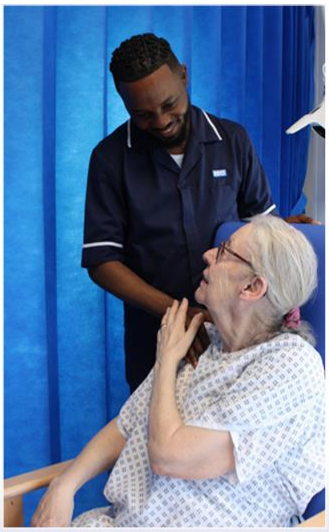
University Hospitals Dorset
NHS Foundation Trust

Annual Quality Account 2025/2026



Contents

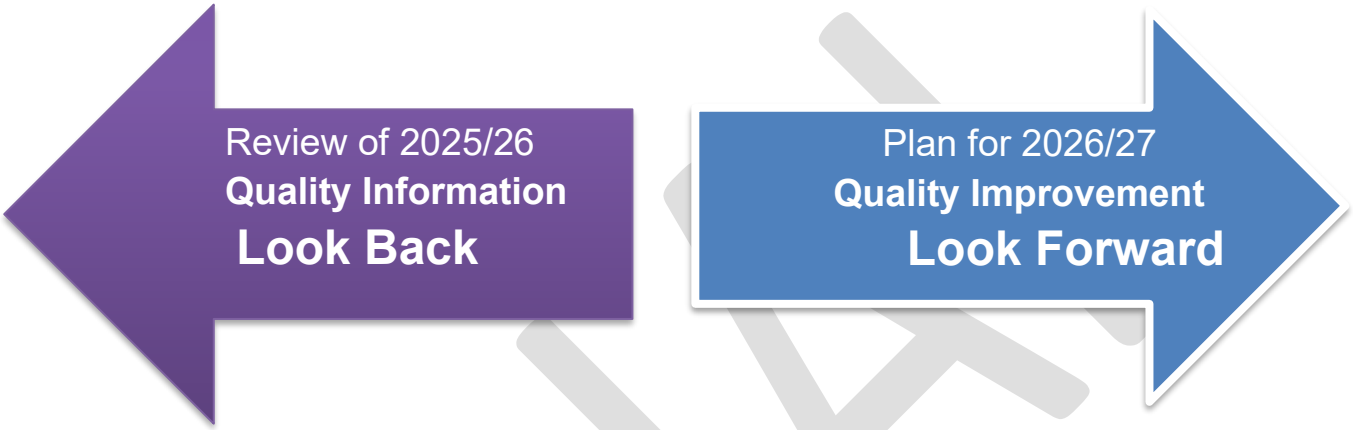
What is a quality account?

As part of the drive across the NHS to be open and honest about the quality of services provided to the public, from 2009, all NHS hospitals are required to publish a Quality Account.

The purpose of this quality account is to:

1. summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2025/26; and

2. set out our quality priorities and objectives for 2026/27.



The report is set out in three sections:

Part 1	*Statement on quality from the Chief Executive*
Part 2	*Performance against 2025/26 quality priorities*
	New priorities for 2026/27
	Statements of assurance from the Board
Part 3	*Other Patient Safety, Clinical Effectiveness and Patient Experience activity during 2025/26*

Some sections of the report use compulsory wording and formatting. Where possible we have tried to add additional information to support mandated requirements. If there are any areas of the quality account that are difficult to read or understand, or you have any questions, please contact Joanne Sims, Associate Director of Quality Governance and Risk at Joanne.Sims12@nhs.uk

Part 1 Statement on quality from the Chief Executive

At University Hospitals Dorset, our purpose remains clear: to provide safe, compassionate and high-quality care for every patient, every day. This Quality Account reflects the progress we have made during 2025/26 in strengthening patient safety, clinical outcomes and patient experience, while also highlighting areas where we know we can continue to improve. Being open about both our achievements and our challenges is an important part of how we learn and continue to build trust with our patients, colleagues and communities.

Throughout the year, I have been proud to see the professionalism, skill and commitment of our staff across every part of the organisation, often in very demanding circumstances. Their efforts have supported progress in a number of key areas. We have consistently met the national standard for VTE risk assessment compliance, strengthened our clinical governance arrangements, and improved how we bring together learning from incidents, complaints, audits and patient feedback. We have also made encouraging progress in several patient safety priorities, including the care of deteriorating patients, and our approach to pressure ulcer prevention, mental health safety, diagnostics follow-up and maternity safety.

This report also highlights the strength of our wider improvement work. During 2025/26, we participated in 91% of national clinical audits and all relevant national confidential enquiries, helping us to learn from and contribute to national standards. This reflects our strong commitment to a learning culture. We have continued to support research, innovation, and quality improvement. Across clinical audit, patient safety, service redesign and research, teams are increasingly turning insight into action and embedding improvement in day-to-day practice.

I would also like to recognise the valuable contribution of patients, relatives, carers, governors, non-executive directors and our Patient Safety Partners. Their insight, feedback and challenge are vital in helping us shape and improve the services we provide.

We know there is more to do, and we remain committed to continuing this work. At the same time, this report reflects the progress we are making, the strong foundations we are building, and the shared commitment of our staff to delivering safe, effective and compassionate care for the communities we serve.

Siobhan Harrington

Chief Executive

Mandatory statement:

It is important to note that there are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported:

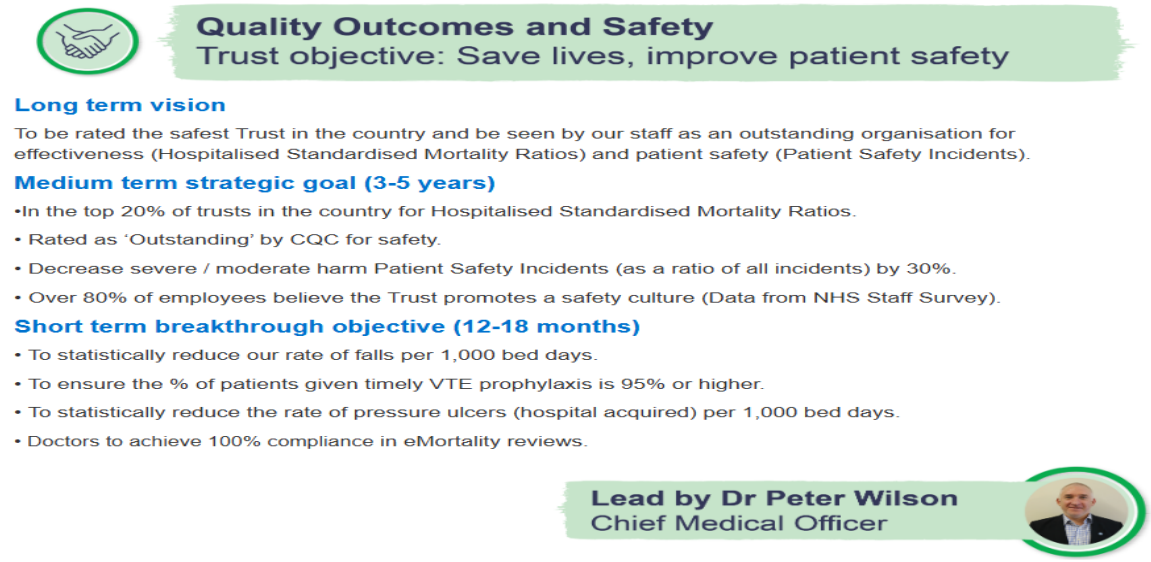
- *data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit programme of work each year*
- *data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently*
- *national data definitions do not necessarily cover all circumstances, and local interpretations may differ*
- *data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.*

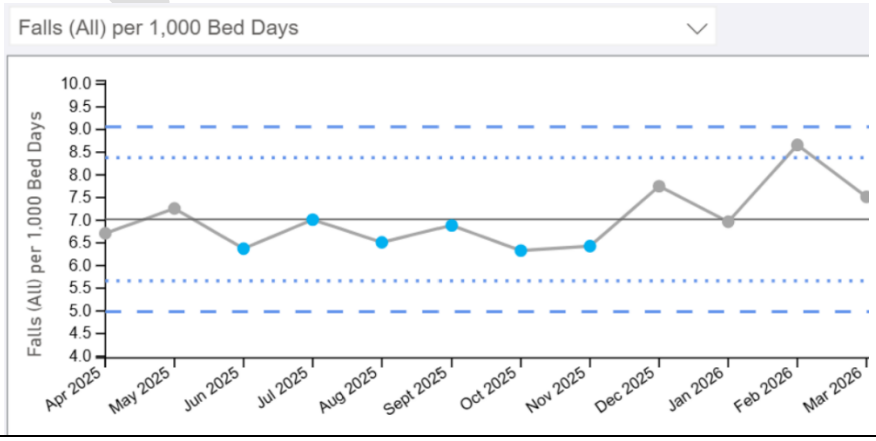
To the best of my knowledge, the information contained within this report is accurate.

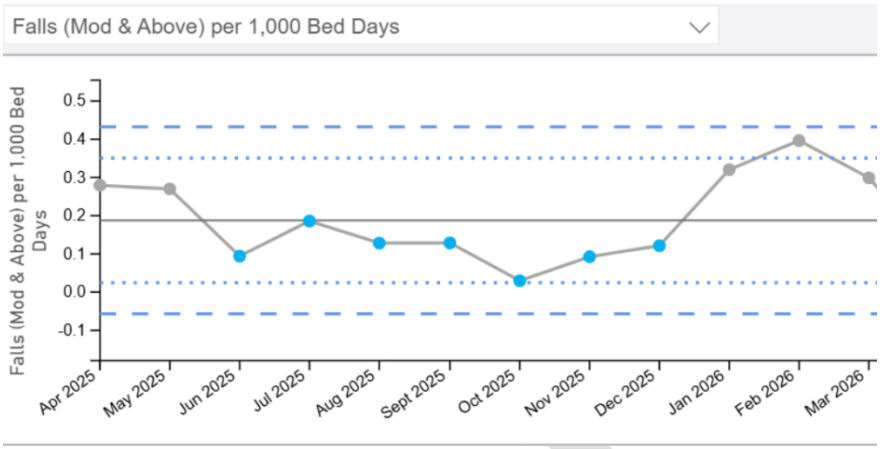
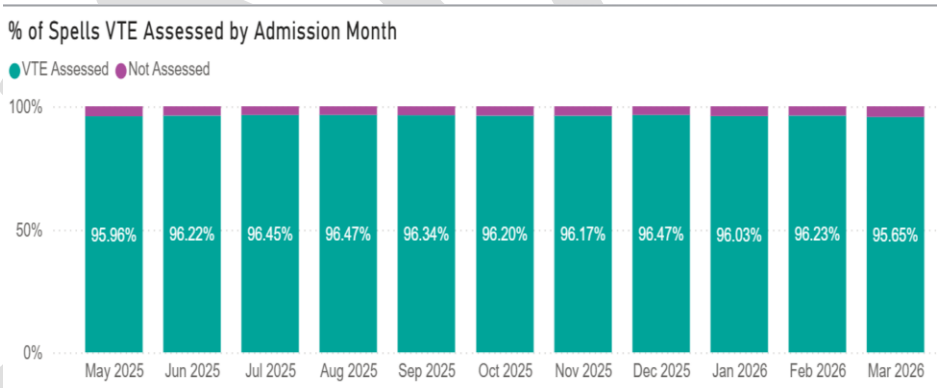
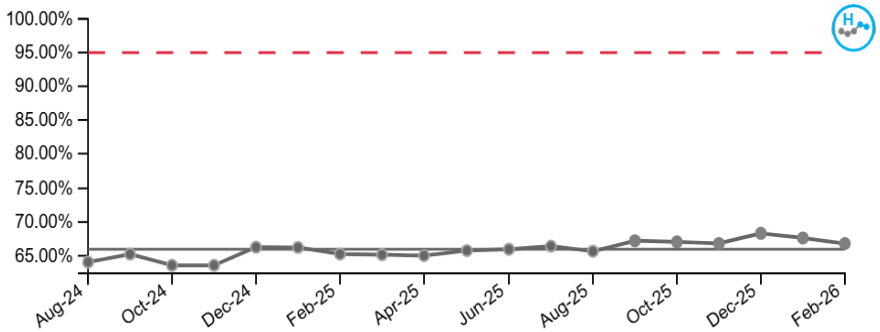
Siobhan Harrington
Chief Executive

