enables sustainable recovery and supports staff to remain in or return to work effectively.

The Psychological Support and Counselling Service (PSC) provides confidential, evidence-based psychological support for staff whose mental health or stress is affecting their ability to work. Support includes assessment and brief interventions for issues such as anxiety, low mood, burnout, sleep disturbance, and trauma-related stress.

Between April 2025 and March 2026, the PSC received 597 referrals. Outcomes remain strong, with 98% of respondents stating they would recommend the service or use it again, and 97% rating it as good or excellent. Importantly, 76% reported that support prevented sickness absence or enabled a faster return to work, demonstrating clear benefit to both staff wellbeing and operational resilience.

A key highlight of 2025/26 was the continued growth and impact of the Thrive Live Health and Wellbeing Fair, which has become a cornerstone of the Trust's preventative wellbeing offer.

The 2025 programme delivered over 40 sessions and engaged more than 1,700 staff contacts. It brought together a broad range of internal and external partners to provide accessible support across key areas including mental health, resilience, menopause, neurodiversity, sleep, physical activity, nutrition, relationships, and financial wellbeing.

The expansion of Thrive Live reflects a deliberate shift towards **a more proactive and preventative approach to staff wellbeing, moving beyond reactive support into earlier engagement, education, and self-management**. Thrive provided dedicated, physical spaces for staff to step away from clinical environments, access support, and focus on their own wellbeing during the working day.

This programme also strengthens system-wide partnership working, enabling NHS services, voluntary sector organisations, and specialist providers to come together in one accessible forum for staff. This integrated approach helps reduce barriers to support, increases awareness of available services, and reinforces a culture where wellbeing is prioritised alongside operational delivery.

Health and Wellbeing Champions

The Health and Wellbeing Champion network is a key enabler of the Thrive Health and Wellbeing approach, supporting the embedding of wellbeing at a local, team-based level across the Trust. The network comprises more than 86 active Champions drawn from a wide range of clinical and non-clinical roles, reflecting a broad cross-section of the workforce.

Champions act as local wellbeing advocates within their teams and departments, helping to promote awareness of available support, signpost colleagues to appropriate services, and encourage early access to help where needed.

They play an important role in normalising conversations about physical and mental wellbeing in the workplace, contributing to a culture where staff feel more able to seek support without stigma.

In addition to signposting and awareness-raising, Champions provide a vital communication link between frontline teams and the wider Thrive Health and Wellbeing programme. They gather feedback on staff needs, emerging pressures, and barriers to accessing support, feeding this intelligence into service development and helping to ensure that wellbeing provision remains relevant, responsive, and grounded in staff experience.

The network also supports the practical delivery of wellbeing initiatives within teams, helping to cascade information, promote participation in Trust-wide programmes such as Thrive Live, and encourage engagement with preventative wellbeing activity. This peer-led model strengthens visibility of health and wellbeing resources at ward and department level, increasing reach and impact across diverse staff groups.

Overall, the Champion network plays an important role in shifting wellbeing from a centrally delivered offer to a shared organisational responsibility, helping to embed it as part of everyday team culture and leadership practice.

Organisational Development

We have continued to support the organisation by developing our offers in leadership and management development, supporting new and existing teams to become more effective, engaging our staff and developing a more inclusive culture at UHD.

Over the last 12 months, our work has been focused on achieving the People and Culture Strategy to support the aspiration to make UHD a great place to work.

Culture and engagement:

People and Culture Champions

Our People and Culture Champions are a small but impactful group, representing around a third of the directorates within the Trust. They are a multidisciplinary group dedicated to listening to colleagues and influencing a positive organisational culture. Representing a wide range of roles, including clinical, administrative and support services, they act as role models for our values and behaviours, promoting inclusivity, collaboration and staff engagement across the Trust.

The Champions play a key role in amplifying employee voice, providing feedback to leadership, and supporting the development of a positive and inclusive workplace. They empower colleagues at all levels, acting as a vital link between staff, leadership teams and the Trust Board.

During the year, the Champions led a range of engagement initiatives, including facilitating Conversation Cafés across multiple sites. Insights gathered have informed targeted work on key themes such as communication and staff rest spaces, which remains ongoing work.

Through walkabouts and surveys, the Champions engaged with over 700 staff, while also supporting local teams by sharing learning, signposting support, and enabling staff-led improvements.

In addition, they established the beginning of a wider staff advocacy network to strengthen engagement, gather feedback, and ensure diverse perspectives continue to shape our culture and improvement efforts.

The initiative has delivered several key improvements, including stronger collaboration with people-focused workstreams such as Health and Wellbeing Champions, Freedom to Speak Up Guardians, and Staff Networks, alongside their own professional development to benefit local teams.

Staff surveys

The National Staff Survey (NSS) is a fundamental annual measure that helps us to accurately measure our staff experience at UHD. It empowers staff to take meaningful action to make UHD a great place to work. It also allows us to measure the progress of our People and Culture Strategy and the Patient First breakthrough objectives.

Alongside the NSS, quarterly NHS People Pulse surveys are used to assess staff experience, wellbeing, communication, and team support. These short surveys provide timely insights, which enable us to identify trends, address concerns quickly, and improve workforce morale, engagement, inclusion, and patient care.

In preparation for the 2025 NSS we increased the number of teams eligible for a localised report (with 10+ responses) by 50%, enabling more employees to be heard and providing teams with tailored insights and feedback.

To improve accessibility for staff with limited IT access, paper surveys were introduced for Housekeeping, Catering and Portering teams ahead of the 2025 survey. This allowed the managers to adopt a different approach to give their teams time to complete the paper surveys in their working day. This resulted in significantly higher engagement from these staffing groups of around 30%.

UHD results are benchmarked against 121 acute and acute and community trusts. There are many positive areas of note in our NSS 2025 results. Our continued support and engagement with our staff were reflected in our response rate of 54.78% (5,539 staff). Although a decrease compared to 2024 (57.66%) this is significantly higher than the national comparator median response rate of 47%. It's important to note that nationally there has been a drop in engagement rates of around 2%.

The 2025 Staff Engagement Theme score is 6.82. While slightly lower than 2024 (6.90), it is better than the average result for our comparator group (6.74). The 2025 People Promise question *'I would recommend my organisation as a place to work'* is 60.1%. While lower than 2024 (63.1%), it is significantly better than the average result for our comparator group (57.77%). However, as we have seen a decline over the last two years, this metric will be a focus for improvement over 2026 which is aligned to our Trust revised People Priorities.

Bank staff responses are not included in the Trust's overall results for the 2025 survey and are reported separately. The response rate for 2025 (20.80%) showed a 6.2% decrease compared to 2024 (27%) results. As we continue to survey bank staff on their experience of working for the Trust, we will build a better picture in of trends and can address points staff have raised.

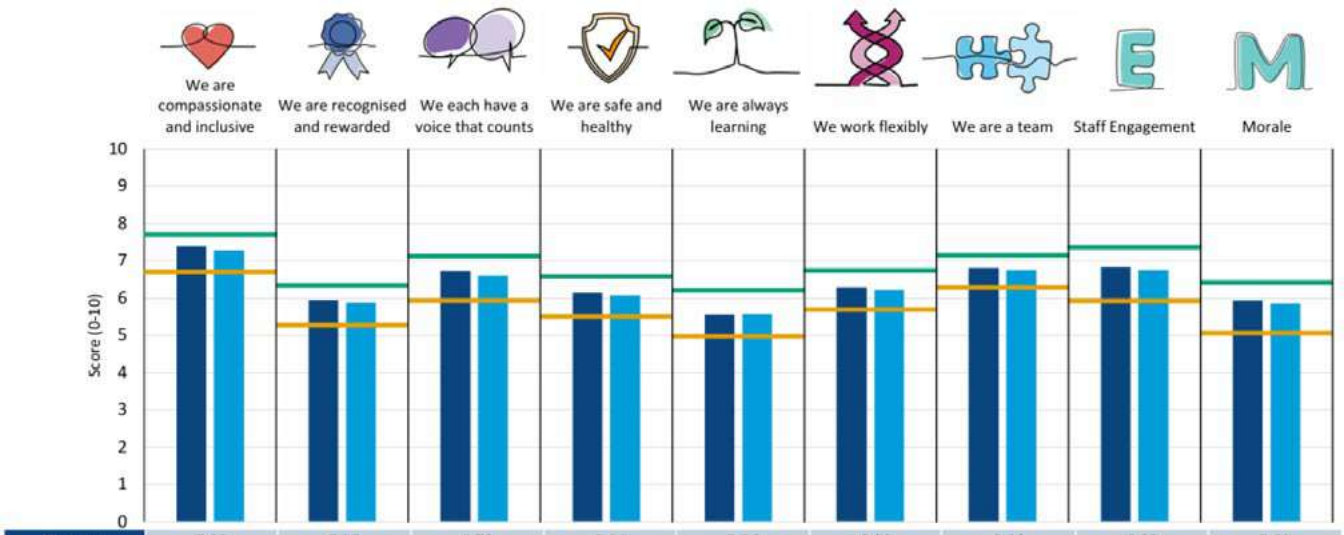
The table below shows an increase in staff satisfaction in all People Promise elements apart from a marginal decline in 'We are always learning'. The table also outlines that bank staff results are significantly better than substantive staff results in four of the seven People Promise themes and staff engagement.

The table below outlines 2024 scores against 2025 for bank staff and outlines the comparison between 2025 bank staff results and 2025 UHD substantive staff results:

People Promise/Theme	2024 Score	Significance	2025 Score	Significance	Sub. Score
Theme - Staff engagement	6.86	Not Significant	7.05	Significantly Better	6.82
Theme - Morale	5.98	Not Significant	6.03	Not Significant	5.94
People Promise 1 - We are compassionate and inclusive	7.29	Not Significant	7.47	Not Significant	7.39
People Promise 2 - We are recognised and rewarded	6.07	Significantly Improved	6.44	Significantly Better	5.95
People Promise 3 - We each have a voice that counts	6.51	Not Significant	6.69	Not Significant	6.72
People Promise 4 - We are safe and healthy	6.79	Not Significant	7.01	Significantly Better	6.15
People Promise 5 - We are always learning	5.94	Not Significant	5.91	Significantly Better	5.54
People Promise 6 - We work flexibly	6.54	Not Significant	6.89	Significantly Better	6.28
People Promise 7 - We are a team	6.65	Not Significant	6.85	Not Significant	6.80

Feedback from substantive staff, demonstrates that our performance is better than average in all People Promise elements and themes except 'We are always learning' compared to our comparator groups, with significantly better scores for staff engagement and morale, 'We are compassionate and inclusive', 'We are recognised and rewarded', 'We have a voice that counts' and 'We are safe and healthy'. Compared to our 2024 Survey, our People Promise element scores show declining trends of statistical significance in the areas of Staff Engagement, 'We are compassionate and inclusive', 'We each have a voice that counts' and 'We are always learning'.

The table below outlines the NSS 2025 results against our comparators and benchmarks the best, average and worst results:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.39	5.95	6.72	6.14	5.56	6.29	6.80	6.83	5.93
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	5514	5518	5450	5471	5268	5474	5500	5518	5518

In order to improve staff experience and address the declining trends outlined above, the following improvements and actions are being implemented.

- **Delivery of improvement plans:** There will be a Trust-level improvement plan to address key issues at a strategic level, such as a focus on improving appraisal experience at UHD. Individual teams, directorate and care groups will be expected to provide improvement plans focusing on two or more priority areas.
- **Strengthened communication, engagement, and accountability:** An engagement and communications plan will be developed which will improve visibility of actions taken in response to staff feedback and ensure consistent messaging across care groups and directorates.
- **Staff Survey and People Pulse results will be embedded within local Service Delivery Reviews** (**SDRs**). This will drive measurable, people-focused improvement and ensure progress is routinely monitored at care group, directorate and executive level.
- **Improved manager and team resources:** These have been developed to guide and support teams to better understand results and improve employee involvement to support the development of local action plans.

To demonstrate we have improved staff experience, engagement and involvement in UHD, we aspire to be in the upper quartile for all People Promise Themes by 2030 measured through the NHS Staff Survey and benchmarked against our comparators.

Leadership and talent management

Management and leadership development forms a core part of our vision to be a great place to work.

Last year, we succeeded in meeting our target of 50% of Band 6 and 7s undertaking formal leadership development following a consistently targeted approach, while simultaneously designing and delivering bespoke leadership support to improve capability and confidence among certain staff groups and teams, for example ED sisters/senior staff nurses and the Matrons Development Programme.

Alongside this, we improved the accessibility and breadth of our in-house leadership and management offers so that both existing and aspiring leaders could access relevant and meaningful professional and personal development. This has included the refinement of our Leadership Fundamentals Programme, the development of a suite of bitesize leadership resources to supplement learning, and a streamlined leadership behaviour framework self-assessment and 360° feedback process. This has allowed us to sustain an alignment to our strategic objectives, our Patient First improvement programme, and the changing national context through our leadership and management programme of work.

We have invested in our in-house coaching capacity and capability as the demand for coaching support has continued to increase over the last year. We have built upon our in-house supervision offer, developing our internal provision to offer 1:1 support and professional development to our coaches. A further 11 UHD staff have started the Level 5 Coaching Apprenticeship which will significantly enhance our ability to respond effectively to an increasing number of coaching requests. We have trained nine additional 360° feedback facilitators and undertaken 38, 360° appraisals since the wider launch of the tool across UHD

in Quarter 2, which has further supported the ongoing personal and professional development of our leaders.

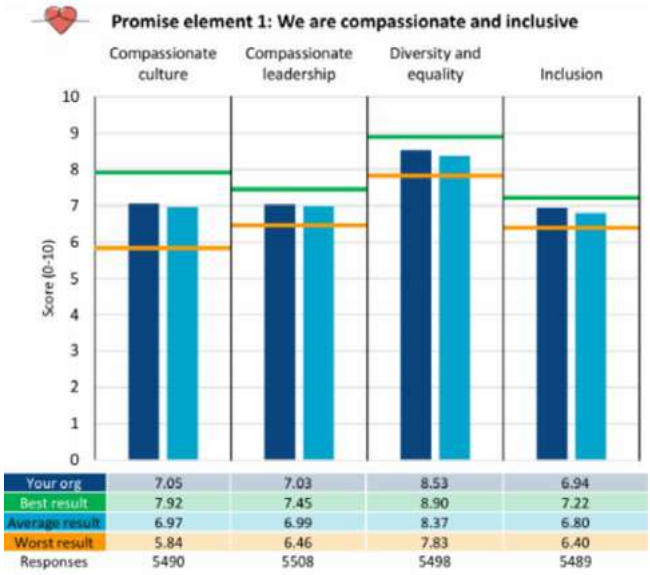
More recently, we have undertaken extensive preparatory work and reviewed draft documentation of the new NHS Management and Leadership Framework in advance of its expected launch in Spring 2026. This has refreshed our focus and provided an opportunity to fully integrate the national competencies and expectations into our in-house offers, while enabling us to consider gaps which will inform future work. We anticipate that this early work will set a strong foundation for the formal launch of the framework across UHD in 2026/27.

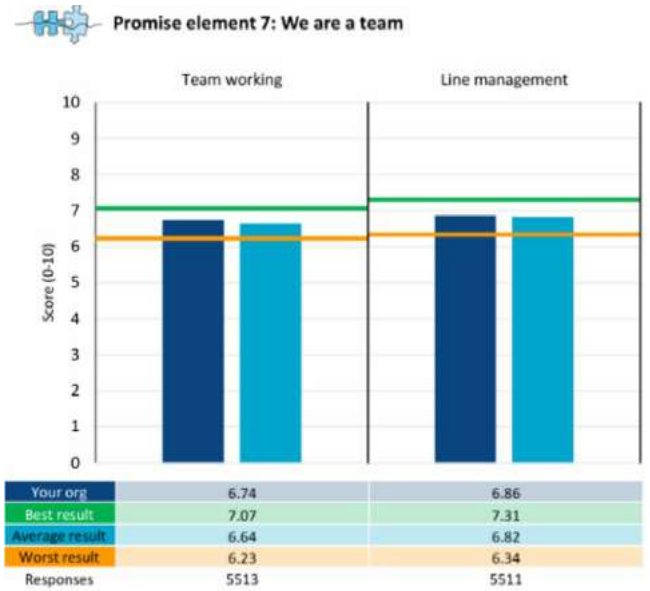
Over the past year, we have worked with a diverse range of leaders from across UHD to develop their leadership and management skills, competencies, and behaviours:

Offer	Number of staff
Leadership in Action Programme	14
Leadership Fundamentals Programme	84
BU Level 7 Senior Leaders Apprenticeship	14
Manager's Induction Programme*	110
Coaching Conversations Workshop*	95
Feedback Skills Workshop*	83
Leading Teams Through Change Workshop*	51
Conscious Inclusion Workshop	133
Patient First for Leaders - Core Skills	185

*Across Quarter 3 and Quarter 4 we have reduced the delivery of our skills-based workshops due to responding to requests for leadership support for upcoming transformation and change (Phase 3 moves).