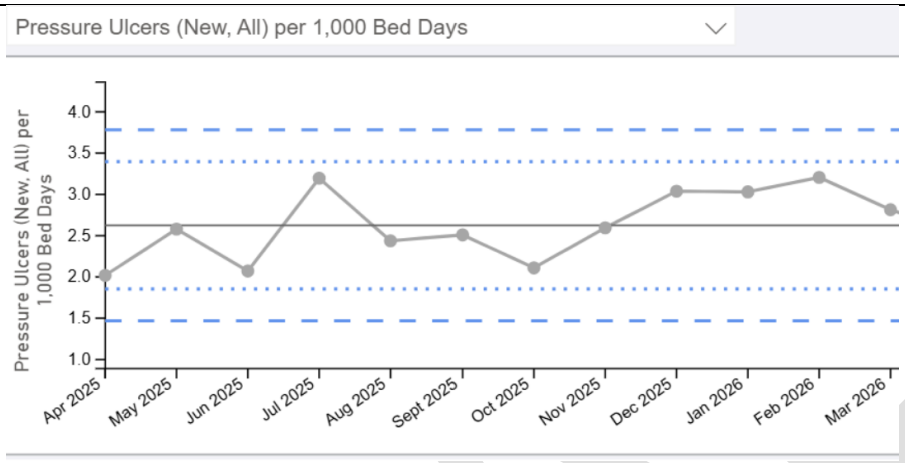
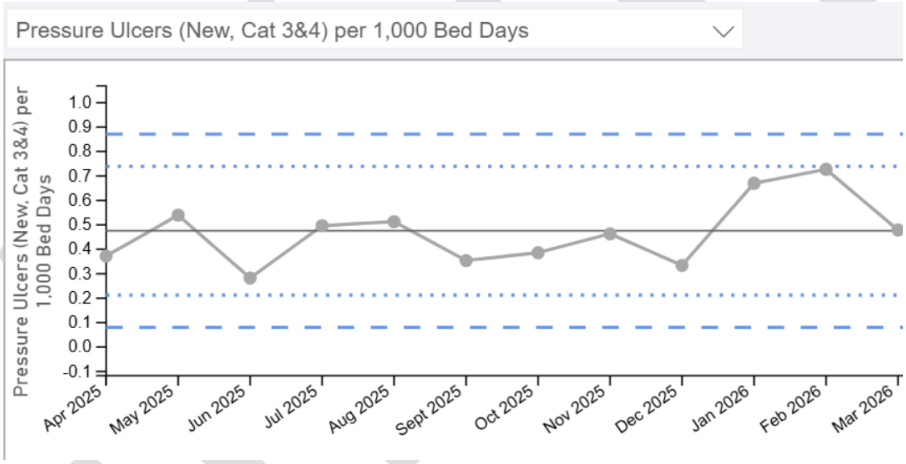
Part 2 - Performance against quality priorities set out in the Trust Quality Strategy for 2025/26

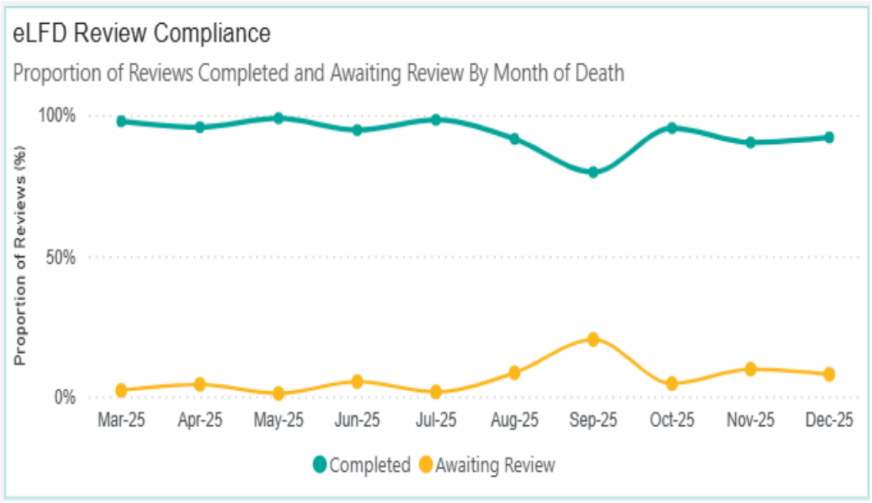
The Trust identified the following priorities for improvement in 2025/26:



Objective	End of Year Position – March 2026	Objective Achieved/ Not Achieved
To statistically reduce our rate of falls per 1000 bed days	Q4 2025/26 falls trend mirrors 2024/25 data. Overall falls rates are stable with expected variation and no evidence of special cause. However, there was a statistically significant improvement in moderate and above harm falls from mid-2025, suggesting that changes made during that period had real impact. Recent data shows a slight increase. Completed reviews suggest this may be related to operational pressures and staffing availability. 	Some improvement was seen, but the overall reduction was not achieved by year end.

	 Despite positive progress and quality improvement actions (see pages 42-43 for details) the overall falls rate has not decreased in year with March 2026 reporting at 7.4 per 1000 bed days overall. A new Falls Steering Group has been established to drive improvement in the year ahead. Our Falls Team has also been reorganised to enable greater support for Trust wide and ward based quality and safety programmes.	
To ensure the % of patients given timely Venous Thromboembolism (VTE) prophylaxis is 95% or higher	The national mandated standard for a VTE risk assessment compliance rate of 95% was achieved in each quarter in 2025/26.  Prescribing compliance (giving timely VTE prophylaxis) was below the target of 95 % for each quarter. 	Partially Achieved

	We have commissioned a thematic review to understand how and where we can improve compliance. Our Patient Safety Partners are supporting the review, including talking to staff, patients and relatives to understand why medication doses may be missed or declined. The review is due to report at the end of July/early August and will be used to drive actions for improvement in 2026.	
To statistically reduce the rate of pressure ulcers (hospital acquired) per 1000 bed days	  Statistical Process Control (SPC) analysis shows that pressure ulcer harm was previously stable, but over the last 2–3 months there is clear special cause variation for Category 3 and 4 ulcers, alongside a sustained upward shift across all pressure ulcer categories. This has resulted in focused investigation and additional targeted improvement actions. A meeting was held in March 2026 with the Deputy Chief Nurse and care group representation to discuss improvement actions. A new Pressure Ulcer Prevention steering group is being formed to oversee implementation in 2026/27.	Rates were initially in line with the previous year but increased slightly in the final quarter. As a result, the overall reduction was not achieved by year end. It is likely that the quality improvement actions introduced during the year (see pages 42 and 43) have not yet had time to take full effect.
Doctors to achieve 100% compliance in eMortality (learning from death) reviews	In March 2026 a compliance rate of 94% was reported. Some specialities achieved 100%	Partially Achieved

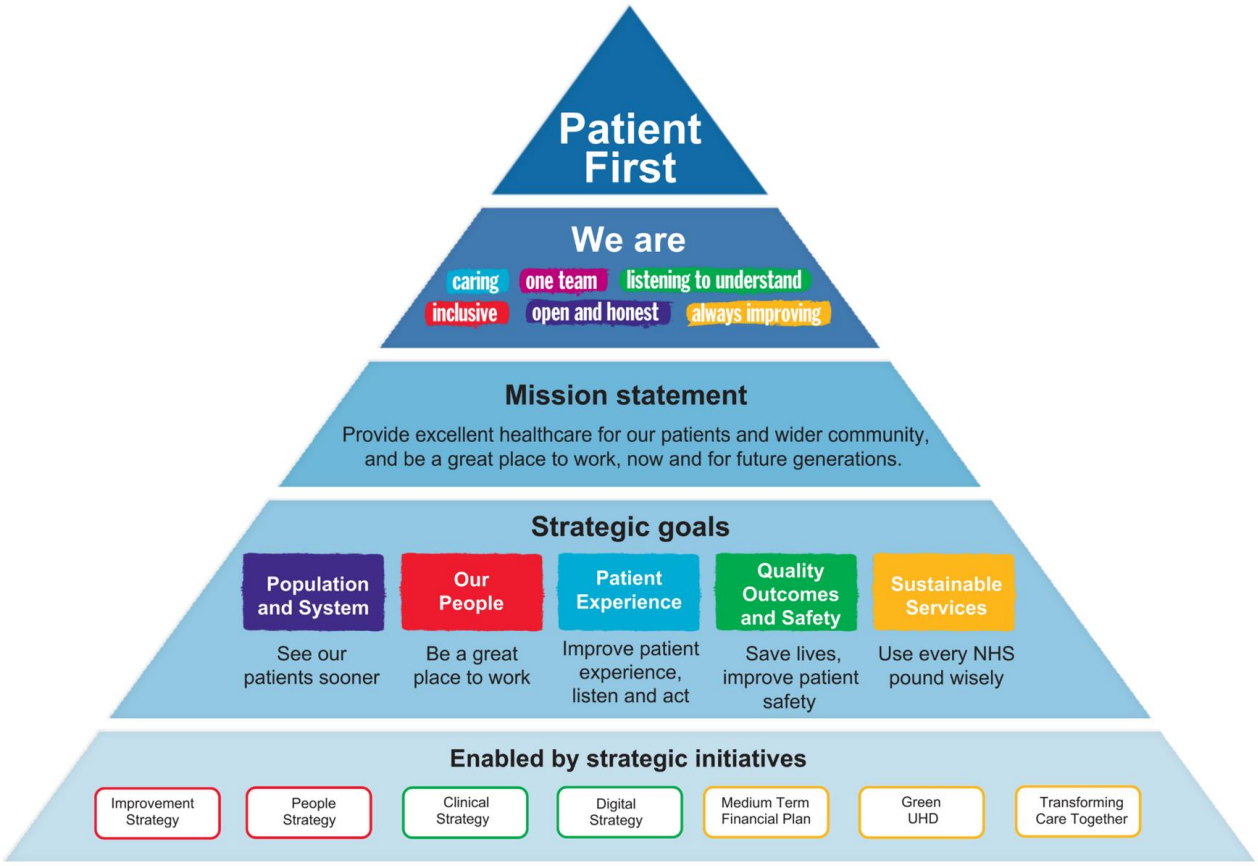
	Trustwide position is 94% complete for December 2025 (as at 8th April)  Clinical engagement in this programme has been strong, with learning from completed reviews shared through speciality, directorate and Trust Mortality Governance meetings.	

Our quality priorities for 2026/27

Our quality priorities for 2026/27 form part of a broader strategy aimed at ongoing improvement and providing stronger support to staff so that patients remain central to everything we do.

The 'Patient First' initiative spans the next three to five years, beginning with ambitious goals while acknowledging our present challenges. We are committed to continual progress and to concentrating efforts on fewer strategic themes we can achieve a greater impact. Throughout this process, our values will guide our actions as we seek to learn and adapt along the way.

This approach is illustrated in the Trust "Patient First" pyramid below.



Our strategic goals at trust level focus on where we most want significant improvements delivered in a sustained way over the next three years. These fit within our Dorset-wide role in the health and care system.

UHD's Trust objectives are based upon the five strategic themes:

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

Our Strategic Goals - What we're focusing on this year

At UHD our mission is simple: to provide excellent care for our patients and community, and to be a great place to work.

To help us all pull in the same direction, our improvement work is guided by five strategic goals. Each year, we agree clear priorities so we know what we're focusing on - and how we'll tell if we're making a difference.

Below is a snapshot of our Year 1 priorities and what success will look like.

1 Population and system

See our patients sooner

Why this matters -
We want patients to get the right care, at the right time, as part of a joined-up health and care system.

This year we're focusing on:

Reducing waiting times and improving outcomes across:

- Planned care
- Urgent and emergency care
- Diagnostics
- Cancer pathways
- New purpose-built Endoscopy Unit, plus MRI/CT

How we'll know it's working

- 82% of patients admitted, transferred or discharged from ED within 4 hours
- 7% improvement in patients waiting 18 weeks or less for elective care
- 80% of cancer patients treated within 62 days of referral

2 Our People

Be a great place to work

Why this matters -
Our people are our greatest asset.
A supported and stable workforce means better care for patients.

This year we're focusing on:

- Increasing permanent staffing
- Reducing reliance on agency and bank staff

How we'll know it's working

- Increased substantive staffing and reduced vacancies
- Lower agency and bank spend
- 15% reduction in premium bank spend (compared to 2025/26)
- Improved staff retention, especially in hard-to-fill roles
- Better workforce cost control aligned to service need

3 Patient Experience

Improve patient experience, listen and act

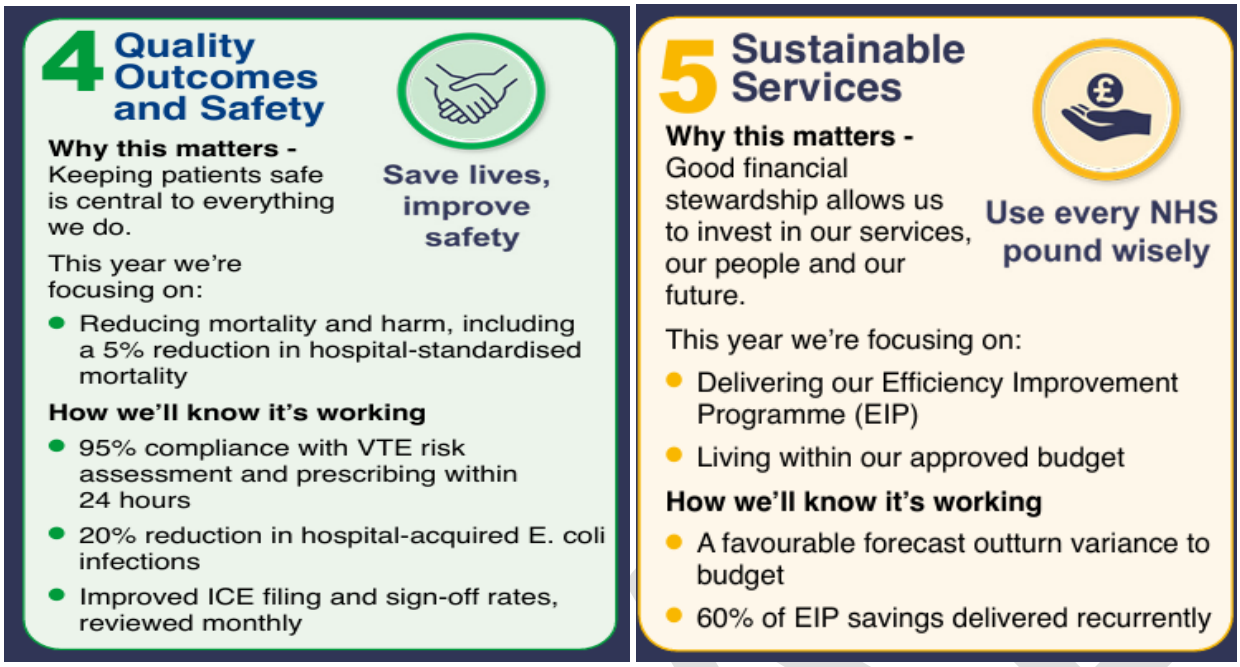
Why this matters -
Every interaction counts. Listening to patients helps us improve the care we provide.

This year we're focusing on:

- Acting on patient feedback and making visible improvements

How we'll know it's working

- 90% of complaints closed within 35 days
- 95% of Friends and Family Test responses rated good or very good



In addition to our strategic objectives, our Patient Safety Incident Response Plan for 2026/28 highlights four key areas for focus:

Incident type	
Recognition and escalation of the deteriorating patient	Recognition and escalation of the deteriorating patient is a key patient safety priority because timely identification and response to early signs of deterioration significantly reduces avoidable harm, improves outcomes, and supports safe, effective care. We aim to strengthen the reliability of observations, ensure prompt escalation when concerns arise, improve communication between teams and with patients, and build staff confidence through training and clearer processes, helping us deliver faster intervention, reduce emergency deterioration events, and improve patient experience and recovery.
Cross site transfer and handover	Cross site transfer and handover has been chosen as a patient safety priority as we enter into a period of transformation, creating an acute site at RBH and elective site at Poole. Moving patients between hospital sites is a point of increased risk, where delays, missed information or unclear responsibility can affect care. We are strengthening and standardising our transfer and handover processes to ensure information is reliably shared, patients are monitored appropriately throughout their journey, and receiving teams are fully prepared. Our aim is to make every transfer safe, well-coordinated and centred on a positive patient experience.
Care in non-clinical areas/ 'corridor care'	Providing care in non-clinical areas, such as corridors or waiting spaces, carries clear risks to patient safety, dignity, and timely clinical monitoring. By making this a priority, we are committed to reducing the need for such areas, ensuring patients are cared for in environments designed to support safe assessment and treatment. Our improvements focus on strengthening oversight and visibility of patients, enhancing privacy and essential equipment provision where temporary use is unavoidable, and tackling the wider flow and capacity challenges.
Medication relating to discharge	Making sure patients receive and use their medicines safely when leaving the hospital is important. When care changes from one place to another, mistakes can happen because details about medicines may be missing or incorrect. Studies show that unclear communication between hospitals, GPs, and community services can lead to preventable problems, confusion about prescriptions, and unexpected returns to the hospital. We aim to give clear medication information, encourage teamwork among healthcare providers, and help patients understand and use their medicines safely after discharge.

Statements of Assurance from the Board

This section contains eight statutory statements concerning the quality of services provided by University Hospitals Dorset NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that gives local context to the information provided in the statutory statements.

1. Review of services

During 2025/26 University Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health services (in accordance with its registration with the Care Quality Commission):

- management of supply of blood and blood derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- maternity and midwifery services
- family planning
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury

The Trust has reviewed all the data available to them on the quality of care in these eight relevant health services. This included data available from the Care Quality Commission, external reviews, participation in National Clinical Audits and National Confidential Enquiries and internal peer reviews.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2025/26.

2. Participation in clinical audit

During 2025/26, there were 64 national clinical audits and five national confidential enquiries which covered relevant health services that University Hospitals Dorset NHS Foundation Trust provides. During that period, University Hospitals Dorset NHS Foundation Trust participated in 91% of national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that University Hospitals Dorset NHS Foundation Trust participated in, and for which data collection was completed during 2025/26 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
British Association of Urological Surgeons A- Investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Y	Y	100%	Audit of the investigation and referral of women with recurrent urinary tract infection.
British Association of Urological Surgeons (BAUS) Audit: Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Y	Y	100%	Audit to evaluate the management pathway for suspected testicular cancer referrals & assess compliance with standard care practices.
Breast and Cosmetic Implant Registry	Y	Y		The registry collects data on all types of breast implant and explant (removal) surgery. This includes revisions and reconstructions, such as temporary tissue expanders.
British Spine Registry	N	N		
Case Mix Programme (CMP)	Y	Y	100%	Audit of patient outcomes from adult general critical care units.
Child Health Clinical Outcome Review Programme	NCEPOD	Y	See table below	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities.
Cleft Registry and Audit Network	N	N		
Emergency Medicine QIPs: Adolescent Mental Health	Y	Y	Not yet started - Data for year 1 is Jan-Dec 2026	Identify current performance in EDs against nationally agreed clinical standards and show the results in comparison with other departments.

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
Emergency Medicine QIPs: Care of Older People	Y	N	Local audit proposed instead of completion of national QIP	As above.
Emergency Medicine QIPs: Mental Health Self Harm	Y	N	As above.	As above.
Emergency Medicine QIPs: Time Critical Medications	Y	N	As above.	As above.
Epilepsy 12: National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	100%	Audit of organisation of paediatric epilepsy services, epilepsy care provided to children and young people and patient reported experience measures.
Falls and Fragility Fractures Audit Programme: Fracture Liaison Service Database	Y	Y	14% Low participation due to limited resources available to support data capture.	Measure against NICE technology assessments and guidance on osteoporosis and clinical standards for FLSs.
Falls and Fragility Fractures Audit Programme: National Audit of Inpatient Falls	Y	Y	100%	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals.
Falls and Fragility Fractures Audit Programme: National Hip Fracture Database	Y	Y	100%	Audits of patients with hip and femoral fractures aim to improve their care through auditing which is fed back to hospitals through targeted reports and online reporting.