We have experienced a slight decline in 'We are compassionate and inclusive', and 'We are a team' People Promise themes compared to our 2024 results, which includes 'Line Management', 'Compassionate Leadership', and 'Compassionate Culture' sub-scores. However, we remain above the sector average for these areas, illustrating the continued effectiveness and positive impact of our leadership and management development at UHD at a time of significant change and transition.





Values-based appraisal

In 2025/26 we took a different approach to the appraisal season which did result in a drop in compliance in Quarters 1 and 2. However, there has been a steady increase in completion rates since September. Our NSS sub-score for appraisals has reduced by 0.25 in our latest results compared to 2024 and we are below the sector average by 0.2 for this area, highlighting this reduction in compliance but also in quality of appraisals. While our overall score has declined, we saw a slight improvement in two out of four of the appraisal survey questions:

- 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%).

We have taken a proactive approach to supporting both appraisers and appraisees over the past year, re-designing our Appraisal Essentials briefings to ensure we are covering the areas of appraisal that staff need the most support with. We also conducted a survey to gain feedback on our appraisal process, form, training, and ideas for improvement. These insights provided a better understanding of some of the challenges that staff face in completing appraisals and will feed into our improvement work on appraisal next year.

Our refreshed People and Culture Strategy for next year captures our ongoing commitment to the development of our leaders, ensuring that our managers are equipped with the skills, confidence, and capabilities to support us in making UHD a great place to work.

Team development

Over a period of significant change and transformation across UHD, we have had to prioritise how we support team leaders and teams to develop and manage change. To support teams facing imminent change, we launched the UHD Building Readiness for Change workshops, designed to support leaders and managers of teams or services facing large-scale change. These were co-designed by Organisational Development, HR and the Patient First teams to provide subject matter expertise on the effects of change and the consultation process, with an improvement lens. Feedback from delegates has highlighted an improvement in knowledge and understanding on how to manage the change process.

UHD now has access to the TED Team Engagement and Development toolkit. TED is a continuous improvement approach designed to help teams take control of their own engagement through a diagnostic approach that prompts structured team conversations about the issues that matter the most to them. Over the past year, we have trained 20 TED practitioners to support this work, and 65 team leaders have undertaken training on how to access the toolkit and effectively use it with their teams.

The UHD Building Effective Teams intranet pages have been redesigned and updated to support staff across UHD, no matter what role they are in. A suite of resources and tools have been developed to build the capability and capacity of team leaders and team members to support in creating a positive culture both organisationally and within local teams. New resources and signposting are shared in our monthly UHD publication, *The Brief*, to keep the importance of effective teamworking at the forefront.

We have supported team development days, team workshops, as well as offered bespoke coaching to team leaders to be able to work on their own team development journeys. We have also worked in partnership with the Patient First Team to support teams to think about culture, as well as improving performance. Our 2025 National Staff Survey results report that UHD scored above average in 11 of the 12 questions that sit under the 'We are a Team' People Promise theme.

Equality, diversity and inclusion

At UHD we strive to ensure each individual patient and member of staff has a positive experience of our services and that we are a great place to work. We know that many of our people are also our patients or family members of 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.

Equality, diversity and inclusion objectives

Despite efforts to promote inclusion and equity it is evident that 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 had identified one key equality objective for UHD for 2024-2026: ***"To have a representative workforce at all levels of the Trust"***.

In order to support the Trust to achieve this, work last year included supporting our staff networks with their membership and calendar of events, alongside the development of the network chairs. It also included the introduction of the UHD Conscious Inclusion workshops with more than 260 delegates attending in 2025/26 and many bite-sized sessions on Conscious Inclusion and our See Me First campaign. Progress was also made on a new one-stop approach to accessing reasonable adjustments.

We had agreed a goal to increase our Black and Minority Ethnic (BME) Staff representation in Band 8a and above to over 9% within 12-18 months. By December 2025, this had increased by 1.92% to 6.82% which still leaves some work to do.

A second goal was to raise BME representation in Band 6 and above by 3% in 24-36 months. This was achieved by December 2025.

Regrettably we recognise we have more to do to support the employment experience of our staff living with a long-term condition, and we must remain vigilant in our gender pay work.

Workforce Profile Headlines 'at a glance' reported in 2025

Workforce analytics by nine protected characteristics

Ethnicity/race

The percentage of Black and Minority Ethnic staff reported in March 2025 was 26.08% which was an increase of 2.2% since 2024.

The 2021 ONS noted that the Dorset Council population increased to 379,584 residents up 4% from that reported in 2011. Bournemouth, Christchurch and Poole Council population increased by 5.7%. The Dorset population was reportedly 97.1% White.

%	UHD 2024	UHD 2025
White	73.3	71.2
BME	23.87	26.10

Sex

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

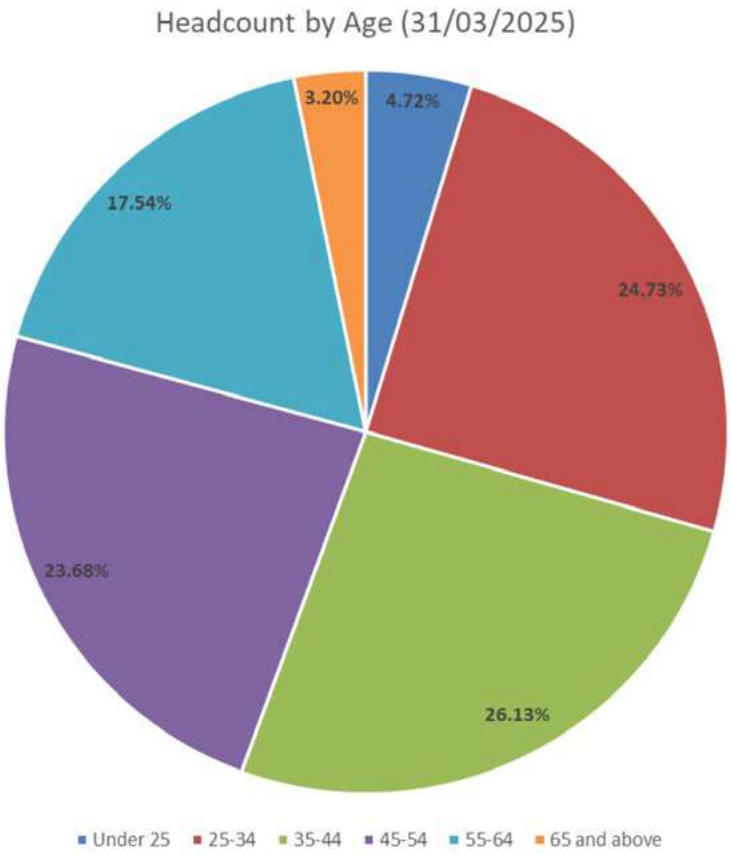
	31/03/2024		31/03/2025	
Gender	Headcount	%	Headcount	%
Female	7299	74.11	7551	74.70%
Male	2550	25.89	2557	25.30%
Grand Total	**9849**	**100.00%**	**10108**	**100.00%**

Disability

The reported declaration for staff who are 'Disabled' increased to 7.10% in 2025, an increase from the 6.34%% reported in 2024. This is a significant increase that is largely attributable to our ProAbility Staff Network's engagement. In the NHS Staff Survey 2024 our respondents reported Disability/long term condition to be much higher at approximately 21.79%.

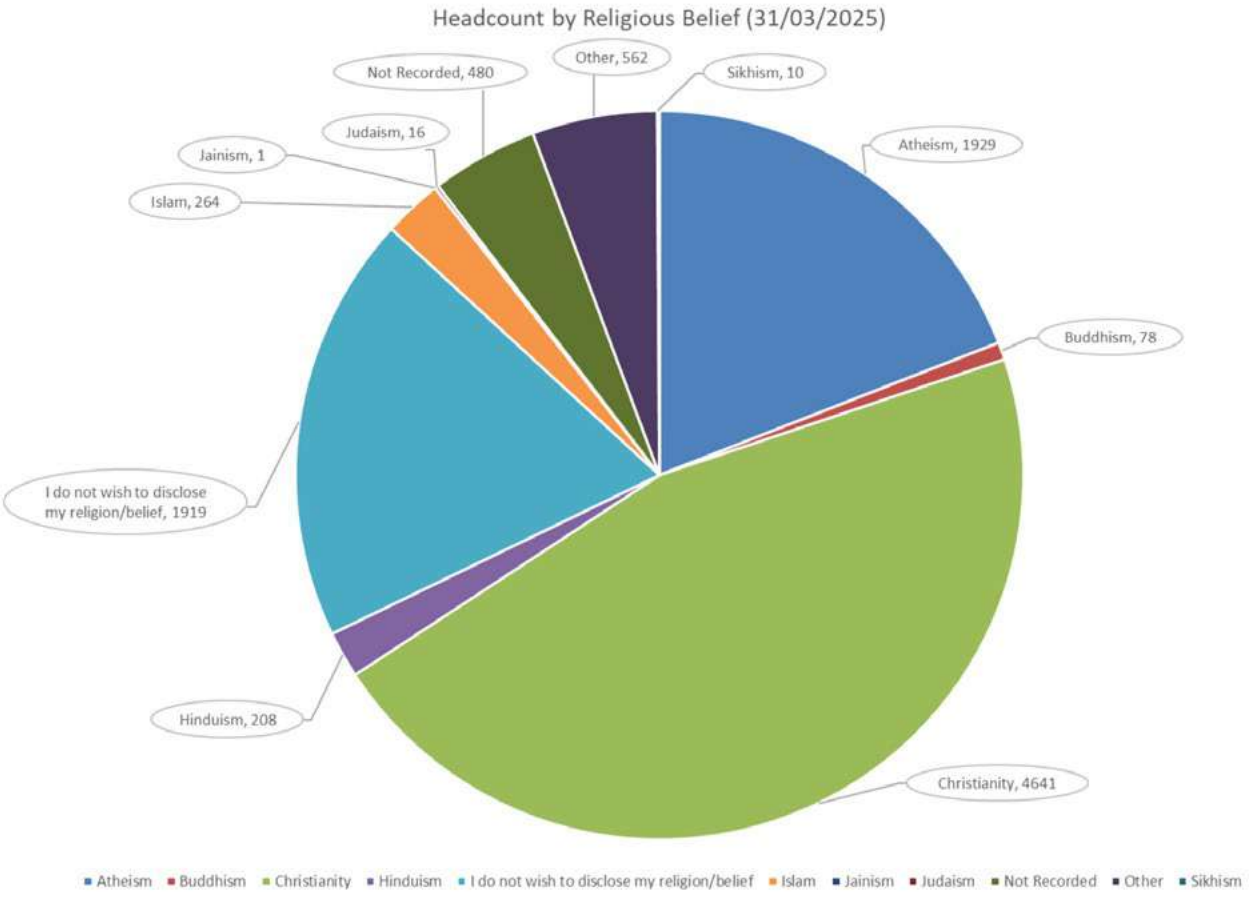
Age

Our workforce age profile remains broadly balanced, with the largest proportion of staff within the 35-44 age group (26.13%), followed by those aged 25-34 (24.73%) and 45-54 (23.68%). This indicates a strong core of mid-career professionals, supporting organisational stability and leadership capacity. A further reported 17.54% of staff were aged 55-64, and 3.20% aged 65 and over, highlighting the continued contribution of experienced colleagues and the importance of targeted retention and flexible working approaches. Employees under 25 accounted for 4.72% of the workforce, reflecting ongoing opportunities to strengthen early career pipelines. Overall, the profile demonstrates a diverse age range across the organisation.



Religion or belief

Our Chaplaincy Service provides multi-faith options on each of our three sites and are notably an important source of support for our staff and patients. Some 1,919 of our staff chose not to disclose their religion or belief.



Sexual orientation

75.52% of staff identify as heterosexual, 2.05% gay or lesbian and 1.16% as bisexual. The percentage in the not stated category has remained at 16.09%.

Marriage and civil partnership

In 2025, 3,871 staff were married compared to 4,230 reported in 2024. The number of unknowns is 422.

Pregnancy and maternity

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

	31/03/2024		31/03/2025	
Accessing parental leave	Headcount	%	Headcount	%
No	9,622	95.19%	9,823	95.19%
Yes	486	4.81%	503	4.81%
Total	**10,108**	**100%**	**10,326**	**100%**

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

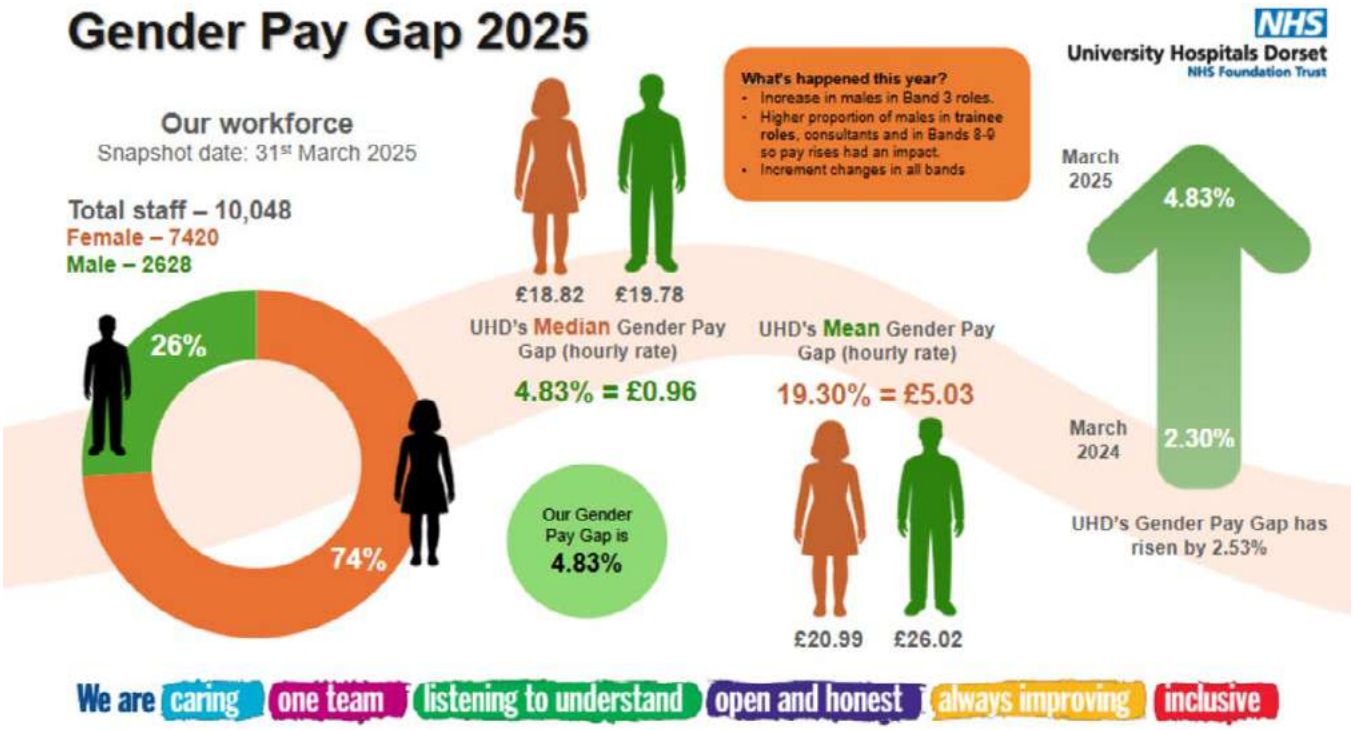
The gender pay gap

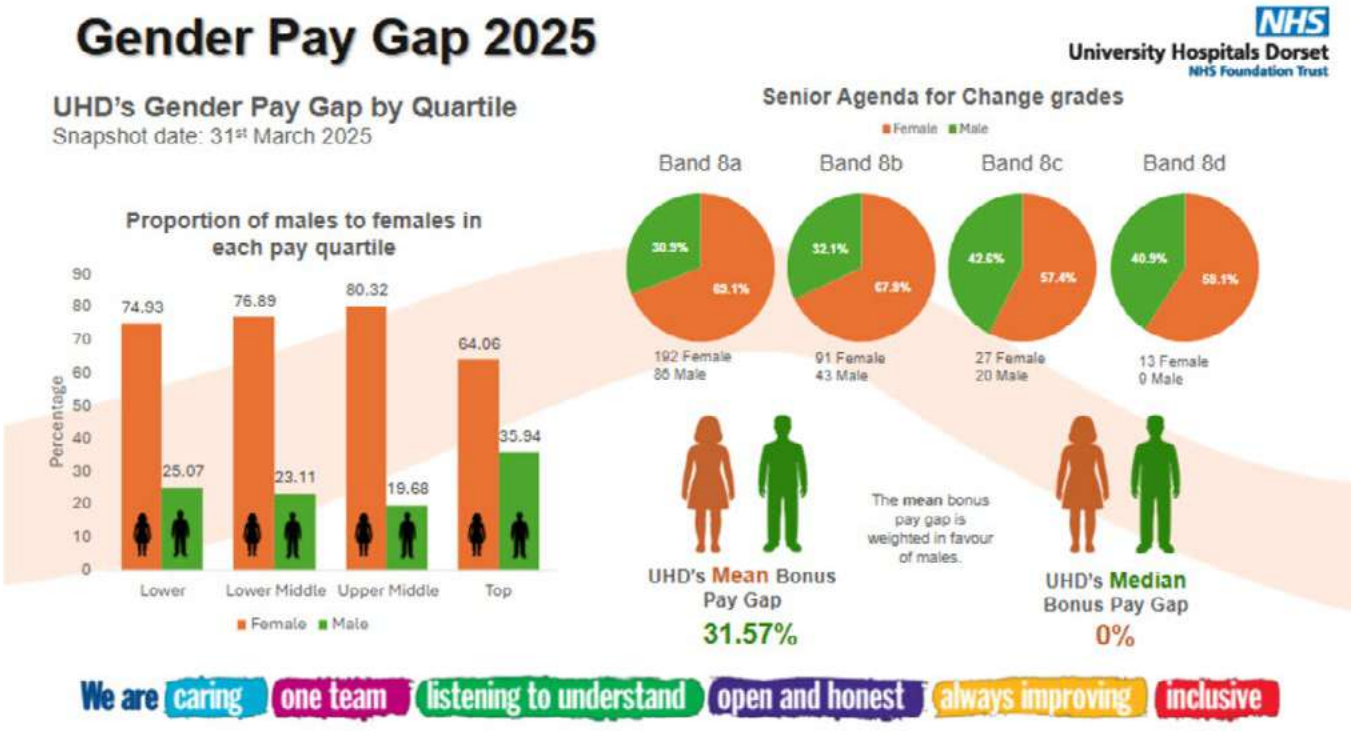
On 31 March 2025 our headcount had increased by 199 to 10,048 since the previous year, with 121 more female and 78 more males across UHD.

This year our reported Gender Pay Gap is 2.30%. This is an increase for the first time since UHD was created in 2020. Significant analysis has been undertaken to understand why the gap increased and the reasons are complex.

We have seen a reduction in the lowest banded roles in Bands 1 and 2 and a subsequent increase in male staff in Band 3 roles. We have a higher proportion of males in trainee roles and also in the more senior roles such as medical consultant and Bands 8 and 9 roles.

We have created one overarching action plan for our Gender Pay Gap and our disability and ethnicity pay gap reports. Aligned to the NHS High Impact Actions, the actions include a focus on inclusive recruitment and career development and progression.





Equality Delivery System Assessment

The Equality Delivery System (EDS) is a locally owned improvement framework to help us assess our progress against the domains.

In 2025, UHD worked with Dorset ICS Services to complete an assessment of EDS Domain 1 using the Dorset Intelligence Information System (Badgernet), incorporating PALS and Friends and Family Test data, alongside Targeted Lung Health Checks. Stakeholder assessments for EDS Domains 1, 2, and 3 were submitted and achieved an overall rating of Achieving, reflecting an improvement on previous assessments.

The full report and associated action plan are published on the UHD website. Preparatory work for the 2026 EDS assessment is currently underway.

Workforce Race Equality Standard 2025 and the Workforce Disability Equality Standard 2025

The national reports for the Workforce Race Equality Standard 2025 and Workforce Disability Equality Standard 2025 have been published on our website.

Workforce Race Equality Standard 2025

Compared to the 2024 WRES data, we have seen a positive and improving trend in a number of indicators. However, there is still a disparity gap across some of the indicators.

Key findings from the 2025 WRES submission

- Black and Minority Ethnic (BME) staff represent 26.08% of the total workforce, an increase of 2.2% from the 2024 data position.
- The UHD workforce continues to show representation across all bands from BME staff with 'Very Senior Manager' representation.
- White candidates are 2.49 times more likely to be appointed from shortlisting than BME staff, a further deterioration from last year (2024 = 1.79).
- BME staff continue to be twice as likely to enter the formal disciplinary process compared to White staff.
- BME staff are as likely than White staff to access non-mandatory training and continued professional development opportunities.
- BME staff continue to experience more harassment, bullying or abuse from patients, relatives or the public than White staff.
- BME 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 (while improving) is lower among BME staff than it is for White staff.
- BME staff are almost three times as likely as White staff to report personally experiencing discrimination at work by a manager/team leader or other colleagues.
- The representation of BME staff on the Trust Board (including non-executive directors) is 16.7% with a disparity of 9.36% compared to organisational representation. If non-executive directors are excluded the representation is 10% with a disparity of 16.06%.

Our 2025 WRES action plan is underpinned by the NHS Equality Diversity and Inclusion Improvement Plan (High Impact Actions) and progress will continue to be monitored by our People and Culture Committee.

Workforce Disability Equality Standard 2025

Compared to the 2024 WDES data, we have seen a positive and improving trend in a number of indicators. In summary, this report highlights the need for sustained action to ensure UHD progresses towards disability equality.

The key findings from the 2025 submission show:

- The declaration of Disability on the Electronic Staff Record (ESR) is now 7.10% compared to 6.3 % in 2024.
- The relative likelihood of a Disabled job applicant being appointed through shortlisting has slightly reduced to 1.05 compared to 1.24 in 2024. A score of 1 indicates equal opportunity.

- This year's data shows no evidence of disabled staff entering the formal performance process.
- 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 their non-disabled counterparts.
- Disabled staff are less inclined to believe the Trust provides equal opportunities for career development as compared to those staff without disabilities, with a disparity of 5.95%.
- Disabled staff feel more pressure than non-disabled staff to come to work when unwell.
- 35.46% of Disabled staff reported that they felt valued for their contribution, a 2.14% decrease from 37.6% reported in 2024.
- 78.44% of Disabled staff reported they had the reasonable adjustment(s) required to perform their duties compared to 78.12% in 2024.
- The staff engagement score for Disabled staff was 6.53%, compared to 6.62% in 2024.
- There is now a declared 4% representation of disabled staff on the Trust Board, compared to no representation in 2024.

Our 2025 WDES action plan is underpinned by the NHS Equality Diversity and Inclusion Improvement Plan (High Impact Actions) and progress will continue to be monitored by our People and Culture Committee.

We are compassionate and inclusive

The voice of our staff networks

Be who you are. Be recognised. Be valued. be all you can be. Staff Networks #TeamUHD

At UHD we have well established and successful staff networks. Our network leads attend a regular huddle and participate in a community of practice. Each of our networks also has a named executive or senior leader as a sponsor to work with the network leads and to raise concerns and celebrations at Board.

Throughout 2025/26 our staff network leads have participated in committees, working groups and interview carousels for senior leaders and board members.

Our Staff Networks at UHD work hard to 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.

NHS UHD Pride Network

uhd.pride.network@nhs.net

UHD Pride Network

Network leads: Melissa Armstrong, Executive sponsor: Pete Papworth, Chief Finance Officer

The UHD Pride Network has had several changes in leads over the last 18 months. Melissa Armstrong has been the lead for a year, and Maggie Baska provides communications support. We are keen in 2026 to strengthen the leadership support.

The network faced a particularly challenging period during the year, shaped in part by a high profile High Court judgement and the subsequent national discussion around the

role of public sector organisations in visible LGBTQIA+ allyship. This created uncertainty and reduced confidence for some staff involved in the network resulting in some uncertainty for the network and the Trust while we seek to ensure compliance, clarity and psychological safety for all involved.

During 2025/26 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 held at the Marquee in RBH, annually attend the local Pride event Bournefree, created inclusive NHS flags to display across all sites and continue to work hard for equality and diversity across UHD.

UHD was awarded the Bronze award through the Rainbow project for support for both LGBTQIA+ staff and patients. Unfortunately NHS England ended this project but an action plan is underway to continue the work this helped to develop including further work on policies and procedures.

ProAbility Network

uhd.pro-ability.network@nhs.net

ProAbility Network

Network leads: Jo Olsen, Lisa Brinkman, Jo Pritchard, Elayne Goulding
Executive sponsor: Irene Mardon, Deputy Chief People Officer

This network aims to listen, understand and support people working in UHD with disabilities and long-term health conditions. They do this by holding listening events and through monthly network meetings. One of their aims is to encourage and support staff to share their information to improve low declaration rates of disabilities on their staff ESR record.

They continue to work closely with their executive sponsor, HR, Occupational Health and the Health and Wellbeing Lead to review and improve the Trust's current reasonable adjustments policy and processes. This was the network's main priority for the year.

The network has recognised the need to support neurodivergent employees in the Trust by setting up a new subgroup for our neurodivergent staff which has been successful and well supported.

The Deaf and Hard of Hearing subgroup continues to provide good peer support with bimonthly meetings.

Monthly ProAbility meetings are very well attended by members, and they invite guest speakers to engage and educate at these sessions.

The network's main celebration 'Positively Purple' took place on 3 December 2025 with a webinar attended by a Disabled motivational speaker.

The Trust also formally acknowledges the significant contribution of Elayne, former Network Co Lead, whose leadership and advocacy were instrumental in driving positive change.

Armed Forces Support Group

uhd.armedforcessupport@nhs.net

Armed Forces Support Group

Network lead: Rob Hornby
Sponsor: Abigail Daughters, Director of Operations (Surgical)

ARMED FORCES COVENANT
EMPLOYER RECOGNITION SCHEME
GOLD AWARD
Proudly supporting those who serve.

UHD continues to demonstrate strong commitment to supporting the Armed Forces Support Group (AFSG) through sustained leadership, accreditation, and practical action. The Armed Forces Community (AFC) Advocate, Rob Hornby, has received consistently positive feedback from stakeholders, patients, staff, and family members, reflecting the strong foundations established to deliver an effective and responsive service. The number of UHD staff members being supported by the AFC has increased over the past year.

UHD proudly achieved the Armed Forces Covenant Employer Recognition Scheme (ERS) Gold Award in 2023 and continues to uphold the standards and behaviours associated with both ERS Gold and

Veteran Aware accreditation. In January 2025, the Trust successfully renewed its Veteran Aware Accreditation for a further three years, reaffirming its commitment to ensuring the armed forces community is not disadvantaged, raising awareness of veteran specific needs, signposting to appropriate services, and supporting armed forces personnel as employees.

Executive sponsorship is provided by Abigail Daughters, Group Director of Operations for the Surgical Care Group. The Armed Forces Support Group (AFSG) meets bimonthly and remains a key forum for engagement and support. The AFSG marked VE Day, Armed Forces Day, and Remembrance Day through promotional stands at Poole and RBH, alongside remembrance services across all three UHD sites, all of which were well attended.

The Trust continues to engage with the Veterans Covenant Healthcare Alliance (VCHA) regional trainer to deliver the new National Armed Forces Healthcare Training and Education Programme. In partnership with the renamed 243 Multi Role Medical Regiment (MMR), regular reservist recruitment days continue at Poole and RBH, generating strong interest and enquiries.

DEN
Diverse Ethnicity Network

uhd.dennetwork@nhs.net

Diverse Ethnicity Network (DEN)

Network leads: Judith Dube and Gabriel Adelaja
Executive sponsor: Sarah Herbert, Chief Nursing Officer

The Diverse Ethnicity Network (DEN) holds monthly meetings to listen to the experiences of Global Majority staff and provide support where needed. The network continues to grow, with increased membership and strong attendance from active allies. Their Executive Sponsor supports the Network's agenda and ongoing development.

In line with the Workforce Race Equality Standard (WRES) action plan, the Trust has reinforced its zero tolerance stance on discrimination and racism. Anti racism and anti antisemitism messages have been shared widely through Trust communications. For the first time, UHD marked Hanukkah in December 2025, demonstrating commitment to inclusion and cultural awareness. Anti racism guidance has also been promoted across multiple platforms.

Several listening events were held to support Global Majority colleagues following global events. These sessions were supported by Board members and allies and provided safe spaces for reflection and discussion. A panel discussion with Yvonne Coghill in December was well attended by network members, allies, and Board representatives.

The UHD Cultural Celebration was delivered successfully across all sites, helping to raise awareness of reducing communication barriers, promoting civility, and strengthening cultural integration. Last year's Black History Month was celebrated at both major hospital sites and supported by DEED, an educational organisation, to enhance awareness of Black history within Dorset, particularly in Bournemouth and Poole.

The network also leads the See Me First campaign, with over 2,500 staff members signed up to demonstrate their commitment to Listen, Speaking Up, Support, to challenge discrimination and racism. Through this work, the network continues to influence senior leaders to drive meaningful change, support career progression, address bias and microaggressions, and promote psychological safety. In addition, it plays a key role in encouraging mentoring, sponsorship, and inclusive cultural celebration across UHD.

WN
Women's Network

uhd.womensnetwork@nhs.net

Women's Network

Network leads: Catherine Bishop, Sam Murray
Executive sponsor: Beverley Bryant, Chief Digital Officer

Women make up 76% of the UHD workforce, with the Women's Network playing a key role in supporting inclusion and wellbeing.

Since its establishment in July 2022, the Network has grown steadily to 345 members and maintains strong attendance at its regular monthly talks.

The network has been instrumental in promoting women's health and wellbeing, including awareness of menopause and baby loss. They have actively supported engagement with both the Sexual Safety Charter and the Trust's Menopause Policy.

UHD celebrates International Women's Day annually, with the Women's Network leading a well attended event that recognised and celebrated inspirational female leaders from across the Trust. The Network also leads the Period Poverty project, ensuring free access to sanitary products in all unisex and female facilities. In addition, it works collaboratively with other staff networks, Dorset Police, BCP Council, and the Dorset Women's Network to strengthen partnership working and maximise impact.

Sam Murray, who established the Women's Network, made a significant contribution to its development and stepped down from the lead role at the end of 2025/26. Cat Bishop, who co led the network alongside Sam, continues this work and aims to recruit new members to take on enhanced leadership roles during 2026.

Charters and partners

UHD champions a range of charters and agreements with external organisations, demonstrating its commitment to being a safe, inclusive, and supportive place to work and to receive care. These include:

Armed Forces Covenant

The Armed Forces Covenant is a pledge to recognise and understand the needs of the Armed Forces community and to build an open and honest relationship between employers, the Ministry of Defence, and reservists. UHD has proudly achieved the ERS Gold Award and has also had its Veteran Aware accreditation renewed for a further three years, until 2028. This accreditation recognises trusts that are leading improvements in veterans' care within the NHS through 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 a movement for change, encouraging employers to think differently about disability and to take action to improve the recruitment, retention, and development of disabled people. Becoming Disability Confident offers a unique opportunity to lead by example within the community and to recognise the value and contribution of disabled talent that organisations cannot afford to overlook.

Mindful Employer

This is a national initiative that encourages employers to take a positive and proactive approach to mental health in the workplace. By signing the Mindful Employer Charter, UHD make a public commitment to supporting the mental wellbeing of their staff.

Sexual Safety Charter

UHD signed up to the new Sexual Safety Charter in 2023 and has since strengthened its approach through a published Sexual Misconduct Policy, supported by dedicated guidance and resources available to staff via the intranet. This is complemented by clear reporting routes, including Freedom to Speak Up, and ongoing awareness activity to promote a culture of safety, respect and confidence in raising concerns. The Trust established a Sexual Safety Review Group to monitor compliance, reporting and learning to ensure a consistent, timely and person-centred response aligned to the Charter's requirements.

University Hospitals Dorset NHS Charity support

University Hospitals Dorset NHS Charity fundraises for and receives kind donations from patients, families and staff who want to help enhance patient care and support staff welfare across our hospitals.