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Y	Y	100%	Programme to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice.
Maternal and Newborn Infant Clinical Outcome Review Programme	Y	Y	100%	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies
Medical and Surgical Clinical Outcome Review Programme	NCEPOD	Y	See table below	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities.
Mental Health Clinical Outcome Review Programme	N	N		
National Adult Diabetes Audit: National Diabetes Core Audit	Y	N	Unable to submit due to significant data burden and resource requirement	Measures the effectiveness of diabetes care compared to NICE guidance.
National Adult Diabetes Audit: Diabetes Prevention Programme (DPP) Audit	N	N		
National Adult Diabetes Audit: National Diabetes Foot Care Audit	Y	Y	23% 180/768	Measures the effectiveness of diabetes care compared to NICE guidance.
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Y	Y	100%	As above.
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Y	Y	100%	As above.

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Adult Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	N	UHD are participating in a different national project on this subject "Diabetes Transition and Young Adult (TYA) Project"	As above.
National Adult Diabetes Audit: Gestational Diabetes Audit	Y	Y	100%	As above.
National Audit of Cardiac Rehabilitation	Y	Y	100%	Aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live
National Audit of Cardiovascular Disease Prevention	N	N		
National Audit of Care at the End of Life	Y	Y	100%	Focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals.
National Audit of Dementia	Y	Y	N/A (No data collection in 2025, data collection to start in 2026/27)	Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.
National Audit of Eating Disorders	N	N		

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Bariatric Surgery Registry	Y	Y	100%	To accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include weight loss, co-morbidity and improvement of quality of life.
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Y	Y	100%	This audit will look at the care that patients are receiving for metastatic (secondary) breast cancer in England and Wales
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Y	Y	100%	The audit aims to bring information all together for the first time, for a comprehensive analysis of all aspects of breast cancer care in England and Wales,
National Cancer Audit Collaborating Centre: National Bowel Cancer Audit	Y	Y	100%	A collaborative, national clinical audit for bowel cancer, including colon and rectal cancer.
National Cancer Audit Collaborating Centre: National Kidney Cancer Audit	Y	Y	100%	The audit process will look at diagnosis and treatment, and how patients are managed, to give the right support and expertise in order to provide the best possible care.
National Cancer Audit Collaborating Centre: National Lung Cancer Audit	Y	Y	100%	Measuring lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit	Y	Y	100%	One of the main objectives of the audit will be to focus on equity, to work towards a service where all patients are given access to the appropriate diagnostic procedures and treatments.
National Cancer Audit Collaborating Centre: National Oesophago-gastric Cancer	Y	Y	100%	The audit evaluates the process of care and the outcomes of treatment for all oesophago-gastric cancer patients, both curative and palliative.
National Cancer Audit Collaborating Centre: National Ovarian Cancer Audit	Y	Y	100%	This new audit will produce granular information on diagnosis, treatment and surgery, to allow the audit team to assess how to improve care in England and Wales, and create better results for patients.
National Cancer Audit Collaborating Centre: National Pancreatic Cancer Audit	Y	Y	100%	The audit will gather information from databases across England and Wales, allowing better comparisons to be made, and revealing where shortfalls need to be addressed
National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	Y	Y	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes.
National Cardiac Arrest Audit	Y	Y	100%	Audit of in-hospital cardiac arrests in the UK and Ireland.

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit	N	N		
National Cardiac Audit Programme (NCAP): Congenital Heart Disease (adult & paediatric)	N	N		
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Y	Y	100%	To recognise areas of clinical excellence that can be adopted across the NHS. Standards should be used to determine local quality improvement aims for clinicians, service managers and commissioners.
National Cardiac Audit Programme (NCAP): Cardiac Rhythm Management	Y	Y	100%	As above.
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project	Y	Y	100%	As above
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	100%	As above
National Cardiac Audit Programme (NCAP): The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N	N		
National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAAO) Registry	N	N		
National Cardiac Audit Programme (NCAP): Patent Foramen Ovale Closure (PFOC) Registry	N	N		
National Cardiac Audit Programme (NCAP): Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	N	N		

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Child Mortality Database	Y	Y	100%	The National Child Mortality Database (NCMD) records comprehensive, standardised information collected by local the Child Death Overview Panels (CDOPs) as part of the Child Death Review (CDR) process.
National Clinical Audit of Psychosis (Core audit & EIP spotlight audit)	N	N		
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	Y	Y	100%	The objective of the programme is to provide evidence blood is being ordered and used appropriately, administered safely, to highlight where practice is deviating from guidelines to the possible detriment of patient care.
National Early Inflammatory Arthritis Audit	Yes	Yes	30% due to workload pressures and staff capacity	Aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales.
National Emergency Laparotomy Audit (NELA) - Laparotomy	Yes	Yes	The 25/26 audit period is open till 31/05/26.	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Emergency Laparotomy Audit - No Laparotomy	Yes	Yes	Unable to submit any data to this new audit in 25/26 due to insufficient resources to support data entry	This is an extension of NELA, focussing on patients who present with a surgical condition requiring operative treatment but who do not have surgery.
National Joint Registry	Y	Y	100%	Data analysis of joint replacement surgery to provide an early warning of issues relating to patient safety
National Major Trauma Registry (NMTR) formerly TARN	Y	Y	100%	Analyses data of trauma care to improve emergency care management and systems.
National Maternity and Perinatal Audit	Y	Y	100%	Evaluates a range of care processes and outcomes to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.
National Neonatal Audit Programme (NNAP)	Y	Y	100%	To audit whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high quality care, and identify areas for quality improvement.
National Obesity Audit	N	N		
National Ophthalmology Database: Age-related Macular Degeneration Audit (AMD)	Y	Y	100%	Project includes large-scale audit for both cataract surgery and age related macular degeneration
National Ophthalmology Database: National Cataract Audit	Y	Y	100%	As above

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
National Paediatric Diabetes Audit	Y	Y	100%	Audit of the care processes received and outcomes achieved by all children and young people attending paediatric diabetes units.
National Perinatal Mortality Review Tool (PMRT)	Y	Y	100%	The aim of the PMRT programme is to standardize perinatal mortality reviews across NHS maternity and neonatal units.
National Pulmonary Hypertension Audit	N	N		
National Respiratory Audit Programme: COPD Secondary Care	Y	Y	60% - submitted up to Nov 2025. Subsequent staff shortages prevented further submissions	Aims to improve the quality of care, services and clinical outcomes for patients with asthma and chronic obstructive pulmonary disease (COPD).
National Respiratory Audit Programme: Pulmonary rehabilitation	Y	Y	100%	As above.
National Respiratory Audit Programme: Adult Asthma Secondary Care	Y	Y	60% - submitted up to Nov 2025. Subsequent staff shortages prevented further submissions	As above.
National Respiratory Audit Programme: Children and Young People's Asthma Secondary Care	Y	Y	100%	As above.
National Vascular Registry	Y	Y		To measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals.
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N	N		

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
Paediatric Intensive Care Audit Network (PICANet) - Level 2 HDU	Y	Y	100%	A web-based audit database that records and stores the details of the treatment of critically ill children in paediatric intensive care units
Perioperative Quality Improvement Programme (PQIP)	Y	Y	100%	The programme measures complications, mortality and patient reported outcome from major non-cardiac surgery.
Prescribing Observatory for Mental Health Audit Programme: Improving the quality of valproate prescribing in adult mental health services	N	N		
Prescribing Observatory for Mental Health Audit Programme: Use of clozapine	N	N		
Prescribing Observatory for Mental Health Audit Programme: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N	N		
Sentinel Stroke National Audit Programme	Y	Y	100%	To provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y	Y	100%	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety.
UK Cystic Fibrosis Registry: Cystic Fibrosis - Adults	N	N		

National Clinical Audits for Inclusion in Quality Report 2025/26	Eligible	Participated in 2025/26	% of cases submitted	Purpose of audit
UK Cystic Fibrosis Registry: Cystic Fibrosis - Children	Y	Y	100%	Non-identifiable Registry data is used to improve the health of people with cystic fibrosis through research, to guide quality improvement at care centres and to monitor the safety of new drugs.
UK Interstitial Lung Disease (ILD) Registry	N	N		
UK Parkinson's Audit	Y	Y	100%	The recognised quality improvement tool for Parkinson's services.
UK Renal Registry Chronic Kidney Disease Audit	N	N		
UK Renal Registry National Acute Kidney Injury Audit (UKRR)	Y	Y	100%	The UKRR manages data collection, analysis and reporting on approximately 70,000 people on kidney replacement therapy and on about 500,000 people with an acute kidney injury each year.

National Confidential Enquiries for Inclusion in Quality Report 2025/26	Eligible to Participate	Participated in 2025/26	% of required cases submitted
Rib Fracture	Yes	Clinical data collection currently open	Clinical questionnaires distributed x12
Stabilisation of the critically ill child	Yes	Organisational questionnaire distributed	Clinical Questionnaire due date to be confirmed
Learning Disability	Yes	Organisational questionnaire not submitted	Clinical Questionnaires 1 of 12 submitted (8%)
Emergency (non-elective) procedures in children and young people	Yes	Organisational questionnaire not submitted	Clinical questionnaires 2 of 2 not submitted (0%)
Acute Limb Ischaemia - Spoke hospital	Yes	Organisational questionnaire submitted	Clinical Questionnaires not applicable

Learning from National Audits

In 2025/26, University Hospitals Dorset NHS Foundation Trust reviewed the findings of 56 national clinical audits. In response, the Trust identified a range of actions to improve the quality of care it provides. Examples include:

- National Oesophago-Gastric Cancer Audit: State of the Nation Report (Cohort 01 April 2021 to 31 March 2023) – Ongoing collaborative work across Wessex is underway to assess pathway compliance, identify areas of concern, and recognise achievements in best practice.

- NHSBTS 2024 re-audit of NICE QS138: Tranexamic Acid added to surgical safety checklist – completed

- National Respiratory Audit Programme (NRAP) - Adult Asthma in Secondary Care (Catching Our Breath Clinical Audit Report 2023/24): Work is currently in progress to align cross-site services and training on peak flow, and steroid timing

- National Respiratory Audit Programme (NRAP) - Chronic Obstructive Pulmonary Disease (COPD) (Catching our breath clinical audit report 2023/24) – Work is in progress to reviewing key elements of the discharge bundle and Stop smoking interventions.

- National Respiratory Audit Programme (NRAP) – Children and Young People's (CYP) Asthma Secondary Care (Catching our breath clinical audit report 2023/24). Development in progress to support using the Royal College of Physicians CYP Asthma discharge letter proforma as part of electronic discharge documentation.