University Hospitals Dorset NHS Charity
Registered Charity No. 1057366

The Charity works in partnership with UHD to put these donations to good use across our hospital sites.

Generous donations to our Stroke Unit have allowed the charity to refurbish gardens for patients and their families' use. The tranquil spaces, which cost £18,364 to refurbish, are adjacent to the Stroke Unit with one garden overlooking the lake at the Royal Bournemouth Hospital (RBH). The patient garden also includes specialist rehabilitation equipment like raised steps and platforms, accessibility improvements, aesthetic plants, comfortable seating and a pergola with a roof so the garden can be enjoyed in all weather. There is a separate, dedicated space for staff to relax and recharge while remaining close to the unit.

"Lovely and bright. It is a lovely break from the ward environment as I have been in hospital for a long time. Lovely to see the ducks and go into the garden, which is clean and accessible!"

Feedback from a patient

In response to the Charity's BEACH appeal to raise funds to support the extras in the new BEACH Building at RBH, the new play area in the Children's Emergency Department waiting room has been transformed into a child-friendly space, thanks to generous gifts from charitable trusts and local rotary groups.

The play area is now a welcoming and accessible space with a whimsical nautical theme, a nod to Bournemouth's coastal location. We installed fun interactive games, a calming sensory trolley, colourful artwork and engaging toys for children and young visitors.

"One little boy was crying as he was injured and saying he did not want to go to hospital. He turned the corner and saw the play equipment and said 'I like it here...'"

Feedback from a colleague in ED

To support staff welfare the charity once again supported the annual UHD Awards. The awards saw more than 950 nominations received from patients and colleagues, recognising the outstanding teams and individuals who work together to provide the best possible care and experience for UHD patients and their loved ones. It was a memorable night, and we are so grateful to all of the companies and organisations who helped to make the night come alive for our staff!

"You can feel the excitement and energy the moment you step into the room at our staff awards. Thanks to the many donations we receive in recognition of patient care, we're able to give our staff a well-deserved evening to celebrate everything they have done for our patients and our organisation. We are incredibly grateful to everyone who helps make it possible to recognise and thank our staff..."

Debbie Anderson, Charity Director

To find out more about our Charity, please visit www.uhdcharity.org

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) Considering financial override which may limit a segment to be no better than 3

c) Contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

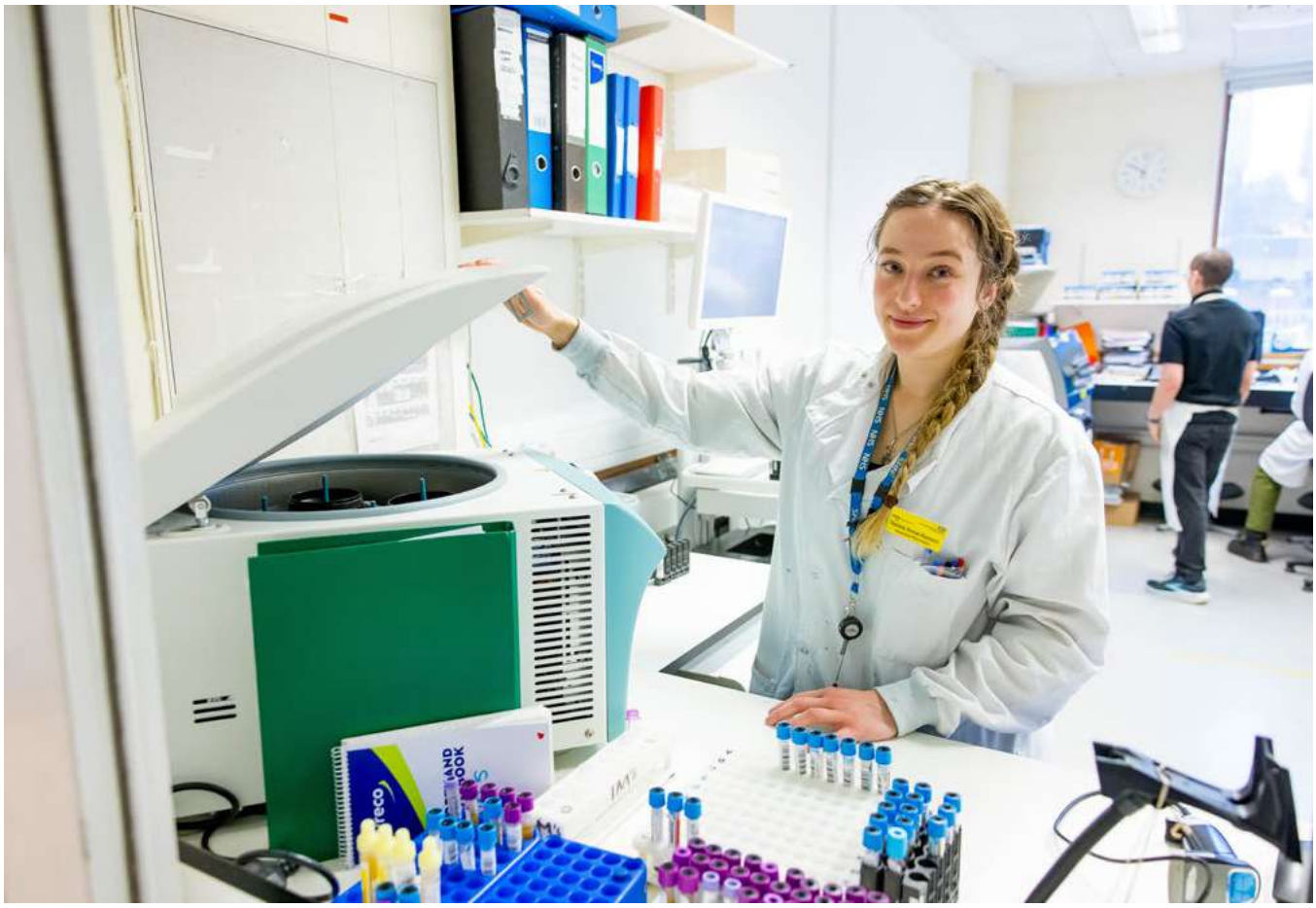
d) Capability assessments which consider the organisation's leadership and governance.

Segmentation

The Trust on Q4 2025/26 is placed in segment 3 and ranked 70 out of 134 acute trusts. This segmentation information is the Trust's position as at 17 June 2026.

This segmentation information is the Trust's position as at 30 April 2026. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: **www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables**.

The Trust is included on the acute Trust dashboard.



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 an NHS Foundation Trust, UHD is required to comply with the provisions of the Code or, where appropriate, to explain any instances of non compliance.

The Code also specifies a number of disclosures that must be included within the Annual Report, which are set out below:

Code reference	Section
Section A, 2.1 - Provider collaborative	Performance Report - page 16
Section A, 2.3 - Culture and staff wellbeing	Staff Report - page 100
Section A, 2.8 - Stakeholders and system working	Stakeholder relations - page 81
Section B, 2.6 - Independence of Non-Executive Directors	Directors' Report - page 57
Section B, 2.13 - Attendance at the Board and Committee meetings	Directors' Report - page 57
Section B, 2.17 - Council of Governors	Directors' Report (Council of Governors and our members) - page 72
Section C, 2.5 - External consultancy	Not applicable
Section C, 2.8 - Governors' Nominations, Remuneration and Evaluation Committee	Remuneration Report - page 88
Section C, 4.2 - Directors' skills, experience and knowledge	Directors' Report - page 57
Section C, 4.7 - Well led review	About us - page 18
Section C, 4.13 - Board of Directors' Appointments and Remuneration Committee	Remuneration Report - page 88
Section C, 5.15 - UHD forward plan	Directors' Report (Council of Governors and our members) - page 72
Section D, 2.4 - Audit Committee	Directors' Report - page 57
Section D, 2.6 - Director's responsibilities	Directors' Report - page 57
Section D, 2.7 - Risk	Performance Report - page 16
Section D, 2.8 - Annual Governance Statement	Annual Governance Statement - page 132
Section D, 2.9 - Going concern statement	Performance Report - page 16
Section E, 2.3 - Remuneration disclosures	Not applicable
Appendix B, para 2.3 - Members of the Council of Governors	Directors' Report (Council of Governors and our members) - page 72
Appendix B, para 2.14 - Communication between Council of Governors and our members	Directors' Report (Council of Governors and our members) - page 72
Appendix B, para 2.15: Engagement with Governors and Members	Directors' Report (Council of Governors and our members) - page 72

The areas of non compliance with the NHS Code of Governance are set out below:

Code of Governance 'Comply or Explain' Requirement	Explanation
B.2.7 - At least half the Board of Directors, excluding the chair, should be non-executive directors whom the Board consider to be independent.	During 2025/26, the Trust has had eight executive directors and seven non-executive directors (excluding the Chair). This is because from May 2025, one of the non-executive directors took up the role of interim Chair. The postholder's substantive role is as a non-executive director. This position was supported by the Board, Council of Governors and the NHSE regional team to provide continuity and stability to the Board during period of significant transformation and change. During the period, the Trust's Constitution was updated to include a casting vote for the Chair.
E.2.2 - Levels of remuneration for the Chair and non-executive directors should reflect NHS England's Chair and non-executive director remuneration structure.	The level of remuneration for the Interim Chair is in keeping with the national structure. The non-executive directors are paid slightly more than the amount recommended by the structure. The Trust pays £16k per annum. The amount recommended by the structure is £13k per annum plus £2k for additional responsibilities. It should be noted that the structure has not been updated since 2019 and that Foundation Trusts retain discretion to depart from the structure with reason. The size of the merged Trust was taken into account as a factor when establishing remuneration for the non-executive directors. It should also be noted that the predecessor trusts to the Trust already paid non-executive directors at a higher remuneration than the levels stated in the structure document.

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 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 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 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, and
- 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
17 June 2026

Annual Governance Statement
(1 April 2025 to 31 March 2026)

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 that 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 in University Hospitals Dorset NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership is given to the risk management process

At Board level, the Trust Board provides overall leadership for risk management by setting the strategic direction and defining the Trust's risk appetite and tolerance. The Board owns and reviews the Board Assurance Framework, ensuring that key strategic risks are identified, monitored and managed, supported by regular horizon scanning and routine consideration of high-rated risks at Board meetings. Through this approach, the Board promotes a culture in which risk management is integral to quality, governance and performance.

Leadership is further exercised through the Board's committee structure, which provides focused assurance and challenge within agreed remits. The Audit Committee oversees the effectiveness of risk management and internal control through regular review of the BAF, while the Quality Committee, Finance and Performance Committee and People and Culture Committee scrutinise risks aligned to their respective domains, using heat maps and escalation arrangements to ensure risks are actively managed in line with the Trust's priorities.

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.

The Trust continued to strengthen its arrangements for the identification, assessment and oversight of risk during the year through its risk strategy arrangements. The Risk Oversight Committee provided

a structured forum for robust scrutiny of corporate and operational risks and supported a more mature and consistent approach to risk management. This led to a clearer distinction between strategic risks and operational issues, improved consistency in risk descriptions, controls and mitigating actions, and a reduction in the overall number of risks on the Trust's risk register through timely review and closure where mitigation was effective.

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

- Executive leadership is a central feature of the strategy, with the Chief Executive holding overall accountability for ensuring an effective risk management system is in place and chairing the executive-level Risk Oversight Committee.
- The Risk Oversight Committee provides leadership through systematic review of corporate risks (risks rated 15-20), scrutiny of controls and action plans, management of breaches in risk appetite and tolerance, and escalation of gaps in controls or assurances to the Board.
- Executive directors act as risk sponsors for corporate risks within their portfolios, ensuring clear ownership, progress against actions, and alignment with strategic objectives, reinforcing executive accountability and the link between strategy, delivery, mitigation and residual risk.
- The Chief Medical Officer and Chief Nursing Officer oversee quality governance, clinical governance, and patient safety. Their roles ensure effective management of safety and quality risks and incorporate learning from incidents, audits, reviews, complaints, and inspections into high-level decisions.
- Operational leadership is exercised through care group directors, directorate leads and senior managers, who are responsible for identifying, reviewing and escalating risks in line with the Trust's framework. They ensure risk management is a standing item within governance meetings, risks are consistently articulated and reviewed, and action plans are delivered, promoting ownership of risk and ensuring clear escalation routes and senior oversight.
- Leadership is reinforced through corporate and enabling roles, including the Associate Director of Quality Governance and Risk and the Head of Patient Safety and Risk. These roles provide expert leadership by maintaining the risk management framework, overseeing the risk register, developing policy and guidance, providing training, and ensuring consistent and high-quality risk identification, assessment and management across the organisation.

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

The Trust provides a range of training and development opportunities to ensure staff are appropriately equipped to manage risk in line with their roles and responsibilities. Risk assessment, incident reporting and investigation training is provided throughout the year for relevant clinical leads, heads of department and ward leaders, supporting effective identification, escalation and management of both clinical and non-clinical risks.

The Trust holds an in-house licence to deliver the Institute of Occupational Safety and Health (IOSH) Managing Safety course, which is delivered on a bi-monthly basis. This training supports frontline leaders to recognise, describe, escalate and manage risks within their areas of responsibility. In addition, targeted training sessions covering risk assessment, incident reporting, Duty of Candour, After Action Reviews and Patient Safety Incident Investigation are delivered routinely to relevant staff.

The Trust's Essential Core Skills Policy sets out minimum training requirements for staff, informed by a formal training needs analysis. Mandatory training includes Health and Safety, Fire, Security and Infection Prevention and Control, delivered through induction and ongoing refresher programmes. In March 2024, Level 1 National Patient Safety Training was incorporated into the essential core skills framework for all staff, further strengthening organisational capability in patient safety and risk awareness.

Formal training is supported by a comprehensive range of learning and feedback mechanisms designed to promote continual improvement. Learning from incidents, complaints, audits, mortality reviews and patient feedback is routinely reviewed through corporate, specialty and directorate governance forums. Key lessons are shared with staff through multiple channels, including Learn at Lunch sessions, Organisational Wide Learning (OWL) safety alerts, learning synopses, Clinical Governance Group newsletters, local team briefings and safety huddles. Learning and improvement actions are also shared with regulators and system partners through Patient Safety Specialist meetings, shared learning forums and multi-agency reviews.

The Risk Management Strategy is underpinned by a culture that encourages open and transparent reporting of risks and continuous organisational learning. This is supported by the Trust's organisational development programme and values. As Chief Executive, I sponsor the Freedom to Speak Up Guardian, who reports regularly to the People and Culture Committee and bi-annually to the Board of Directors, providing additional assurance on the effectiveness of the Trust's reporting, safety and learning culture and highlighting emerging themes.

The Risk and Control Framework

Key elements of the Risk Management Strategy

The Trust has a comprehensive Risk Management Strategy in place which sets out a clear and systematic approach for identifying, evaluating, managing and escalating risk across the organisation. The strategy applies to all forms of risk, including clinical, operational, financial, workforce, digital and strategic risks, and is embedded within the Trust's wider quality governance and accountability framework.

Identification of risk: Risks are identified through a range of internal and external sources, including service delivery, incident reporting, patient safety investigations, complaints, audits, inspections, horizon scanning and changes in national or system requirements. Risks are consistently articulated using an "if…then" format and assessed using the Trust's standard 5x5 scoring matrix to evaluate likelihood and impact. Initial, current and target risk scores are recorded, enabling changes in risk exposure to be monitored and emerging or deteriorating risks to be identified promptly.

Evaluation of risk: Risks are evaluated to determine the most appropriate management response, including additional controls or mitigations, tolerance where controls are effective, transfer where appropriate, or cessation of activity where risks exceed appetite. All risks are recorded on the Trust's risk register with clear ownership, actions and review arrangements, and are subject to defined escalation thresholds to ensure higher-rated risks receive enhanced scrutiny and senior approval.

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, nominate clear owners, and provide a date 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 (**The Trust's appetite for our people risk is Cautious**)
- Population and System Working risk (**The Trust's appetite for operational and performance risk is Cautious**)
- Quality (Outcome and Safety) risk (**The Trust's appetite for clinical risk is averse**)
- Sustainable Services risk (**The Trust's appetite for financial risk is Cautious**)
- Patient Experience risk (**The Trust's appetite for patient experience risk is minimal**)

The Trust's Risk Appetite Statement sets out the Board of Directors' expectations regarding the nature and level of risk the Trust is prepared to accept in pursuit of its strategic objectives. It provides clarity on the categories of risk to be identified by management and the extent to which those risks are considered acceptable. A lower risk appetite reflects a lower tolerance for risk and a corresponding requirement for stronger controls, while a higher risk appetite allows for greater acceptance of risk where established systems of internal control are considered sufficient.

Risk appetite provides a framework to support informed planning and decision making by defining the optimum balance

between risk and opportunity in delivering the Trust's strategy and vision. The Trust has adopted recognised definitions of risk appetite and risk tolerance, with risk appetite describing the level of risk the Trust seeks to operate within and risk tolerance defining the maximum level of risk it is willing to accept.

The Trust's risk appetite has been developed iteratively through engagement with the Board, its committees, the Executive Team and specialist risk and governance expertise, supported by internal audit. Risk appetite levels are defined for each risk type and category using a consistent five point scale, with thresholds adapted to reflect the nature of different risk areas. This approach is intended to mature over time and to support consistent application and embedding across the organisation. 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	16-25

The Trust's Risk Management Strategy sets out a clear and consistent approach to risk identification, assessment, control and the management and investigation of adverse events, aligned to the Trust's values and a culture of openness, accountability and transparency. Through its integrated governance framework, the Trust identifies, prioritises and manages risks across all areas of activity. Risks to the delivery of strategic objectives are captured within the Board Assurance Framework, which is aligned to the Trust's Patient First methodology and supports greater alignment between strategic themes, breakthrough objectives and enabling programmes.

The Trust operates a single, standardised risk register and applies a consistent process for recording and managing risk. Risk mitigation is supported through a continuous cycle of identification, assessment, control and review. Corporate risks (currently those scored 15-25), and any material changes to these risks, are reported to and reviewed by the Board of Directors at Part 1 meetings. The Board and its committees are supported by a range of specialist governance groups, including Trustwide management, clinical governance, clinical audit and effectiveness, risk oversight and, care group quality governance forums. Where appropriate, the Board and its committees commission focused deep-dives into specific risks and consider independent sources of assurance, including internal and external audit, counter-fraud activity, national clinical audit and national patient and staff survey findings.

The Risk Management Strategy supports the Trust in delivering devolved decision making and clear accountability for risk management from the point of care through to the Board. It promotes a robust culture of assurance, monitoring and continuous improvement, ensuring that risks to the achievement of strategic objectives are well understood. The strategy supports patients, carers and stakeholders through the effective management of risks to patient safety, patient experience, staff safety and service delivery, and enables timely, well-informed decision making through efficient processes, clear reporting and effective scrutiny. It also provides assurance to the Trust Board,

commissioners and other stakeholders that the Trust understands its risk profile and is taking appropriate and timely action to mitigate key risks.

The effectiveness of the Trust's Risk Management Framework is subject to regular review through the internal audit programme, with reports considered by the Audit Committee to provide independent assurance on the adequacy and operation of risk management and internal control arrangements.

Risks are recorded on the Trust's risk register from a wide range of sources, including issues identified by staff, directorates, internal and external reviews, audits, incident investigations, complaints, service developments and feedback from patients and the public. Learning and recommendations arising from incidents, complaints, audits, peer reviews and claims are discussed locally at ward, directorate and Care Group level and are used both to strengthen controls and to inform how risks are identified and managed more effectively.

Risks may also be escalated or generated through the Board of Directors, its committees and specialist governance groups, including the Quality Committee, Finance and Performance Committee, People and Culture Committee, Infection Prevention and Control Group, Medicines Optimisation Group, Clinical Governance Group and Health and Safety Group. All risks are categorised and assessed in line with the Trust's Risk Management Strategy using a standard risk matrix, combining likelihood and consequence to determine a current and target risk rating. Each risk has a named lead, clearly defined actions and timescales, with executive director sponsorship assigned to all corporate risks and the Board Assurance Framework.

Quality governance arrangements

Overall coordination of compliance with the Health and Social Care Act 2008 (Registration Regulations) 2010 is led by the Chief Nursing Officer. Compliance is managed through a structured and systematic approach that includes ongoing review of outcomes and themes arising from Care Quality Commission (CQC) inspections, reports and regulatory engagement.

Action plans arising from CQC activity and registration requirements are routinely monitored to ensure timely delivery and sustained improvement. The Trust maintains regular liaison with the CQC and works with care group teams to address areas of concern and supports planned and responsive engagement with the regulator, including inspections, information requests and formal engagement meetings.

Assurance on compliance is further informed through analysis of trends from incident reporting, complaints, patient and staff surveys, and national and local clinical audit programmes, enabling early identification of potential risks or areas of non-compliance at specialty or service level. This is supported by routine review of the effectiveness of controls in place to manage identified risks.

Additional assurance is obtained through consideration of internal audit findings, peer review outputs, internal and external accreditation reports, external reviews, system-level reports and integrated performance data. Together, these arrangements provide the Board with ongoing assurance that appropriate governance, oversight and controls are in place to support continued compliance with statutory and regulatory requirements.§

Board Assurance Framework risks

The Board of Directors has reviewed the Trust's principal strategic themes and objectives and, through the Board Assurance Framework (BAF) process, identified the risks that may impact delivery. The BAF sets out the Trust's principal risks to achieving each strategic objective, alongside the identification of key controls and assurances, any gaps in controls and assurances and any planned actions for mitigation. The BAF is reviewed quarterly and includes consideration of any relevant corporate risks held on the Trust risk register. Management of the BAF is supported through a continuous cycle of identification, assessment, control and review.

During 2025/26, progress against strategic priorities has been further monitored through the Strategy Deployment Review (SDR) process, with monthly oversight at Care Group and Trust Management Group level. A counter-measures methodology was applied to support timely and proportionate responses where objectives or programmes were identified as off track, supported where appropriate by statistical process control techniques.

Through the Board Assurance Framework, the Trust identified significant in-year risks impacting achievement of its strategic priorities.

The most significant risks in 2025/26 facing the Trust 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 corporate risks rated 15 or above at the end of 2025/26 align directly to the Board Assurance Framework and the delivery of the Trust's strategic objectives.

Risks within the **Population and System** strategic theme reflect continued system-wide pressures affecting the Trust's ability to deliver timely, equitable and accessible care, including challenges in meeting urgent and emergency care standards, capacity constraints within diagnostic and pathology services, neurodevelopmental pathways, and the resilience of critical infrastructure supporting theatre activity.

A significant number of principal risks are aligned to the **Quality Outcomes and Safety** strategic theme, highlighting key areas where sustained focus is required to ensure the delivery of safe, effective and high-quality care, including workforce capacity in specialist services, the safe management of clinical technologies, timely access to diagnostics and treatment, digital safety controls, and the safe management of patient flow at times of peak operational pressure, particularly within maternity and emergency care.

Risks aligned to the **Sustainable Services** strategic them objective reflect the Board's oversight of the Trust's long-term operational and financial resilience, encompassing the stability and delivery of the Electronic Patient Record, the integrity of clinical coding and data quality, and the maintenance of medium-term financial sustainability to support ongoing service delivery and improvement. Collectively, these principal risks provide assurance that the Board's oversight of risk is closely aligned with the Trust's strategic priorities, with mitigating actions and controls focused on delivering high-quality care, safeguarding patient safety, and ensuring services remain sustainable and resilient.

Risk mitigations are routinely reviewed at the relevant Board Committees.

NHS Provider Licence

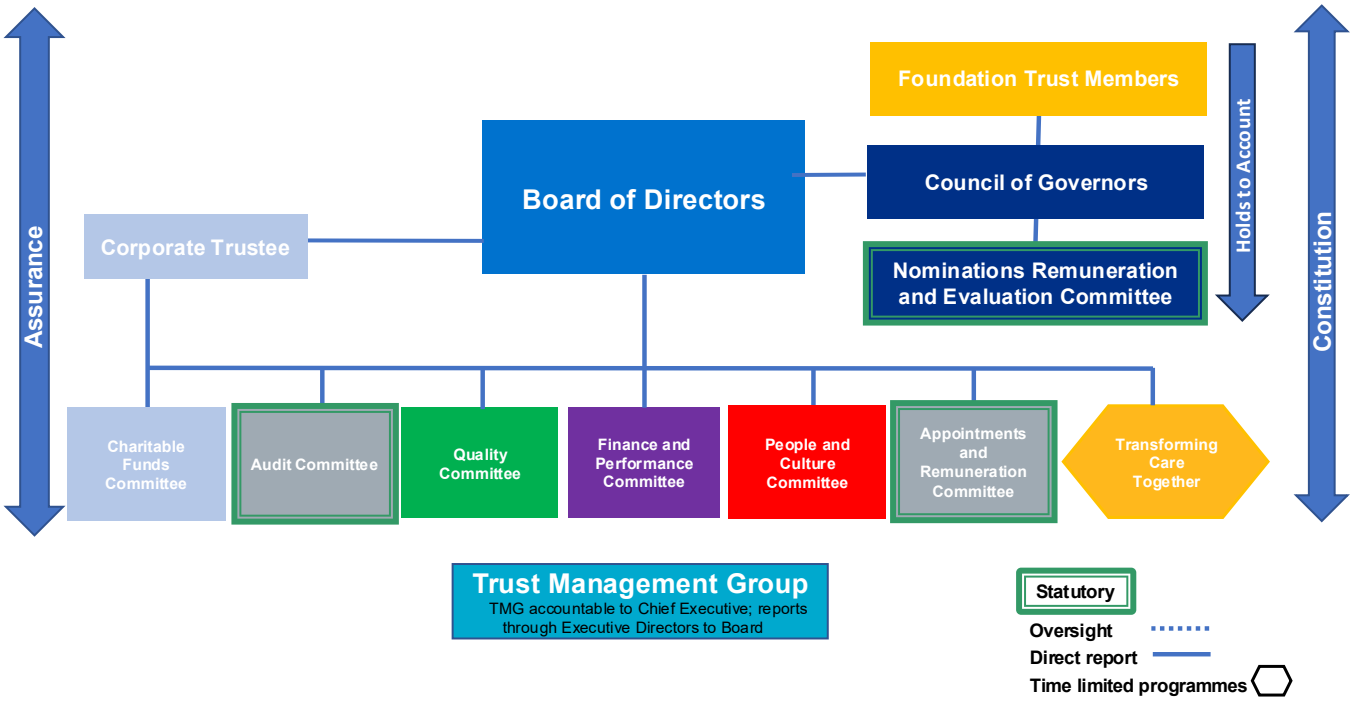
The NHS Provider Licence sets out specific responsibilities in relation to the Trust's governance arrangements. The Board of Directors is supported by a structured committee framework that provides scrutiny, challenge and assurance across key areas of activity.

Our assurance Committees are: Audit, Quality, Finance and Performance and People and Culture with membership of these Committees comprising non-executive directors and executive directors. Other executive directors and invitees - including representatives from the Integrated Care Board, 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 and 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 67.

The Board of Directors considers statements relating to compliance with the NHS Provider Licence on an annual basis, supported by issues and areas of concern highlighted through routine performance and assurance reporting throughout the year. Annual compliance with the principles of good corporate governance and the detailed provisions of the NHS Code of Governance for Provider Trusts is reviewed as part of the formal disclosure included within this Annual Report.

In addition, the Board of Directors undertakes regular reviews of its governance structures, including the effectiveness and performance of its committees, to ensure that the information presented enables clear identification of key performance risks, risks to compliance with the Provider Licence, and risks associated with local and national requirements, including the Trust's own performance objectives. Appraisals of both non-executive directors and executive directors are undertaken annually, with objectives agreed and development plans established to support effective leadership, governance and continuous improvement.



During 2025/26, the Trust delivered the Organising for Success corporate programme, which aimed to strengthen and align governance arrangements across the organisation. The programme focused on clearly defining roles, responsibilities and accountability at every level to support effective delivery of the governance framework. As a result, standardised document templates were introduced, governance cycles were aligned for groups reporting to the Trust Management Group and Board committees, and a clearer, more structured approach to information flow through the organisation was established. This has improved consistency, clarity and assurance within governance and decision-making processes.

Workforce strategies and staffing systems

People Strategy

During 2025/26, the Trust's People Strategy provided the overarching framework for workforce planning and staffing assurance. The strategy aligned local workforce priorities with the NHS People Plan, the NHS People Promise and emerging national workforce policy, and was refreshed to reflect future service requirements and system-wide change. It set clear ambitions to strengthen workforce capacity, capability and retention, ensuring the Trust continued to deliver safe and effective care during a period of sustained operational pressure. The Board received assurance that workforce strategy remained integral to the Trust's strategic planning and system of internal control.

Health and wellbeing

The Trust maintained a comprehensive health and wellbeing offer to support workforce resilience and sustainability. This included occupational health, musculoskeletal services, psychological support and proactive wellbeing initiatives, all of which contributed to stabilising sickness absence levels and supporting earlier return to work where appropriate. These arrangements supported the Board's assurance that staff wellbeing was actively managed as a core enabler of safe and sustainable staffing, consistent with the principles of the Developing Workforce Safeguards guidance.

Staff networks

Staff networks and champion roles played an important role in strengthening staff engagement, inclusion and psychological safety across the organisation. These forums enabled staff to share lived experience, influence workforce priorities and shape improvement actions. The Board received assurance that staff voice was systematically embedded through established engagement routes, providing visibility of workforce risks and supporting a culture of openness, inclusion and continuous improvement.

Joint working

Workforce policies and employment practices were developed and reviewed in partnership with trade unions and staff-side representatives. Formal joint working arrangements supported fairness, consistency and compliance with employment standards, with policies approved through established governance routes. This approach provided assurance to the Board that workforce decisions were informed, transparent and aligned with best practice and national expectations.

Workforce planning

Short, medium and long-term workforce planning arrangements were in place to assure the Board that staffing processes were safe, sustainable and effective. In the short term, workforce safety was supported through establishment management, proactive monitoring of sickness absence and turnover, and a focus on reducing reliance on temporary staffing. In the medium term, sustainability was strengthened through leadership development, appraisal quality improvement and systematic use

of staff survey and People Pulse feedback within service delivery and performance reviews. In the long term, workforce planning focused on talent development, inclusion and future leadership capability, supporting the Trust's ability to attract, retain and develop a workforce fit for future service needs.

System-wide projects

The Trust's Workforce Strategy was aligned with system-wide service transformation and emerging national workforce priorities. Workforce considerations formed part of broader organisational and system-level projects, ensuring that staffing implications of service redesign were identified early and managed appropriately. This approach provided further assurance that workforce risks were considered alongside quality, safety and operational change at both Trust and system level.

Ongoing recruitment and retention initiatives
The Trust continued to prioritise recruitment and retention as key components of workforce sustainability. Growth in substantive staffing and a reduction in reliance on bank staff improved continuity of care and workforce stability during the year. Targeted retention activity, leadership development and enhanced staff engagement supported improvements in turnover during the latter part of the year. These arrangements contributed to the Board's assurance that recruitment and retention risks were actively managed and that staffing systems remained effective and financially sustainable.

Care Quality Commission (CQC) registration requirements

The Trust considers that it remained compliant with the registration requirements of the CQC during 2025/26. In September 2025, the CQC carried out an inspection of Maternity Services at RBH, with inspection visits on 16 and 27 September 2025. The final report was published on 27 March 2026 and rated the Maternity Service as 'Requires Improvement'.

The inspection identified a number of areas requiring improvement, including inconsistent staffing of the maternity advice line, delays to the induction of labour process, and the cancellation of some elective caesarean sections due to workforce and theatre capacity constraints. The Trust recognises these findings and has taken responsibility for addressing the underlying causes, with clear improvement actions, ownership and oversight through established quality governance arrangements.

The inspection also highlighted areas of good practice that provide assurance over the quality and safety of care. The service met all 10 standards in a review of monitoring babies during labour, early booking rates exceeded national targets helping women begin pregnancy care earlier, and women reported positive, person-centred experiences of care. Inspectors noted the availability of specialist midwives to support vulnerable women, the presence of consultant obstetricians for complex births, and facilities that enabled partners to remain with women throughout their care.

The Trust is actively using both the challenges and strengths identified by the CQC to drive continuous improvement. Progress against CQC action plans is monitored through executive and Board-level governance structures, ensuring sustained focus on safe, effective and compassionate maternity care and ongoing compliance with regulatory requirements.

Conflicts of interest

The Foundation 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 Foundation 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

The Board of Directors is responsible for ensuring the economy, efficiency and effectiveness of the Trust's use of resources. This is supported by robust systems of internal control designed to ensure that resources are applied appropriately and effectively. The Trust operates within an established framework of key financial policies, supported by a clear Scheme of Delegation and Standing Financial Instructions that define financial authority and accountability.