- Saving Lives, Improving Mothers' Care State of the Nation Report 2025 (data 2021-23). Provision of additional education for Resident Doctors and Postnatal midwives to focus on improving the quality and consistency of discharge summaries.

- National Early Inflammatory Autoimmune Diseases Audit (NEIAA) Summary Report 2025. Annual Primary care educational day as well as other educational events to highlight the importance of referring within 3 days of suspecting EIA.

- Sentinel Stroke National Audit Programme (SSNAP) State of the Nation Report 2025 - 1st April 2024 to 31st March 2025 (Annual Results Portfolio). Delivery plan for all domains driven by the stroke service.

- Stepping towards improvement: The 2025 National Audit of Inpatient Falls (NAIF) report on 2024 clinical data. Plan established to develop and launch an updated IT Observational assessment tool (eObs) with the additional functionality to record lying and standing blood pressure across all inpatient areas.

- National Audit of Care at the End of Life (NACEL) 2024 State of the Nations Report. A Quality Improvement programme focusing on Symptom Control and Recognising Dying has been initiated by the Trust End of Life Steering Group.

- National Respiratory Audit Programme (NRAP) - Pulmonary Rehabilitation report 2023/24. Changing from the six-minute walk test to the incremental walk test to support patient outcomes.

- National Audit: BAUS Nephrostomy Audit – Action plan in progress to encourage submission of urine culture from nephrostomies when inserted.

- National Audit: 2025 report: The National Hip Fracture Database (NHFD)(FFFAP) (2024 data). Action completed to change to recording of spinal anaesthetics and hip block.

- National Audit: National Ophthalmology Database (NOD) Audit: Age-related Macular Degeneration (AMD) Audit - 2023/24 data. Software provider requested to see if they can provide individual data for the timings of the first 3 injections in order drive improvements in our initial 3 injection delivery.

Learning from Local Audits

The reports of 359 local clinical audits were reviewed by the Trust in 2025/26 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Re-Audit of Traumatic Hemopneumothorax - Redesign of the pathway placing new emphasis on the escalation status of the patient at the point of admission - completed

- Trial without Catheter (TWOC) Audit – Implementation of TWOC stickers; either in addition to, or an extension of the catheter insertion stickers – in progress

- Audit to assess the quality of provision of outpatient care for patients with chronic pancreatitis – Development of a standard operating procedure for patients with chronic pancreatitis – in progress

- Patient initiated follow-ups audit in the Elective upper-limb clinic – Creation of a new patient information leaflet – completed

- Intrapartum Cardiotocography (CTG) Fetal Monitoring Audit - To continue to audit and to feedback to staff compliance rates and areas for improvement through education and training – completed

- Audit of Texture Modified Meals - Catering team to review and amend Level 6 soft & bite sized meals. Viscgo testing forks purchased to support – completed

- Non-Specific Lower Back Pain Pathway Audit – Amended clinical documentation to allow for better documentation of biopsychosocial aspects, patient ideas, concerns and expectations and social histories – completed

- Efficacy of Escalation of NEWS2 Scores on a Ward - Timing change to ensure a review of electronic observations at morning and afternoon medical/ nursing handovers – completed

- Evaluating the Effectiveness of Shoulder Orthopaedic Clinics at the Outpatient Assessment Centre - Action plan to integrate digital communications with patients to collect outcome measures pre and post attendance/surgery – in progress

- Audit to assess appropriate VTE prescribing in Acute Medicine patients in the first 24 hours of their admission – Creation of a poster to remind AMU ward doctors and medical clerking doctors about the key VTE guideline targets: 1. VTE prophylaxis offered within 14 hours of admission, 2. Risk of VTE and bleeding reassessed with 24 hours **–** completed

- Audit to look at sodium levels in babies born with mother having hyponatremia – Action to ensure that all cases of maternal hyponatremia are promptly escalated to the neonatal team and that neonatal sodium levels are checked within the first 12 hours of life – completed

- Saving Babies' Lives Audit: Reducing smoking in pregnancy. 20 new machines ordered to improve access to testing – completed

- Audit of Knowledge of Anaesthetic Named Consultant Contact Details - Re-implemented the ability to fast bleep the named anaesthetic consultant / ward **–** completed

- Children's Services Department (Nursing and Medical) Record Keeping Audit - Pain tool completion to be highlighted at nursing safety huddle – in progress

- WHO Safety Checklist Communication Audit – Action to provide more training, including simulation, to teams and to consider how staff introduce themselves to the patients and how that can affect the patient experience **–** completed

- Fascia Iliaca for Hip Fracture (2nd round) – Development of a single proforma across both sites to improve standardisation– in progress

- Audit of clinical initial assessment of suspected Cauda Equina Syndrome in the emergency department – Development of patient information cards on red flag symptoms, patients to complete prior to assessment from a doctor given at triage **–** completed

- Time Critical Medications in ED – Introduction of early prescribing prompts in ED software system to specify if the patient has any time critical medications and record if the dose was given and flag when the next dose is due – completed

- Oxygen and suction audit - Completion of risk assessment of all bed spaces that do not have piped supply, including mitigations and access to emergency equipment in an emergency - in progress

- WHO Surgical Safety Checklist: Quality Audit in Theatres - Define clear time points for "Sign In", "Time Out", and "Sign Out", and use closed-loop communication (repeat-back technique) – completed

- Service evaluation on circulating tumour DNA (ctDNA) testing and application in non-small cell lung cancer - Lung oncology team have now set up weekly molecular meeting to review all ctDNA reports to ensure that all somatic and potential germline mutations are picked up in a timely manner, and in the case of germline mutations, referred on to genetics – completed

- Paediatric Insulin Pump Service Hybrid Closed Loop (HCL) Service Audit - Update the pump start handbook to include HCL pump information so families know what processes to expect – in progress

- Documentation audit of height, weight and head circumference and plotting of growth charts in babies 0-6 months presenting to the Children's Assessment Unit - iGrow login to be created for non-specialty trainees to be able to record results and plot – completed

- Audit of electrocardiogram (ECG) Timing Compliance in Adult Patients with Non-Traumatic Chest Pain presenting to the emergency department - All patients presenting with non-traumatic chest pain will be provided with a designated band. This will act as a visual prompt for staff, ensuring that such patients are prioritised and undergo ECG promptly – completed

- Audit of compliance with national stroke guidance on imaging – A CT scanner has been relocated as part of UHD building works and is now situated closer to ED – completed

- Malnutrition Universal Screening Tool (MUST) Audit on the Stroke Unit - A one-page quick reference guide outlining MUST requirements (initial assessment, weekly reassessment, referral triggers) has been displayed in clinical areas and handed out to nursing staff. These resources will act as visual prompts to ensure staff are reminded of the MUST referral process whenever they assess a patient – completed

- Iron Deficiency Anaemia (IDA) Audit - Initiation of new referrals process from secondary care to IDA service which prompts pre-endoscopic management steps that are best initiated at time of referral – completed

- Improving the Management of Tinnitus Referrals - Information sent out to GP practices to act as referral guidelines – completed

- Audit of Inherited Bleeding Disorders Emergency and Out of Hours (OOH) care - Tag patients on ED Software system to highlight cases and include how to contact the bleeding disorder teams - in progress

- Domestic Abuse ED Audit – Develop a small credit card sized card that can be laminated and attached to uniform to provide details on the referral pathway to follow **–** in progress

The Clinical Audit Team routinely tracks and monitors results and action plans from both national and local audits. Findings, actions and learning are shared through the monthly Clinical Audit and Effectiveness Group and, where appropriate, escalated to the Trust Clinical Governance Group and Quality Committee.

To strengthen governance of audit actions and improve the identification and tracking of improvements, the Trust purchased a new Audit Management and Tracking System in February 2026. The system will go live on 1 April and will enable staff to register audits and improvement projects, complete audits online, and manage action plans. The system will also support monthly data collection for projects such as fire safety, infection control, safe environment, hand hygiene, emergency trolley and fridge temperature audits.

Clinical Audit Awareness Week (CAAW), organised nationally by the Healthcare Quality Improvement Partnership (HQIP), gives Trusts and other organisations an opportunity to celebrate good practice in clinical audit and promote collaboration to improve patient care. During the June 2025 event, the clinical audit team hosted promotional stands at Poole and Bournemouth to encourage engagement. Activities included a clinical audit 'spin the wheel' based on stages of the audit cycle.

The value of clinical audit was also highlighted during a successful 'Learn at Lunch' session in January 2026. Open to all staff, the session explained the clinical audit cycle and its importance, followed by a demonstration of how to register a project, record results and create actions. Feedback was very positive.

3. Participation in clinical research:

This year was the official launch of Wessex Commercial Research Delivery Centre (CRDC), a collaboration of research hubs, including UHD, across Wessex part-funded through the National Institute for Health and Care Research (NIHR) CRDC programme.

Last winter we ran our second norovirus study through this collaboration recruiting 158 patients. This is an important study as Norovirus is highly contagious and outbreaks can produce huge pressures on our healthcare system and our economy. Health and Social Care Secretary Wes Streeting said: "*Norovirus is highly infectious and puts the NHS under huge strain every winter, costing taxpayers around £100 million a year. The UK is leading the way to develop a world-first vaccine for this vomiting bug, starting with this innovative vaccine trial delivered through the government-funded National Institute for Health and Care Research*". We are now preparing for the launch of an avian flu study in April 2026. This is part of an initiative to prepare or prevent potential pandemics in the future. Since 2024, there have been 116 confirmed human cases of avian flu across the world. Wessex research hubs are the only sites in the UK currently selected to trial this innovative vaccine.

This is lower than in previous years, likely due to a combination of internal factors, the closure of large-scale reproductive health studies, and a national decline in recruitment.

In term of numbers of patients recruiting out highest recruiting areas were Reproductive Health and Maternity, Cancer, Cardiology and Critical Care. We also sponsored studies in interventional radiology, imaging and cardiology. This includes Charlie Martin's RAPPORT study, which looked at reducing patient anxiety during radiotherapy by offering appointments to discuss the equipment used during their treatment.

Nationally, there is an emphasis on increasing commercial research through rapid set-up. This has resulted in the NIHR 150-day target. The target is that in 80% of cases it should take no longer than 150 days from Health Research Authority (HRA) submission to recruitment of first patient.

The government expects that monitoring this metric will increase the UK's ability to attract commercial research. At UHD, 67% of our studies hit this target. The national average is currently 57% and the regional average is 47%. Looking more closely, the 60-day local set-up target was met in 75% of cases (actual) and 81% (projected, including studies still in set-up that are on track to meet the target). The 30 day set-up to first patient target is more variable but still tracks above the regional average and includes UK commercial first recruited patient, another measure of successful set up and delivery of commercial research

The research department has been restructured in year to align with care groups, improving visibility and accountability.

4. Use of Commissioning for Quality and Innovation (CQUIN) payment framework

The Trust's income in 2025/26 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because of the agreement reached with the NHS Dorset Integrated Care Board (ICB) to use the CQUIN payment to source a fund available non-recurrently to protect the quality of care and safety of the service with a particular focus on areas that are giving rise to the CQUIN areas. The Trust agreed use of this fund directly with the ICB.

5. Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC), and its current registration status is unconditional, meaning there are no restrictions on its practice or services. University Hospitals Dorset NHS Foundation Trust has not yet received an overall CQC rating. The individual location ratings are as follows: Royal Bournemouth Hospital – Requires Improvement; Christchurch Hospital – Good and Poole Hospital is currently not rated.

An announced inspection of maternity services at the Royal Bournemouth Hospital took place on 16 and 27 September 2025. This was the first inspection of maternity services in their new location within the Birth, Emergency, Critical Care and Child Health (BEACH) building. The service moved into this purpose-built unit in March 2025, which now provides antenatal, triage, birth and postnatal care. CQC carried out the inspection to assess how well the new unit was functioning and whether it was keeping women and babies safe.

Following the inspection, the maternity service was rated requires improvement for being well-led and safe. Effective, caring and responsive were rated as good.

	Overall	Safe	Effective	Caring	Responsive	Well-led
CQC Maternity Ratings UHD Assessment Sept 2025	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

Inspectors found the following strengths:

- Staff enabled 79% of women to book their first appointment by 10 weeks, exceeding national targets and supporting earlier access to pregnancy care.
- Women reported positive experiences of person-centred care, stating that staff involved them in decisions, listened to their concerns, and provided appropriate support.
- Women valued having their own rooms and appreciated that partners were able to stay with them.
- The service had specialist midwives to support vulnerable women, and consultant obstetricians were present for complex births.
- The service met all ten standards in a review of fetal monitoring during labour, strengthening safety for women.

Inspectors also identified areas requiring improvement:

- The maternity advice line was frequently left unstaffed, resulting in calls being diverted to triage or the labour ward and delaying urgent advice for women.
- There were delays in the induction of labour process, with some women waiting many hours or days, increasing distress and the likelihood of intervention.
- Staffing shortages and limited theatre capacity led to the cancellation of some elective caesarean sections, causing uncertainty and anxiety for women.

The Trust provided immediate assurances in response to several of these concerns. Improvements have been clearly set out and are being actively monitored.

The Trust received an Ionising Radiation (Medical Exposure) Regulations (IR(ME)R IRMER inspection to Nuclear Medicine on 5 November 2026 at Poole Hospital.

The Inspectors found overall compliance with IR(ME)R was excellent. No recommendations or enforcement action were identified. The service demonstrated several examples of good practice, including a strong regulatory audit programme, robust document control, an effective system for recording carer and comforter exposures, and a monthly practitioner newsletter that supported good communication. A couple of minor areas for improvement were identified relating to the clinically significant accidental or unintended exposures (CSAUE) procedure and the absence of clear authorisation guidelines for medical operators. These have been actioned.

It should be noted that the CQC does not publish IR(ME)R inspection reports on their website although they may include some details from the inspection anonymously in an overall annual report. This national report is primarily aimed at professionals in the radiology, nuclear medicine, and radiotherapy communities, to share learning and improve compliance with IR(ME)R.

6. Data Quality

University Hospitals Dorset NHS Foundation Trust submitted records during 2025/26 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS number was 99.8% for admitted patient care; 99.9% for outpatient care; and 98.6% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 100% for admitted patient care: 100% for outpatient care; and 100% for accident and emergency care.

Collecting the correct NHS number and supplying correct information to the Secondary Uses Service is important because it:

- is the only national unique patient identifier
- supports safer patient identification practices
- helps create a complete record, linking every episode of care across organisations

7. Data Security and Protection Toolkit attainment levels

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.

8. Learning from deaths

The Trust has a Medical Examiner process for all inpatient deaths. Part of the Medical Examiner process includes completion of an initial case note screen by a senior clinician. The aim of the screening process is to highlight any cases that require a full learning from deaths ("e-mortality") case note review.

Consultants review all inpatient deaths flagged for follow-up using a structured judgement questionnaire. The review covers the patient's journey, noting good practice and areas for improvement.

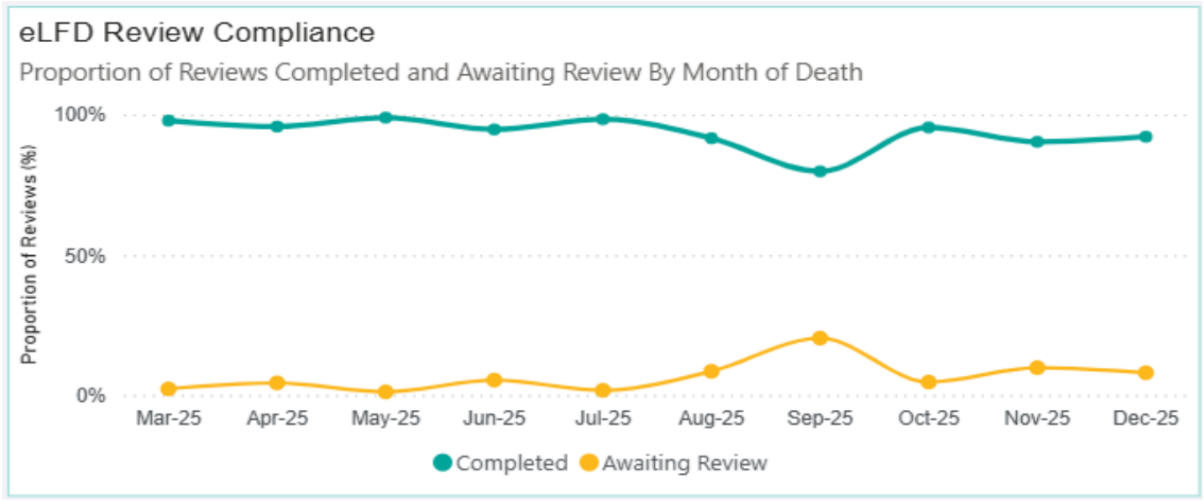
The Trust Mortality Surveillance Group (MSG), under the leadership of the Associate Medical Director for Quality and Safety, convenes monthly to assess the Trust's mortality metrics, including the Hospital Standardised Mortality Ratio (HSMR) and both internal and external reports relating to mortality risk.

The Mortality Surveillance Group evaluates potential concerns associated with clinical care or coding, and determines necessary follow-up actions, such as comprehensive case note audits and presentations from pertinent specialties. Key insights and learning outcomes from MSG deliberations are communicated across Directorate and Care Group governance structures, as well as shared with the Trust Clinical Governance Group and Quality Committee.

Insights from mortality reviews and medical examiner feedback have informed patient safety response priorities and quality improvement initiatives for 2026/27.

When a full case note review is required, it must be completed within three months and then discussed at the relevant speciality mortality meeting. The Trust position at year end (taken 08/04/2026) is represented in the table below:

Trustwide position is 94% complete for December 2025 (as at 8th April)



The "e-mortality" Learning from Deaths pro forma also includes a nationally recognised grading system to ensure that avoidable mortality is clearly categorised. The tool codes the reviews into one of the following categories:

- Grade 0-Unavoidable Death, No Suboptimal Care.
- Grade 1-Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2-Possibly Avoidable Death, Suboptimal care, but different care might have affected the outcome.
- Grade 3-Probable Avoidable Death, Suboptimal care, different care would reasonably be expected to have affected the outcome.

All cases graded as 2 or 3 are reported as a patient safety Learning Event Report Notification (LERN) and investigated in accordance with the Trust Patient Safety Response Framework (PSIRF) Policy and Plan. This includes ensuring a proportionate learning response is undertaken and compassionate engagement undertaken.

Figures for reviews completed in 2026/26 are as follows:

Grade	April – June 2025	July-Sept 2025	October – December 2025	January – March 2025
0	209 (84.0%)	132 (82.5%)	125 (80%)	103 (86.5%)
1	38 (15.2%)	25(15.6%)	29 (18.5%)	15 (12.6%)
2	1 (0.4%)	3 (1.9%)	2 (1.5%)	1 (0.9%
3	1 (0.4%)	0	0	0

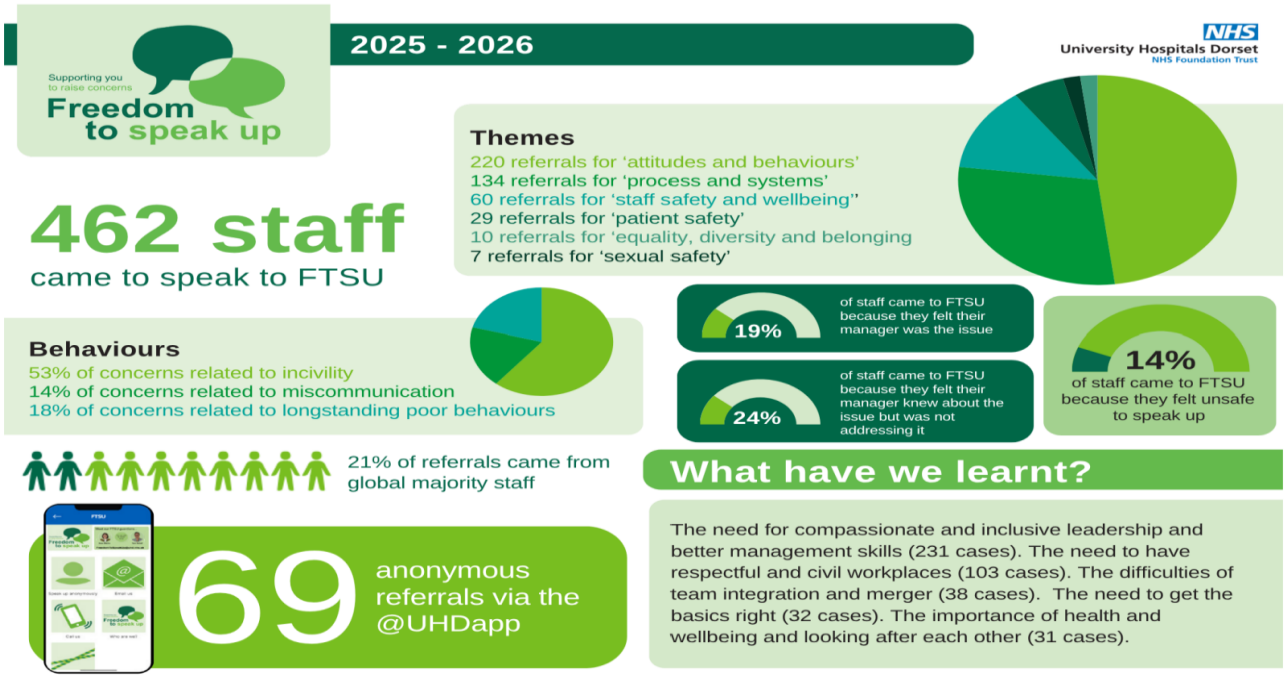
Reviews are discussed at specialty Mortality and Morbidity meetings. The chairs of these meetings report into their respective Care Group Quality meetings as well as the Trust Mortality Surveillance Group. This ensures that reviews of all deaths within the hospital are discussed both locally and centrally and ensures actions for improvement are fully considered.

In 2026/27 we aim to further improve our learning from deaths processes including:

- Amending our emortality process to enable specialist input and review of any ITU admissions included in the patient's inpatient journey
- Establishing a consistent methodology for the review of all national and Trust level mortality alerts. A new process flowchart has been agreed. The Mortality Surveillance Group will review all Alert's and agree appropriate actions to be taken.
- Amending our emortality process to improve the recording of the actions agreed and learning captured during speciality mortality and morbidity (M&M) meetings.
- Auditing the effectiveness of local M&M meetings.
- Improving data capture of themes and ensuring closer links with Trust and PSIRF priorities
- Improving capturing and sharing of quality improvement measures undertaken following reviews

9. Freedom to Speak Up (F2SU)

A detailed Freedom to Speak Up Annual Report is presented to the Board of Directors and available on the Trust website. A summary of F2SU activities for 2025/26 is provided in the infographic below:



10.0 Guardian of Safe Working Hours

The full Guardian of Safe Working Hours Annual report (1 January 2025 – 31 December 2025) was received by the People and Culture Committee in May 2026.

National changes to the exception reporting process were mandated from 6th February 2026. The Trust was an early adopter for many of these changes and has systems in place to ensure compliance with the new guidance. The changes were introduced with the aim of simplifying the Exception Reporting process and increasing confidentiality for resident doctors.

Nationally, there has been reports of large increases in exception reporting since reforms were introduced, with some trusts reporting a 3-fold increase in monthly reporting since February.

The reforms mean local departments are no longer able to see the number or nature of exception reports, increasing the importance of the Guardian of Safe Working (GOSW) maintaining oversight of the data and proactively contacting areas of concern. All Immediate Safety Concerns (ISCs) are followed up by the Guardian of Safe Working with the resident doctor who submitted the concern.

ISCs have been raised in surgery, medicine and haematology. Most relate to staffing gaps on specific days or acute pressures that require residents to stay late to maintain safe care. Some reports reflect incorrect selection of the ISC status, and in other cases concerns were not escalated at the time but submitted later as ISCs.

To support consistent use of the process, resident doctor induction will place greater emphasis on how to manage an ISC and the expectation to escalate concerns promptly to the responsible senior clinician.

A resident doctors forum meets monthly and is attended by a representation of the executive team, medical education and human resources.

11.0 National 7 Day Services Clinical Standards

In recent years there has been an increasing focus nationally on the need to strengthen emergency and acute care in hospitals in England during evenings, nights and weekends (generally known as “7-day working”).

The national Clinical Standards (published 2017 and updated 2022) set out expectations for the patient admitted to an acute Trust. These standards are independent of the day of the week. They are quality standards, one component of which is timeliness, ensuring that the patient pathway continues seamlessly throughout the weekend. Although the Standards are constructed from a patient focus, their implementation should also lead to an improvement in patient flow and efficiencies.

Consistent high quality services 7-days per week are a key tenet of UHD’s Transforming Care Together service reconfiguration (planned and emergency hospitals). In addition to supporting timely, quality care and effective clinical outcomes for all patients regardless of day/time of admission, achieving these standards will be critical to optimising our bed base and hospital flow on hospital reconfiguration.

Material improvement to compliance against the standards is expected to be delivered following reconfiguration, particularly Phase 3. In the interim, development in a number of priority areas continues with a strong focus on improving cover, pathways and processes that will deliver measurable improvements against the four key 7-Day Standards.

- Standard 2 - Time to first consultant review
- Standard 5 – Diagnostics
- Standard 6 – Interventions
- Standard 8 – Ongoing Review

An update report on the Trust's action plan against the 7-Day Services national standards was submitted to the Quality Committee in March 2026. An action tracker details progress to date, but includes:

- 7-day service plans remain part of Service Delivery Frameworks, Gateway Review panels, and business cases, supported by the Planned Care Site and Emergency Care Site Groups.
- A project to redesign out-of-hours clinical services is underway across all specialties, with most workforce plans now approved, including those for Surgical Tier 1-2 Resident Doctors. Nearly every specialty has plans for extended Consultant or senior Middle Grade coverage until at least 8:00 pm, often in key areas like the Acute Medical Unit and Older Peoples Assessment Unit. Weekend Resident Doctor coverage will see further improvements in Phase 3. Rotas for Gynaecology and Oncology have already been updated, alongside changes in emergency services.

Recent efforts across the Southwest 'First 72 Hours', Future Care, and Winter Plan Projects have improved extended day services. Key developments include:

- New combined Surgical Same Day Emergency Care (SDEC) (including Gynaecology) and 7-day Haematology/Oncology SDEC at Royal Bournemouth Hospital
- Enhanced SDEC pathways
- Expanded 7-day services throughout winter, such as weekend discharge lounge, improved transfer of care hub cycles, enhanced therapy, and virtual wards, which have reduced Occupied Bed Days.

A Getting it Right First Time (GIRFT) external review of Urgent and Emergency Care has been completed. The report will be available soon and will be used to identify quality improvement opportunities.

The Elective Hub Clinical Redesign Project is progressing post-Phase 3, focusing on cover, pathway development, theatre scheduling, and exploring 6-day working at the specialty level.

Completed and ongoing reconfigurations include Pathology, Radiology CT, Emergency Gynaecology, Cardiology, Stroke services including 24/7 Thrombectomy, Maternity, Neonatal and Oncology.

Interventions and Diagnostics are expanding via recruitment in Endoscopy and Cardiac Physiology.

Reporting against core indicators

NHS foundation trusts are required to report against a set of core indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator the number, percentage, value, score or rate (as applicable) for the last two reporting periods (where available) are presented in the table below. In addition, where the required data has been made available by the HSCIC, a comparison with the national average and the highest and lowest national values for the same indicator has been included. The Trust considers that the data presented is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Summary hospital level mortality indicator (SHMI)	NHS England	Jan 2025 – Dec 2025 0.8539 Jan 2024 – Dec 2024 0.8711 Jan 23 – Dec 2023 0.8682	1.000 1.000 1.000	1.3228 1.3323 1.2548	0.7454 0.6991 0.7202
The source data for this indicator is routinely validated and audited prior to submission to HSCIC. The data has been extracted from available Department of Health information sources. The SHMI data is taken from https://digital.nhs.uk/data-and-information/publications/statistical/shmi					
University Hospitals Dorset NHS Foundation Trust has taken action to continue to improve this rate, and so the quality of its services, by routinely monitoring mortality rates. This includes looking at mortality rates by specialty diagnosis and procedure. A systematic approach is adopted whenever an early warning of a potential problem is detected – this includes external review where appropriate. The Trust Mortality Surveillance Group routinely reviews mortality data and initiates quality improvement actions where appropriate.					
Quality Indicator	**Data Source**	**Trust rate for noted reporting period**	**National average value**	**Highest value**	**Lowest value**
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	NHS Digital	January 2025 – December 2025 57% January 2024 – December 2024 51% January 2023 – December 2023 32%	45% 44% 42%	70% 66% 67%	17% 17% 16%
The data has been extracted from available Department of Health information sources. Figures reported are 'diagnosis rate' figures and the published value for England (ENG) is used for the national value.					
University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: - Routine review of mortality reports at the Trust Mortality Surveillance Group.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (i) aged 0 to 15 (ii) aged 16 +	NHS Digital	April 2024 – March 2025 (i) 15.7% (ii) 14.9% April 2023 – March 2024 (i) = 12.5% (640) (ii) = 12.8% (5560)	 12.2% 11.6% 12.8% 11.8%	 48.1% 40.3% 69.1% 99.6%	 1.2% 0.6% 1.6% 1.7%
The Trust considers that this data is as described. The source data for this indicator is routinely audited prior to submission.					
University Hospitals Dorset NHS Foundation Trust has taken routine monitoring of performance data where appropriate.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Responsiveness to the personal needs of patients	National Inpatient Survey	2024 – 7.84	7.95	9.23	6.86
Staff who would recommend the Trust to family or friends	National Staff Survey	2025 – 65.6% 2024 – 67.0%	60.7% 61.5%	88.4% 89.5%	34.7% 39.7%
The National staff survey exercise is undertaken by an external organisation with adherence to strict national criteria and protocols.					
The results of the survey have been presented to the People and Culture Committee (a sub-committee of the Board of Directors) and key actions are being developed at Trust and local level.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The rate per 100,000 bed days Of cases of C difficile infection reported within the trust during reporting period.	Public Health England (PHE)	2024/25 – 17.33 per 100,000 overnight bed days 2023/24 – 18.6 per 100,000 overnight bed days.	23.48 18.81	80.97 56.65	1.79 0
The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors as part of the Integrated Performance Report.					
University Hospitals Dorset NHS Foundation Trust has taken actions to improve this rate, and so the quality of its services, by ensuring high standards of infection prevention and control are implemented, monitored and maintained.					

Part 3 – Patient Safety, Clinical Effectiveness and Patient Experience activity during 2025/26

The Quality Account data covers patient safety, clinical effectiveness, and patient experience. Reviewed sources include clinical governance, risk registers, audits, surveys, real-time feedback, complaints, compliments, incidents, quality dashboards, and risk data.

This information is regularly discussed at Care Group and Directorate meetings, with reports presented to the Quality Committee, Clinical Governance Group, Trust Management Group, Council of Governors, and Board of Directors.

The next section summarises 2025/26 performance against selected quality indicators, as reported in our monthly Integrated Performance Report.

Patient Safety Incident Response Framework (PSIRF)

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as “a foundation for change” and as such, it challenges us to think and respond differently when a patient safety incident occurs. PSIRF is a complete change in how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement.

PSIRF and the responsibility for the entire process, including what to investigate and how, is down to our Trust as a whole. There are now no set timescales or external organisations to approve what we do. There are a set of principles that we need to work towards but outside of that, it is up to us to agree and approve what is the right direction for finding the learning from each Patient Safety incident and this will be done in several ways. The exciting change of implementing PSIRF is that we can focus on improving our approach to patient safety incidents and develop a culture in which people feel safe to talk.

In November 2023 we set out our UHD Patient Safety Response Plan and the patient safety priorities we would focus for the next 18 months. In April 2024 we moved over completely to adopting PSIRF principles and methodology. **Our PSIRF priorities in our 2024-2026 Plan were as follows:**

PSIRP priority:
Improve the safety of the care we provide to our patients

Incident type	Speciality
Patient falls	Trust-wide
Medication (VTE)	Trust-wide
Pressure ulcers	Trust-wide
Diagnostics (follow up of radiology and laboratory investigations)	Trust-wide
Deteriorating patient	Trust-wide
Mental health (management and reducing restrictive intervention)	Trust-wide
Post partum haemorrhage	Maternity
Unexpected term admission to neonatal intensive care (NICU)	Maternity
Still births	Maternity

The following section sets out the work that has been undertaken in 2025/26 in each of the main themes:

Falls:

Falls among inpatients that cause moderate or serious harm continue to pose a significant patient safety concern. The Trust's PSIRP outlines specific measures for quickly recognising such incidents, responding with empathy, promoting organisational learning, and achieving lasting improvements.