The Trust has established systems to set, review and deliver strategic and operational objectives, to engage with patients, staff, members and other stakeholders, to monitor and improve organisational performance, and to develop and deliver efficiency improvement plans. Each year, the Board agrees a set of corporate objectives which are communicated internally and publicly and form the basis for performance management and review.

Operational performance is monitored continually by the Executive Team and through formal oversight by the Finance and Performance Committee and the Board of Directors, supported by the Strategy Deployment Review process. Delivery of the annual objectives is reviewed at each public Board meeting through consideration of an Integrated Performance Report, providing assurance across patient safety, quality, access, experience and financial performance.

In discharging its responsibilities for economy, efficiency and effectiveness, the Board is supported by the work of the Audit Committee and draws assurance from internal audit and the external auditor's work on the Trust's value for money arrangements, including their annual audit findings and recommendations.

During 2025/26, internal audits have included:		
Audit	**Design**	**Effectiveness**
Salary errors	**Moderate**	**Moderate**
KFS - drugs spend	**Moderate**	**Limited**

The Trust incorporates quality impact assessments within its cost improvement programme, ensuring that efficiency initiatives are explicitly linked to the maintenance and improvement of quality and patient safety. Executive and senior managers are accountable for the effective management and deployment of staff and other resources within their areas of responsibility, maximising efficiency while maintaining safe and effective services.

In support of longer-term financial sustainability, the Trust continues to work in partnership with other provider organisations and commissioners across Dorset. This includes collaborative planning through the Clinical Services Review and wider system-level initiatives, enabling coordinated decision making and more resilient service delivery across the local health and care system.

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 2026, the Trust notified the Information Commissioner's Office (ICO) of four information governance related incidents, using the Data Security Incident Reporting Tool. In all cases, the ICO has closed the report and confirmed that no further investigation is required.

One incident involved a group of patients being contacted by email regarding their care, where the email addresses of recipients were added to the 'To' box instead of the 'Bcc' box, meaning that all recipients could see each other's email addresses. This led to the indirect disclosure of confidential information. Processes within the department have been amended as a result.

One incident related to results of blood-borne virus (BBV) testing being sent into the local shared care record (Dorset Care Record), in contravention of advice from NHS England on managing these test results. As a result, this flow of data was stopped, and all previously shared results were retracted from the shared record.

One incident related to inappropriate access to medical records, where appropriate action was taken against the person in question.

The final incident related to a letter containing a patient's medical results being sent to the incorrect address, resulting in the submission of a formal complaint. This was the result of human error, and departmental processes have been updated accordingly.

The Data Security Protection Toolkit (DSPT) is a mandatory annual self-assessment audit produced by NHS England. In 2025/26 the DSPT provided acute trusts with numerous assertions to which a response was required by the end of June 2026, 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 2025/26 publication on 30 June 2026, 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 as at the time of the audit and, where necessary, to identify how compliance could be improved for the year end return. All suggested actions have now been completed.

Data quality and governance

The Trust reports elective waiting times throughout the year through nationally mandated submissions and regular internal reporting to committees and governance forums, including the Finance and Performance Committee and the Trust Board. Waiting list validation processes are routinely undertaken to confirm the accuracy of waiting time data for patients awaiting assessment or treatment.

Teams are supported through targeted training delivered by the IT Training Team, with additional specialist support provided by the Patient Access Team where data quality concerns are identified or where further assistance is requested. A range of national and internal reports is used to identify potential data quality issues and areas for improvement.

The Trust also submits data to the LUNA (List Validation and Analytics) health system, operated by North of England Commissioning Support (NECS), which supports assurance over elective waiting list data quality, pathway risks and system-wide performance. In parallel, a well established clinical harm review process is in place to assess the risks and potential harm associated with prolonged waits, with significant risks recorded and monitored through 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 of the effectiveness of the System of Internal Control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation 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.

See our patients sooner

During 2025/26, internal audits have included:

Audit	Design	Effectiveness
Harm investigation action plans	**Moderate**	**Moderate**
Data quality	**Moderate**	**Moderate**
Outpatient Did Not Attend process	**Moderate**	**Moderate**

2025/26 Internal Audit Plan

BDO provides the Trust's internal audit service. The Internal Audit Plan is developed through engagement with executive directors and is presented to the Audit Committee for review and approval. The plan is maintained under continuous review throughout the year and is informed by a multi-year planning approach, ensuring that all key risk areas are subject to internal audit coverage over a rolling three-year cycle.

The Internal Audit Programme adopts a risk based approach, using the Trust's Risk Management Framework and risk register as the primary basis for audit planning. This ensures that audit activity is aligned to the Trust's assessment of the principal risks to achieving its strategic objectives and provides appropriate assurance over the effectiveness of key systems of control.

Internal Audit Opinion

Internal Audit is required to provide an opinion to the Trust 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. Our opinion is as follows: ***Generally satisfactory with improvements required in some areas****.*

Overall, the controls in the areas reviewed were generally appropriately designed, supported by established governance frameworks and structured reporting arrangements. However, the effectiveness of these controls in practice was variable, with identified weaknesses in implementation, monitoring and follow-through which, if not addressed, may impact the achievement of organisational objectives.

The 2025/26 Internal Audit Programme included assessment of controls across a range of strategic, clinical, operational and financial areas. This work provided assurance on the effectiveness of key systems and processes supporting the delivery of the Trust's objectives.

The Trust's Accountability Framework underpins delivery of the Annual Operational Plan and sets out the core governance structures and processes that support achievement of the Trust's vision, strategic themes, objectives and enabling programmes. The framework supports leaders, managers and staff in delivering continuous improvement and achieving high-quality services and outcomes for patients, service users and local communities.

As described above, the Integrated Quality and Performance Report provides the Board with an overview of performance against key metrics and actions, aligned to the Trust's strategic objectives and informed by the CQC's well-led domains.

During the year, the Audit Committee also held development sessions to identify opportunities to further enhance and strengthen risk management arrangements from ward to Board. These areas will form a focus for continued development in the coming year.

The annual Clinical Audit Plan, approved by the Trust Management Group, sets out the programme of clinical audit activity for the year and is overseen through the Clinical Audit and Effectiveness Group, Quality Committee and Audit Committee. The plan meets national clinical audit requirements while reflecting local priorities. Clinical audits are reviewed through the Clinical Audit and Effectiveness Group, with learning and good practice is shared via specialty and directorate governance forums, the Trust Clinical Governance Group and the Trust Management Group. The Quality Committee receives regular updates on progress against the plan and assurance regarding any risks associated with compliance with national or local audit requirements.

Conclusion

Based on Department of Health guidance and the views of both internal and external auditors, the Board of Directors has not identified any significant weaknesses in internal control at this time.

Siobhan Harrington
Chief Executive
17 June 2026

Consolidated Financial Statements

For the year ended 31 March 2026

Contents

The Foundation Trust

NHS Foundation Trust Code:	**R0D**	
Registered Office:	**Poole Hospital** Longfleet Road Poole BH15 2JB	
Executive Directors:	**Siobhan Harrington**	Chief Executive Officer
	Dr Peter Wilson	Chief Medical Officer
	Sarah Herbert	Chief Nursing Officer
	Mark Mould	Chief Operating Officer
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy and Transformation Officer
	Melanie Whitfield	Chief People Officer
	Beverley Bryant	Chief Digital Officer
Non-executive directors:	**Judy Gillow MBE**	Interim Chair
	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
	Dr Michael Marsh MBE	Non Executive Director
	Alastair Matthews	Non Executive Director
	Andrew Doe	Associate Non Executive Director
	Prof. Alison Honour	Associate Non Executive Director
Trust Secretary:	**Klaudia Zwolinska**	
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 2026, have been prepared by University Hospitals Dorset NHS Foundation Trust (the “Foundation Trust”) in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Siobhan Harrington
Chief Executive Officer
17 June 2026

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 and
- 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
17 June 2026

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 2026 which comprise the Group and Trust Statement of Comprehensive Income, the Group and Trust Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Group and Trust Statement of Cashflows, 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 2026 and of the Group's and Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; 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 Trust's services or dissolve the Group and Trust without the transfer of their 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 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 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 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, including the internal audit function, and the Trust's channel for "whistleblowing", 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 Trust by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Group's accounting policies.

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 nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Group 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 non-pay expenditure recognition, particularly in relation to year-end accruals.

We 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 journal entries with unusual characteristics compared to the total journal population.
- Inspecting a sample of invoices of expenditure and cash payments, in the period post 31 March 2026, to determine whether expenditure has been recognised in the appropriate accounting period.

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 and employment law recognising the nature of the Group and 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 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 126, 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 Group and 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 Group and Trust or dissolve the Group and Trust without the transfer of its services to another public sector entity.

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 130, 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.

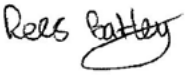
The purpose of our audit work and to whom we owe our responsibilities

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 2026 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 University Hospitals Dorset NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

24 June 2026

Statement of Comprehensive Income

		Group		Trust	
	Notes	**2025/26**	2024/25	**2025/26**	2024/25
		£'000	£'000	**£'000**	£'000
Operating income from patient care activities	4	**916,205**	843,553	**916,205**	842,699
Other operating income	4	**70,166**	68,665	**64,613**	63,565
Operating expenses of continuing operations	7	**(1,014,029)**	(986,224)	**(1,007,251)**	(982,090)
Operating (deficit) / surplus		**(27,658)**	(74,006)	**(26,433)**	(75,826)
Finance income	12	**5,114**	6,477	**4,717**	5,547
Finance expense	13	**(807)**	(1,206)	**(807)**	(1,206)
Public Dividend Capital: Dividends payable		**(12,936)**	(11,469)	**(12,936)**	(11,469)
Net finance costs		**(8,629)**	(6,198)	**(9,026)**	(7,128)
Other gains / (losses)		**-**	(69)	**-**	(69)
Movement in fair value of investment property and other investments		**8,001**	116	**7,144**	-
Profit / (Loss) from Joint Venture	12.2	**1,039**	1,045	**1,039**	1,045
Deficit for the year		**(27,247)**	(79,112)	**(27,276)**	(81,978)
Other comprehensive Income					
Impairment (chargeable to revaluation reserve)		**(14,021)**	(39,176)	**(14,021)**	(39,176)
Revaluation (taken to revaluation reserve)		**1,260**	8,817	**1,260**	8,851
Other reserve movements		**130**	25	**-**	-
Total comprehensive income for the year		**(39,878)**	(109,446)	**(40,037)**	(112,303)

The notes on pages 15 to 58 form part of these accounts.

Statement of Financial Position

		Group		Trust	
	Notes	**31 March 2026**	31 March 2025	**31 March 2026**	31 March 2025
		£'000	£'000	**£'000**	£'000
Non-current assets					
Intangible assets	14	**34,739**	16,519	**34,739**	16,519
Property, plant and equipment	14	**656,524**	555,410	**656,410**	555,289
Right of use assets	15	**11,135**	12,059	**11,135**	12,059
Investment property	12.4	**9,430**	11,554	**9,430**	11,554
Investments in LLP Joint Venture	12.2	**643**	232	**643**	232
Other Investments	12.3	**9,340**	8,483	**-**	-
Trade and other receivables	19	**656**	827	**656**	827
Total non-current assets		**722,467**	605,084	**713,013**	596,480
Current assets					
Inventories	18	**10,289**	9,934	**10,289**	9,934
Trade and other receivables	19	**26,824**	20,190	**27,434**	19,303
Cash and cash equivalents	20	**149,824**	113,227	**133,194**	98,603
Total current assets		**186,937**	143,351	**170,917**	127,840
Current liabilities					
Trade and other payables	21	**(152,007)**	(106,091)	**(147,476)**	(102,760)
Borrowings	23	**(3,372)**	(3,315)	**(3,372)**	(3,315)
Provisions	25	**(4,350)**	(893)	**(4,350)**	(893)
Other liabilities	22	**(3,679)**	(1,872)	**(3,679)**	(1,872)
Total current liabilities		**(163,408)**	(112,171)	**(158,877)**	(108,840)
Total assets less current liabilities		**745,996**	636,264	**725,053**	615,480
Non-current liabilities					
Borrowings	23	**(36,283)**	(39,508)	**(36,283)**	(39,508)
Provisions	25	**(1,963)**	(2,233)	**(1,963)**	(2,233)
Other liabilities	22	**(690)**	(723)	**(690)**	(723)
Total non-current liabilities		**(38,936)**	(42,464)	**(38,936)**	(42,464)
Total assets employed:		**707,060**	593,800	**686,117**	573,016
Taxpayers' equity					
Public Dividend Capital		**738,252**	585,114	**738,252**	585,114
Revaluation reserve		**37,315**	51,887	**37,315**	51,887
Income and expenditure reserve		**(89,450)**	(63,985)	**(89,450)**	(63,985)
BPHT(1) Charitable Fund Reserve		**-**	2,819	**-**	-
BPHT NHS Charitable Fund Reserve	35	**2,956**	-	**-**	-
UHD NHS Charitable Fund Reserve	35	**17,987**	17,965	**-**	-
Total Taxpayers' equity:		**707,060**	593,800	**686,117**	573,016

The notes on pages 15 to 58 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 17 June 2026 and signed on its behalf by:

Siobhan Harrington, Chief Executive Officer, 17 June 2026

Statement of Changes in Taxpayers' Equity

	Trust				BPHT (1) Charity	BPHT Charity	UHD NHS Charity	Group
	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Trust Reserves	Charitable Fund Reserve	Charitable Fund Reserve	Charitable Fund Reserve	Total Reserves
Current Year	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Taxpayers' Equity at 1 April 2025	**585,114**	**51,887**	**(63,985)**	**573,016**	**2,819**	**-**	**17,965**	**593,800**
Surplus /(Deficit) for the year	-	-	(27,276)	(27,276)	-	-	22	(27,247)
Transfers between reserves	-	(1,811)	1,811	-	(2,819)	2,819	-	-
Impairment losses on property, plant and equipment	-	(14,021)	-	(14,021)	-	-	-	(14,021)
Revaluations of property, plant and equipment	-	1,260	-	1,260	-	-	-	1,260
Public Dividend Capital received	159,161	-	-	159,161	-	-	-	159,161
Public Dividend Capital repayed	(6,023)	-	-	(6,023)	-	-	-	(6,023)
Other movements	-	-	-	-	-	130	-	130
Taxpayers' Equity at 31 March 2026	**738,252**	**37,315**	**(89,450)**	**686,117**	**-**	**2,956**	**17,987**	**707,060**

	Trust				BPHT (1) Charity	BPHT Charity	UHD NHS Charity	Group
	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Trust Reserves	Charitable Fund Reserve	Charitable Fund Reserve	Charitable Fund Reserve	Total Reserves
Prior Year	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Taxpayers' Equity at 1 April 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 on property ,plant and equipment	-	8,851	-	8,851	-	-	(34)	8,817
Public Dividend Capital received	138,364	-	-	138,364	-	-	-	138,364
Public Dividend Capital repayed	(12,251)	-	-	(12,251)	-	-	-	(12,251)
Other movements	-	-	-	-	25	-	-	25
Taxpayers' Equity at 31 March 2025	**585,114**	**51,887**	**(63,985)**	**573,016**	**2,819**	**-**	**17,965**	**593,800**

The notes on pages 15 to 58 form part of these accounts.

Statement of Cash Flows

	Notes	Group				Trust			
		2025/26		2024/25		2025/26		2024/25	
		£'000		£'000		£'000		£'000	
Cash flows from operating activities									
Operating surplus from continuing operations			(27,658)		(74,006)		(29,649)		(75,826)
Operating surplus/(Deficit)			(27,658)		(74,006)		(29,649)		(75,826)
Non-cash income and expense									
Depreciation and amortisation	14	37,022		30,838		37,019		30,834	
Impairments / Reversal of Impairments	14	32,241		81,517		32,237		81,517	
Non-cash donations/grants credited to income		(1,943)		(1,256)		(1,943)		(1,256)	
(Increase)/Decrease in Trade and Other Receivables		(4,010)		7,865		(3,777)		8,026	
(Increase)/Decrease in Inventories		(354)		(1,063)		(354)		(1,063)	
Increase/(Decrease) in Trade and Other Payables		18,527		(2,084)		23,505		(2,119)	
Increase/(Decrease) in Other Liabilitiies		1,774		(921)		1,774		(921)	
(Increase)/Decrease in provisions		3,155		(675)		3,155		(675)	
NHS Charitable Funds - net adjustments for working capital movements and non-cash transactions		3,695		(455)		(1,524)		-	
			90,107		113,766		90,092		114,343
Net cash flow from operations			62,449		39,760		60,443		38,517
Cash flow from investing activities									
Interest received		4,717		5,547		4,717		5,547	
Purchase of intangible assets		(23,292)		(322)		(23,292)		(322)	
Purchase of property, plant and equipment		(141,766)		(162,640)		(141,766)		(162,640)	
Cash donations to purchase capital assets		1,943		1,256		1,943		1,256	
Net cash flow from investing activities			(158,398)		(156,159)		(158,398)		(156,159)
Cash flow from investing activities									
Public dividend capital received		159,161		138,364		159,161		138,364	
Public dividend capital repaid		(6,023)		(12,251)		(6,023)		(12,251)	
Loans received and repaid		(2,273)		(2,925)		(2,273)		(2,925)	
Capital element of finance lease rental payments		(943)		(1,164)		(943)		(1,164)	
Interest on DHSC loans		(653)		(1,012)		(653)		(1,012)	
Interest element of finance lease		(129)		(136)		(129)		(136)	
PDC Dividend paid		(16,594)		(9,676)		(16,594)		(9,676)	
			132,546		111,200		132,546		111,200
Net increase in cash and cash equivalents			36,597		(5,199)		34,591		(6,442)
Cash and cash equivalents at 1 April			113,227		118,426		98,603		105,045
Cash and cash equivalents at end of year	20		149,824		113,227		133,194		98,603

The notes on pages 15 to 58 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 2025/26 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. 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:

- A net downwards revaluation of land and buildings of £32.2m has been charged to the revaluation reserve, with a further £14m 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 Trusts external valuers.
- The valuation exercise was carried out in March 2026 with a valuation date of 31 March 2026. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'). This interim revaluation included physical onsite attendance.

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 2025/26:

- The DHSC GAM does not require the following Standards and amendments to be applied in DHSC group accounts 2025/26:
- 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 UKendorsed 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.

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; and
- eliminate intra-group transactions, balances, gains and losses.

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 costs 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 Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such 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 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 Where research contracts fall under IFRS 15, revenue is recognised as and when performamce obligations are satified. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligtion 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 outsources the operating of car parking services for employees and patients. Revenue is recognised on a straight-line basis over the term of the contract including an annual reconciliation.

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 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 NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**.
Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the

economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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 desktop valuation (excluding Assets Under Construction/ Work In Progress) was undertaken as at 31 March 2026. 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.

Key factors impacting on the land and property valuation

In arriving at the replacement build cost rates used in the DRC Desktop Update valuations, the valuer has used the RICS Building Costs Information Service 'All In' Tender Price Index, together with a Location Factor, and adjusted the remaining useful lives for each element within a building to take account of the anticipated physical depreciation since the previous valuation. The indices used are shown below:

- All in' Tender Price Index (TPI) - 411
- Location Factor - 98

A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality, given the estimation uncertainty implicit in the valuation.

The table below sets out the impact of a high level sensitivity of these key assumptions on the 31 March 2026 valuation of £365.9m. A 1% movement in the TPI and Location Factor assumptions would not result in a material

Assumption	Baseline Assumption	Sensitivity Assumption +1%	+1% Impact on Valuation £m	Sensitivity Assumption -1%	-1% Impact on Valuation £m
TPI	411	415	3.3	407	-3.3
Location Factor	98	99	3.3	97	-3.3

	Minimum life (years)	Maximum life (years)
Buildings and dwellings	1	100
Furniture/fittings	5	20
Set-up costs	5	15
Medical and other equipment	5	15
Vehicles	7	15
Radiology equipment	5	15
IT equipment	2	10

impact.

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 on the table above.

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 2026, 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'.

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 twelve months of the date of the classification as 'Held for Sale'; and
  - 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; and

- 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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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 live of assets are summarised below:

	Minimum (years)	Maximum (years)
Software	2	7

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.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 24 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 in Note 24. 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

Public dividend capital (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 (iiv) 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 20 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 it's 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.

The Board has considered the Trust's overall financial position against the requirements of IAS1, and are satisified there is sufficient evidence the Trust will continue as a going concern.

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 2025/26.

2 Operating segments

The Foundation Trust has determined the operating segments based on the reports reviewed by the Trust Board that are used to make strategic decisions. The Trust Board 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 Trust Board for the reportable segments for the year ended 31 March 2026 is as follows:

	Group		Trust	
	Healthcare 2025/26	Healthcare 2024/25	**Healthcare 2025/26**	Healthcare 2024/25
	£'000	£'000	**£'000**	£'000
Segment revenue	**986,371**	912,218	**980,818**	906,264
Patient and other income	**986,371**	912,218	**980,818**	906,264

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 (by nature)

	Group	
	Continuing Operations 2025/26	Continuing Operations 2024/25
	£'000	£'000
Acute services		
Income from commissioners under API contracts - variable element	**125,450**	184,753
Income from commissioners under API contracts - fixed element	**624,345**	539,615
High cost drugs income from commissioners	**72,122**	70,912
Other NHS clinical income	**6,159**	5,602
Private patient income	**3,943**	5,119
National pay award central funding*	**-**	1,995
Additional pension contribution central funding**	**37,519**	35,557
Other clinical income	**46,667**	-
Total income from activities	**916,205**	843,553

*Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

**Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

4.2 Income from patient related activities (by source)

	Group		Trust	
	Continuing Operations 2025/26	Continuing Operations 2024/25	**Continuing Operations 2025/26**	Continuing Operations 2024/25
	£'000	£'000	**£'000**	£'000
Foundation Trusts and NHS Trusts	**4,081**	6,327	**4,081**	6,327
Integrated Care Boards	**798,930**	659,172	**798,930**	659,172
NHS England	**106,738**	170,401	**106,738**	170,401
NHS Other	**192**	215	**192**	215
Non NHS:				
- Private patients	**3,943**	5,119	**3,943**	4,265
- Overseas patients (non-reciprocal)	**295**	327	**295**	327
- NHS Injury Scheme income	**1,994**	1,968	**1,994**	1,968
- Other	**32**	24	**32**	24
	916,205	843,553	**916,205**	842,699

The Trust recognises a notional income amount of £37,519,000 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 24.62% doubtful debt provision is included in expenditure, which represents expected recovery rates.

4.3 Other operating income

	Group		Trust	
	Continuing Operations 2025/26	Continuing Operations 2024/25	**Continuing Operations 2025/26**	Continuing Operations 2024/25
	£'000	£'000	**£'000**	£'000
Research and development	**4,939**	5,189	**4,939**	5,189
Education and training	**30,335**	28,046	**30,335**	28,046
Cash grants for the purchase of capital assets - received from other bodies	**1,943**	1,256	**1,943**	1,256
Charitable and other contributions to expenditure - received from other bodies	**3,301**	2,918	**3,301**	2,918
NHS Charitable Funds: Incoming resources excluding investment income	**5,553**	5,100	**-**	-
Non-patient care services to other bodies	**9,845**	8,528	**9,845**	8,528
Education and training - notional income from apprenticeship fund	**1,701**	1,669	**1,701**	1,669
Top up			**-**	-
Other:				
- NHS drug sales	**135**	122	**135**	122
- Car parking	**3,584**	2,760	**3,584**	2,760
- Catering services	**2,401**	2,379	**2,401**	2,379
- Miscellaneous other	**4,218**	8,690	**4,218**	8,690
Income from operating leases	**2,211**	2,008	**2,211**	2,008
	70,166	68,665	**64,613**	63,565
Total	**986,371**	912,218	**980,818**	906,264

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	
	2025/26	2024/25	**2025/26**	2024/25
	£'000	£'000	**£'000**	£'000
Commissioner requested services	**946,540**	871,599	**946,540**	870,745
Non commissioner requested services	**39,831**	40,619	**34,278**	35,519
	986,371	912,218	**980,818**	906,264

7 Operating expenses

7.1 Operating expenditure

	Group		Trust	
	Continuing Operations 2025/26	Continuing Operations 2024/25	**Continuing Operations 2025/26**	Continuing Operations 2024/25
	£'000	£'000	**£'000**	£'000
Purchase of healthcare from NHS and DHSC bodies	**3,977**	5,417	**3,977**	5,417
Purchase of healthcare from non-NHS and non-DHSC bodies	**19,982**	14,499	**19,982**	14,499
Purchase of social care	**-**	7	**-**	7
Employee expenses - executive directors	**1,958**	1,878	**1,958**	1,878
Employee expenses - non-executive directors	**202**	188	**202**	188
Employee expenses - staff	**607,858**	571,126	**607,858**	571,126
Employee expenses - redundancy	**13**	7	**13**	7
Employee expenses - notional employer contributions paid by NHSE (6.3%)	**37,519**	35,557	**37,519**	35,557
Supplies and services - clinical (excluding drug costs)	**77,838**	73,097	**77,838**	73,097
Supplies and services - general	**16,808**	15,535	**16,808**	15,535
Establishment	**4,828**	5,034	**4,828**	5,034
Research and development (excluding employee expenses)	**93**	87	**93**	87
Education and training - non-staff costs	**2,998**	2,828	**2,998**	2,828
Education and training - notional expenditure funded from apprenticeship fund	**1,701**	1,669	**1,701**	1,669
Transport (staff travel)	**496**	500	**496**	500
Transport (patient transport services)	**1,011**	1,003	**1,011**	1,003
Premises - rates	**4,937**	3,516	**4,937**	3,516
Premises	**32,474**	26,941	**32,474**	26,941

	Group		Trust	
	Continuing Operations 2025/26	Continuing Operations 2024/25	**Continuing Operations 2025/26**	Continuing Operations 2024/25
	£'000	£'000	**£'000**	£'000
Movement in credit loss allowance: all other receivables and investments	**157**	(76)	**157**	(76)
Movement in credit loss allowance: contract receivables/assets	**263**	281	**263**	281
Provisions arising/released in year	**214**	(39)	**214**	(39)
Change in provisions discount rate(s)	**(57)**	6	**(57)**	6
Drug costs	**89,853**	87,286	**89,853**	87,286
Operating lease payments	**1**	8	**1**	8
Depreciation on property, plant and equipment	**31,949**	26,916	**31,946**	26,912
Amortisation on intangible assets	**5,073**	3,922	**5,073**	3,922
Impairments net of (reversals)	**32,241**	81,517	**32,237**	81,517
Audit fees:				
External audit services - financial statement audit	**185**	174	**185**	174
External audit services - charitable fund accounts	**7**	7	**-**	-
Internal Audit and Counter Fraud	**200**	196	**200**	196
Clinical negligence premium	**18,049**	16,650	**18,049**	16,650
Legal fees	**398**	638	**398**	638
Insurance (as a policy holder)	**804**	597	**804**	597
Other services	**10,809**	5,820	**13,133**	5,080
Losses, ex gratia and special payments	**102**	49	**102**	49
NHS Charitable funds: Other resources expended (balance not analysed above)	**9,088**	3,383	**-**	-
Total	**1,014,029**	986,224	**1,007,251**	982,090

The Trust has made no donations/contributions to any political party.

7.2 Other auditor remuneration

All remuneration paid to the external auditor was in relation to the audit of the financial statements of the Trust and it's Charitable Funds as identified above.

7.3 Limitation on auditor's liability

There is no limitation on auditor's liability for the external audit work carried out for the financial years 2025/26 or 2024/25.

8 Operating leases

8.1 Operating leases, as lessee

	Group	Trust
	2025/26	2024/25
	£'000	£'000
Total operating leases	**1**	8
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
Lease ending:		
No later than one year	**-**	-
Total	**-**	-

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
	2025/26	2024/25
	£'000	£'000
Total operating leases	**2,211**	2,008
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
No later than one year	**-**	-
Total	**-**	-

9 Staff costs and numbers

9.1 Staff costs

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£'000	£'000	**£'000**	£'000
Salaries and wages	**488,616**	461,284	**488,616**	461,284
Social security costs	**61,246**	46,919	**61,246**	46,919
Apprenticeship levy	**2,393**	2,269	**2,393**	2,269
Employer's contributions to NHS Pensions	**57,280**	54,333	**57,280**	54,333
Pension cost - other contributions	**37,519**	35,557	**37,519**	35,557
Agency/contract staff	**5,780**	13,641	**5,780**	13,641
Pension costs - other	**51**	72	**51**	72
Total	**652,885**	614,075	**652,885**	614,075

This note excludes non-executive directors, in line with national guidance.

9.2 Average number of persons employed

	2025/26	2024/25
	Number	Number
Medical and dental	1,398	1,443
Ambulance staff	1	1
Administration and estates	1,398	1,364
Healthcare assistants and other support staff	1,509	1,613
Nursing, midwifery and health visiting staff	2,845	2,821
Scientific, therapeutic and technical staff	2,428	2,421
Healthcare science staff	238	222
Total	**9,817**	9,885
Of which:		
Permanent	8,951	8,795
Other	866	1,090
Total	**9,817**	9,885

This note excludes non-executive directors, in line with national guidance.

10 Retirements due to ill-health

There were 16 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 £1,097,000. 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	
	2025/26	2024/25	**2025/26**	2024/25
			£'000	£'000
Interest on bank accounts	**4,717**	5,547	**4,717**	5,547
NHS charitable funds: investment income	**397**	930	**-**	-
Total	**5,114**	6,477	**4,717**	5,547

Government Banking Service interest is paid at 0.11% below the Bank of England Base rate.

12.2 Investment in joint ventures

	Group / Trust	
	2025/26	2024/25
	£'000	£'000
Opening balance	**232**	103
Share of profit / (loss)	**1,039**	1,045
Disbursements / dividends received	**(628)**	(916)
Closing balance	**643**	232

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 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'000	£'000	**£'000**	£'000
Opening balance	**8,483**	8,367	**-**	-
Movement in fair value	**857**	116	**-**	-
Closing balance	**9,340**	8,483	**-**	-

The Trust Charity has achieved an increase of £857,000 in it's investment holding in 2025/26. 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 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'000	£'000	**£'000**	£'000
Opening balance	**11,554**	-	**11,554**	-
Additions	**-**	11,554	**-**	11,554
Fair value gains	**7,144**	-	**7,144**	-
Reclassifications to PPE	**(9,268)**	-	**(9,268)**	-
Closing balance	**9,430**	11,554	**9,430**	11,554

The Trust's investment property relates to an office building and is measured at fair value of future economic benefits.

13 Finance costs

	Group / Trust	
	2025/26	2024/25
	£'000	£'000
Loans from the Independent Trust Financing Facility	**647**	1,036
Finance leases	**128**	136
Unwinding of discount on provisions	**32**	34
Total	**807**	1,206

14 Intangible assets, property, plant and equipment

	Group												Trust
	Intangible	Tangible									TOTAL		TOTAL
	Software Licences (incl Work in progess)	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	Trust Assets
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2025	47,147	18,738	329,486	15,147	127,569	155,123	668	48,808	14,718	139	757,543	139	757,404
Additions - purchased / internally generated	23,264	8,400	22,896	106	128,155	5,099	-	819	433	-	189,172	-	189,172
Additions - assets purchased from cash donations/grants	29	-	1,212	-	-	446	-	41	215	-	1,943	-	1,943
Impairments charged to operating expenses	-	(2,320)	(29,775)	(142)	-	-	-	-	-	(4)	(32,241)	(4)	(32,237)
Impairments charged to the revaluation reserve	-	(5)	(23,111)	(313)	-	-	-	-	-	-	(23,429)	-	(23,429)
Revaluations	-	980	185	95	-	-	-	-	-	-	1,260	-	1,260
Reclassifications	-	2,600	23,329	(470)	(45,366)	11,322	-	13,425	4,428	-	9,268	-	9,268
Disposals	-	-	-	-	-	(600)	-	-	-	-	(600)	-	(600)
Cost or valuation at 31 March 2026	**70,440**	**28,393**	**324,222**	**14,423**	**210,358**	**171,390**	**668**	**63,093**	**19,794**	**135**	**902,916**	**135**	**902,781**
Accumulated depreciation at 1 April 2025	30,628	-	9,019	470	-	103,010	515	36,725	5,229	18	185,614	18	185,596
Provided during the year	5,073	-	10,261	436	-	12,857	55	6,178	1,180	3	36,043	3	36,040
Impairments - Revaluation reserve	-	-	(9,359)	(49)	-	-	-	-	-	-	(9,408)	-	(9,408)
Reclassifications	-	-	341	(421)	-	55	-	-	25	-	-	-	-
Disposals	-	-	-	-	-	(596)	-	-	-	-	(596)	-	(596)
Accumulated depreciation at 31 March 2026	**35,701**	**-**	**10,262**	**436**	**-**	**115,326**	**570**	**42,903**	**6,434**	**21**	**211,653**	**21**	**211,632**
Net book value													
Owned	34,739	28,393	302,957	13,987	210,358	52,478	63	20,104	12,887	114	676,080	114	675,966
Donated	-	-	11,003	-	-	3,586	35	86	473	-	15,183	-	15,183
NBV total at 31 March 2026	**34,739**	**28,393**	**313,960**	**13,987**	**210,358**	**56,064**	**98**	**20,190**	**13,360**	**114**	**691,263**	**114**	**691,149**

14 Intangible assets, property, plant and equipment prior year

	Group												Trust
	Intangible	Tangible									TOTAL		TOTAL
	Software Licences (incl Work in progess)	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	Trust Assets
	£'000	£'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	740,898
Additions - purchased / internally generated	314	-	15,678	268	125,101	1,592	-	121	-	-	143,074	-	143,074
Additions - assets purchased from cash donations/grants	8	-	140	-	448	622	19	8	11	-	1,256	-	1,256
Impairments charged to operating expenses	-	(2,899)	(78,618)	-	-	-	-	-	-	-	(81,517)	-	(81,517)
Impairments charged to the revaluation reserve	-	(17,835)	(29,777)	(584)	-	-	-	-	-	(34)	(48,230)	(34)	(48,196)
Reversal of impairments credited to operating expenses	-	33	(246)	213	-	-	-	-	-	-	-	-	-
Revaluations	-	148	8,519	184	-	-	-	-	-	-	8,851	-	8,851
Reclassifications	-	-	154,879	(467)	(166,976)	7,674	-	5,120	(392)	-	(162)	-	(162)
Disposals	(25)	-	-	-	-	(6,775)	-	-	-	-	(6,800)	-	(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	171,697
Provided during the year	3,922	-	8,964	470	-	11,534	54	3,990	878	4	29,816	4	29,812
Impairments - Revaluation reserve	-	-	(9,020)	-	-	-	-	-	-	-	(9,020)	-	(9,020)
Reclassifications	-	-	361	(467)	-	-	-	-	(56)	-	(162)	-	(162)
Disposals	(7)	-	-	-	-	(6,724)	-	-	-	-	(6,731)	-	(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	552,873
Donated	-	-	13,449	-	1,258	4,051	41	75	61	-	18,935	-	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**

15 Right of use assets

	Group / Trust			
	Tangible			TOTAL
	Property (land and buildings)	Plant and Machinery	Information Technology	Non Current Assets
	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2025	11,347	6,600	1,151	19,098
Additions - lease liability	23	32	-	55
Reclassifications	-	-	-	-
Disposals/derecognition - lease termination	-	-	-	-
Cost or valuation at 31 March 2026	**11,370**	**6,632**	**1,151**	**19,153**
Accumulated depreciation at 1 April 2025	1,854	4,131	1,054	7,039
Provided during the year - right of use asset	524	441	14	979
Reclassifications	-	-	-	-
Disposals/derecognition - lease termination	-	-	-	-
Accumulated depreciation at 31 March 2026	**2,378**	**4,572**	**1,068**	**8,018**
NBV total at 31 March 2026	**8,992**	**2,060**	**83**	**11,135**

The Foundation Trust leases various property, medical equipment and IT equipment under non-cancellable finance lease agreements. The remaining lease terms are between one and 29 years.

15 Right of use assets prior year

	Group / Trust			
	Tangible			TOTAL
	Property (land and buildings)	Plant and Machinery	Information Technology	Non Current Assets
	£'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 30 years.

16 Impairment of property, plant and equipment

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'000	£'000	**£'000**	£'000
Changes in market price (as advised by the Trust's external valuer)	**32,241**	81,517	**32,237**	81,517
Total net impairments charged to operating expenditure	**32,241**	81,517	**32,237**	81,517
Impairments charged to revaluation reserve	**14,021**	39,176	**14,021**	-
Total net impairments	**46,262**	120,693	**46,258**	81,517

17 Capital commitments

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	**£'000**
Property, plant and equipment	**47,938**	99,659
Intangible assets	**2,157**	2,161
Total	**50,095**	101,820

18 Inventories

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Drugs	**3,569**	3,416
Consumables	**6,720**	6,518
Total	**10,289**	9,934

18.1 Inventories recognised in expenses

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Inventories recognised as an expense in the period	**103,148**	102,526
Total	**103,148**	102,526

19 Trade and other receivables

19.1 Amounts falling due within one year:

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'000	£'000	**£'000**	£'000
Contract receivables (IFRS 15): invoiced	**8,387**	8,516	**8,387**	8,516
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**13,272**	6,782	**14,796**	7,015
Allowance for impaired contract receivables / assets	**(576)**	(585)	**(576)**	(585)
Allowance for impaired other receivables	**(2,376)**	(2,219)	**(2,376)**	(2,219)
Prepayments (revenue) [non-PFI]	**4,049**	4,936	**4,049**	4,936
PDC dividend receivable	**2,659**	-	**2,659**	-
VAT receivable	**433**	1,605	**433**	1,605
Clinician pension tax provision reimbursement funding from NHSE	**62**	35	**62**	35
NHS charitable funds: receivables	**914**	1,120	**-**	-
Total	**26,824**	20,190	**27,434**	19,303
Amounts falling due over one year:				
Clinician pension tax provision reimbursement funding from NHSE	**656**	827	**656**	827
Total	**27,480**	21,017	**28,090**	20,130

The provision for impairment of receivables relates to specific receivables.

19.2 Allowances for credit losses (doubtful debts)

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Contract receivables and contract assets:		
At 1 April	**585**	521
New allowances arising	**438**	428
Changes in the calculation of existing allowances	**4**	31
Reversals of allowances (where receivable is collected in-year)	**(179)**	(178)
Utilisation of allowances (where receivable is written off)	**(272)**	(217)
At 31 March	**576**	585
All other receivables:		
At 1 April	**2,219**	2,425
New allowances arising	**227**	503
Changes in the calculation of existing allowances	**-**	(349)
Reversals of allowances (where receivable is collected in-year)	**(70)**	(230)
Utilisation of allowances (where receivable is written off)	**-**	(130)
At 31 March	**2,376**	2,219

20 Cash and cash equivalents

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'000	£'000	**£'000**	£'000
Balance 1 April	**113,227**	118,426	**98,603**	105,109
Net movement in year	**36,597**	(5,199)	**34,591**	(6,506)
Balance at 31 March	**149,824**	113,227	**133,194**	98,603
Made up of:				
Cash at commercial banks and in hand	**16,660**	14,652	**30**	28
Cash with the Government Banking Service	**133,164**	98,575	**133,164**	98,575
Cash and cash equivalents	**149,824**	113,227	**133,194**	98,603

The patient monies amount held on trust was below £1,000, and is not included in the above figures.

21 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'000	£'000	**£'000**	£'000
Amounts falling due within one year:				
Trade payables	**31,429**	16,482	**31,429**	15,408
Capital payables (including capital accruals)	**44,650**	18,593	**44,650**	18,593
Accruals (revenue costs only)	**48,254**	47,005	**48,943**	47,005
Annual leave accrual	**640**	640	**640**	640
Social security costs	**7,101**	5,977	**7,101**	5,977
Other taxes payable	**6,748**	6,499	**6,748**	6,499
PDC dividend payable	**-**	999	**-**	999
Pension contributions payable	**7,965**	7,639	**7,965**	7,639
NHS Charitable funds: trade and other payables	**5,220**	2,257	**-**	-
Total	**152,007**	106,091	**147,476**	102,760

22 Other liabilities

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Amounts falling due within one year:		
Receipts in advance - Heart Club	**15**	15
Receipts in advance - Other	**3,664**	1,857
Total	**3,679**	1,872
Amounts falling due over one year:		
Receipts in advance - Heart Club	**690**	723
Total	**4,369**	2,595

23 Borrowings

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Finance lease liabilities		
- Current	**1,020**	955
- Non current	**10,227**	11,181
Total	**11,247**	12,136
Independent Trust Financing Facility (ITFF) Loan		
- Current	**2,352**	2,360
- Non current	**26,056**	28,327
Total	**28,408**	30,687

As at 31 March 2026, the Foundation Trust has three outstanding ITFF loans:

- £8.8m Christchurch Hospital site development
- £4.6m Poole Hospital capital programme
- £15m development of pathology facilities

The total loans figure above (£28,407,000) includes £79,000 of accrued interest. Further details are available in Note 28.

24 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 1-29 years. A summary of the Foundation Trust's right of use assets resulting from these finance leases is recorded in Note 15 in these accounts.

	Group / Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Amounts payable under finance leases		
Within one year	**1,133**	1,081
Between one and five years	**3,406**	3,657
After five years	**7,882**	8,695
Less future finance charges	**(1,174)**	(1,297)
Total	**11,247**	12,136

25 Provisions for liabilities and charges

	Group / Trust				
	£'000	£'000	£'000	£'000	**£'000**
	Early Retirement	Injury Benefit	Legal claims	Other	**Total**
Opening balance	88	1,253	545	1,240	**3,126**
Change in the discount rate	(1)	(56)	-	(55)	**(112)**
Arising during the year	41	1	645	3,609	**4,296**
Utilised during the year	(27)	(98)	(211)	(62)	**(398)**
Reversed unused	-	-	(226)	(451)	**(677)**
Unwinding of discount	2	30	-	46	**78**
At 31 March 2026	103	1,130	753	4,327	**6,313**
Expected timing of cashflows:					
Within one year	29	98	753	3,470	**4,350**
Between one and five years	74	392	-	408	**874**
After five years	0	640	-	449	**1,089**
	103	1,130	753	4,327	**6,313**

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 Clinican Pensions Tax Scheme has been created as at 31 March 2026 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.

£216,109,000 is included in the provisions of NHS Resolution at 31 March 2026 in respect of clinical negligence liabilities of the Foundation Trust.

The Trust has no contingent liabilties to disclose.

26 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	679,467	313	6,551	0
NHS Hampshire and Isle of Wight ICB	47,180	0	288	0
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	2,069	0	0	0
NHS Somerset ICB	65,892	0	0	0
NHS Resolution (formerly NHS Litigation Authority)	0	18,049	0	11
NHS England - Core	29,728	14	21	13
NHS England - Central Specialised Commissioning Hub	16,287	0	1,404	0
NHS England - South West Regional Office	54,460	0	77	0
NHS Blood	12	2,951	0	0
Dorset County Hospital NHS FT	4,469	4,299	2,060	3,447
Dorset Healthcare Unversity NHS FT	6,832	2,705	1,487	282
Lancaster Teaching Hospitals NHS FT	0	606	0	34
Oxford Health NHS FT	0	3,174	0	270
Salisbury NHS FT	613	1,112	206	235
University Hospitals Bristol and Weston NHS FT	2,619	72	303	27
University Hospitals Southampton NHS FT	1,509	1,903	856	765
Other transactions less than £500,000	7,153	2,988	496	586
	918,290	**38,186**	**13,749**	**5,670**

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	-	94,799	-	7,965
HM Revenue and Customs (Income tax and National Insurance)	-	63,639	-	13,849
	-	**158,438**	**-**	**21,814**

27 Post statement of financial position events

There were no post statement of financial position events.

28 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 £4,717,000 during 2025/26, which is reflective of current Bank of England base rate levels.

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 2026 and as a result of this review, has provided £2,376,000 in relation to doubtful debts. A further £576,000 has been provided for in relation to the Injury Cost Recovery Scheme income, in accordance with national requirements.

Liquidity risk

Loans

The Foundation Trust has four fixed rate loans from the Independent Trust Financing Facility:

1. £8,483,000 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. £4,618,000 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. £14,946,000 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 £133,194,000. As such, the Trust is a minimal risk to its creditors.

29 Financial instruments

29.1 Financial assets

	Group				Trust	
	31 March 2026		31 March 2025		**31 March 2026**	31 March 2025
	£'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	**19,425**	**-**	13,356	**-**	**19,425**	13,356
Other Investments	**4,049**	**-**	4,936	**-**	**4,049**	4,936
Cash and cash equivalents at bank and in hand	**133,194**	**-**	102,496	**-**	**133,194**	98,816
NHS Charitable funds: financial assets as at 31 March	**17,544**	**9,340**	11,851	8,483	**-**	-
Total	**174,212**	**9,340**	132,639	8,483	**156,668**	117,108
Assets held in £ sterling		**183,552**		141,122	**156,668**	117,108

29.2 Financial liabilities

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£'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	**28,407**	30,686	**28,407**	30,686
Obligations under finance leases	**11,247**	12,136	**11,247**	12,136
NHS trade and other payables excluding non-financial liabilities	**5,668**	6,954	**5,668**	6,954
Non-NHS trade and other payables excluding non-financial liabilities	**118,665**	75,126	**118,665**	75,126
Provisions under contract	**6,313**	3,126	**6,313**	3,126
NHS Charitable funds: financial liabilities as at 31 March	**5,220**	2,257	**-**	-
Total	**175,520**	130,285	**170,300**	128,028
Liabilities held in £ sterling	**175,520**	130,285	**170,300**	128,028

29.3 Financial assets / liabilities - fair values

	Group		Trust	
	31 March 2026		**31 March 2026**	
	£'000	**£'000**	**£'000**	**£'000**
	Book Value	**Fair Value**	**Book Value**	**Fair Value**
Financial assets				
Receivables over one year				
Other	**656**	**656**	**656**	**656**
NHS charitable funds: non-current financial assets	**9,340**	**9,340**	**-**	**-**
Total	**9,996**	**9,996**	**656**	**656**
Financial liabilities				
Non-current trade and other payables excluding non-financial liabilities	**690**	**690**	**690**	**690**
Provisions under contract	**6,313**	**6,313**	**6,313**	**6,313**
Total	**7,003**	**7,003**	**7,003**	**7,003**

30 Intra-Government and NHS balances

	Group / Trust	
	31 March 2026	
	Receivables: amounts falling due within one year	Payables: amounts falling due within one year
	£'000	£'000
Providers	**5,090**	**5,552**
NHS and Department of Health	**8,513**	**117**
Local Government	**70**	**-**
Other Government Bodies	**509**	**21,815**
Total	**14,182**	**27,484**

31 Losses and special payments

	Group / Trust			
	Twelve months to 31 March 2026		Six months to 31 March 2025	
	Number	**£'000**	Number	£'000
Losses				
Losses of cash due to:				
Other causes	**7**	**1**	1	-
Damage to buildings, property and equipment	**24**	**461**	24	583
Bad debts - overseas visitors	**-**	**-**	26	121
Total losses	**31**	**462**	51	704
Special payments				
Ex gratia payments in respect of:				
Loss of personal effects	**39**	**26**	45	36
Personal injury with advice	**5**	**99**	7	42
Miscellaneous other	**7**	**1**	5	7
Special severance payments	**2**	**25**	1	32
Total special payments	**53**	**151**	58	117
Total	**84**	**613**	109	821

There were no individual cases where the net payment exceeded £100,000.

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.

32 Senior manager remuneration

Directors' remuneration totalled £1,958,000 for the twelve months ended 31 March 2026. Full details are provided within the Remuneration Report.

33 Senior manager pension entitlements

There were benefits accruing to seven of the Foundation Trust's Executive Directors under the NHS Pension Scheme in 2025/26. Full details are provided within the Remuneration Report.

34 Charitable Fund Reserve

The Charitable Fund Reserve comprises:

	Charity	
	31 March 2026	31 March 2025
	£'000	£'000
UHD NHS Charity - Restricted Funds	**6,696**	7,606
UHD NHS Charity - Unrestricted Funds	**11,291**	10,359
Bournemouth and Poole Healthcare Trust	**2,956**	2,819
Total	**20,943**	20,784

35 Capital Resource Limit

	Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Gross capital expenditure	**191,170**	156,779
Less: Disposals	**(4)**	(69)
Less: Donated, granted and peppercorn leased capital additions	**(1,943)**	(1,256)
Charge against Capital Resource Limit	**189,223**	155,454

36 Adjusted Financial Performance

	Trust	
	31 March 2026	31 March 2025
	£'000	£'000
Surplus/(deficit) for the period per SOCI	**(27,276)**	(81,864)
Remove net impairments not scoring to the departmental expenditure limit	**32,237**	81,517
Remove I&E impact of capital grants and donations	**(13)**	440
Adjusted financial performance surplus	**4,948**	93
Less non-recurrent deficit funding	**(4,915)**	-
Adjusted financial performance surplus excluding non-recurrent deficit funding	**33**	93

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

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