Throughout the year we have reviewed incidents where patients fell in the hospital, including cases where the falls caused moderate or greater harm. We have analysed these events as part of a Patient Safety Incident Investigation (PSII) Thematic Review to learn how we can make care safer. We created new checklists and held safety meetings after each fall to help prevent future incidents. When things go wrong, we are honest with patients and families and show compassion.

Our Falls Team has been reorganised and a Falls Steering Group, led by a nursing director, now oversees our progress. We review data regularly to help hospital wards improve patient safety and have provided extra training and support in areas with more fall risks. We identify high-risk situations quickly so that we can respond and help prevent harm.

Serious falls have shown a decline since March 2025 showing that our efforts are working. However, we've noticed some recent increases, which may be attributed to staff shortages or busy periods.

We've learned there are still things to improve, for example, making risk assessments easier to use electronically, enhance blood pressure recording, making sure everyone's mobility status is visible, fixing issues with availability of non-slip shoes and walking aids, and keeping clear records.

We're using strong systems to track and address patient falls. Our leadership team provides oversight and direction, and we're managing ongoing risks while planning further improvements to keep everyone safer.

Pressure Ulcers:

The Trust has put clear steps in place to quickly spot and respond to pressure ulcers with care and understanding, while always working to learn and improve.

Between April and December 2025, staff recorded 175 reports about pressure ulcers, including 43 more serious cases. Rapid reviews, a PSII Thematic review and specific After Action Reviews (AARs) have helped us learn more about what causes hospital acquired pressure ulcers and how we can do better in the future.

Some important quality improvement we have made include:

- Introducing a new tool (PURPOSE-T) to help assess risks and starting the aSSKINg care bundle.

- Updating how our Tissue Viability Team works to support everyone more effectively.
- Providing training for nursing staff on how to prevent, check, and treat wounds.
- Creating guides for learning, holding weekly sessions where staff can ask questions, and working together through care improvement projects.
- Setting up better equipment management systems so the right resources are available when needed.

All work related to pressure ulcer prevention is carefully managed with strict rules and tracking systems. We now have dashboards that show patterns and progress, and we're still working to make this system stronger. In April 2026 a new Pressure Ulcer Prevention Panel will be launched. This group, chaired by a Nurse Director, will help make sure everything runs smoothly, problems are spotted early, and improvements are tracked clearly.

From what we've learned, we're focusing efforts on wards where most ulcers happen - especially for those who are frail or nearing the end of life. We're making our paperwork and practices consistent, running educational programmes, and helping nurses and support staff build their skills. Local teams are being trained to take on more responsibility, instead of relying on specialists.

We're also trying out digital tools, like taking photos for wound documentation, to speed up communication and care. Equipment, such as mattresses and cushions, is being reviewed to make sure it's available when needed.

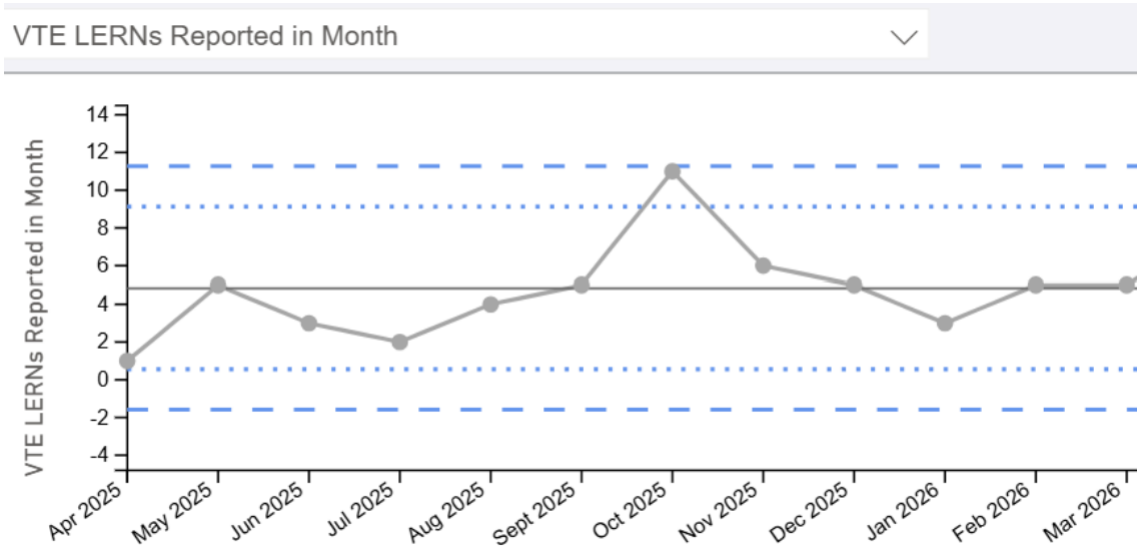
In the past, pressure ulcer rates stayed about the same, but recently there has been an increase in the most serious cases. Not all data is fully checked yet, which means we can't give a complete report, but we're improving how we monitor this. We know we have more improvement work to do. There are still differences in how things are done, skill gaps among staff, reliance on specialist teams, and limits with equipment—all of which present ongoing risks. We know current methods are not enough to solve every problem.

With the launch of the Pressure Ulcer Prevention Panel, we expect better teamwork, clear roles, and improved tracking of progress. This initiative will help us manage risks faster, prove our commitment to preventing pressure ulcers, and ensure that patients get safer, better care.

Venous Thromboembolism (VTE):

The Patient Safety Incident Response Plan (PSIRP) gives a straightforward way to address patient safety concerns related to blood clots (VTE). It includes actions like taking steps right away, reviewing incidents thoroughly when needed, talking compassionately with patients and families, learning from what happened, checking patterns using dashboards, and making sure everything is overseen by a special group.

We created a special category for VTE incidents in our incident reporting system to help track and review these cases.



Between April 2024 and December 2025, we identified 60 incidents, seven of which caused/potentially caused a level of harm. We carried out incident reviews and learning responses, including five After Action Reviews. We also commission a PSII Thematic review which started in December 2025. Common findings are that although VTE risk assessments are done reliably (we consistently score above 95% in VTE risk assessments meeting national standards) it is still difficult to make sure medicines are prescribed and administered correctly and in a timely manner.

Our Anticoagulation and Thrombosis Group leads efforts to reduce risks from blood clots, with support from the patient safety team. Dashboards and reports make problem trends visible across the hospital and Trust.

We've focused on improving systems and making things clearer. This includes creating a tool to monitor VTE risk assessment completion and prophylaxis prescribing, making our records easier to spot missed doses, and building ways to flag patients who haven't received their blood clot prevention medication. We're also working to better understand why doses are missed.

Key lessons include the need for clearer links between our response plan and learning reviews, sharing responsibility for improvement among more people, and finding better ways to turn assessments into action. Risks remain where system changes and new reporting tools aren't fully or consistently embedded, or where we could involve patients more in VTE management.

Results from the current thematic review will guide whether we need more targeted actions or deeper analysis. Ongoing monitoring and Trust-wide reporting will keep us moving forward. Our main goals are to strengthen controls already in place, boost clinical involvement, empower patients in managing VTE risks, and ensure our learning responses are always appropriate.

Mental Health:

The Trust has set processes for handling violence and aggression towards staff, as well as for using restraint. These processes include quick safety actions, organised reviews of incidents, steps for reporting more serious cases, and learning from events when needed. Oversight is

managed by established governance meetings, with system level mental health care pathways and capacity challenges are recognised as requiring multi agency improvement work.

To ensure learning from restraint, a new group has been set up to review all incidents. Every two weeks restraint incidents are reviewed to learn from them and ensure safety. While a final version of the policy is still being developed, a checklist helps keep these reviews consistent. The number of reported incidents has remained stable, and reviews have provided assurance that patients have not been harmed as a result of any action taken during necessary restraint.

Risks related to mental health safety are discussed at the Mental Health Steering Group that meets each month and shares information with the Clinical Governance Group and Quality Committee. The Mental Health Steering Group focuses on four main areas: improving environments, education and training, clinical procedures, and reviewing patient pathways.

Targeted improvement work has focused on staff safety. Changes have been made to security staffing models, training, and equipment, as well as how violent incidents are recorded. Meetings with outside partners, like mental health community services and police, happen regularly to support and strengthen collaboration.

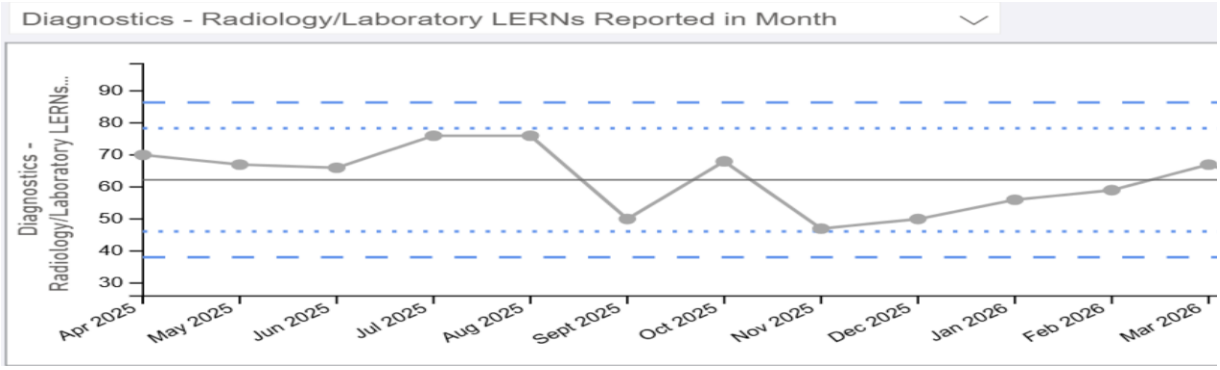
Due to quality improvement work undertaken Mental health patients without physical health have spent less time in the hospital. This data is reviewed by the Mental Health Steering Group.

Some environmental risks remain and this work is on-going. A draft policy on restrictive interventions and rapid tranquilisation has been developed and is currently being consulted on. Security staff are trained and respond well, but more work is needed to improve how capacity assessments are documentated before using restraint.

The Trust will keep monitoring violence, aggression, and restraint through existing review systems, continued learning, and teamwork across the wider system. More progress is planned with new policies, better environments, and joint efforts to reduce delays in mental health care pathways.

Diagnostics – the follow up of radiology and pathology results:

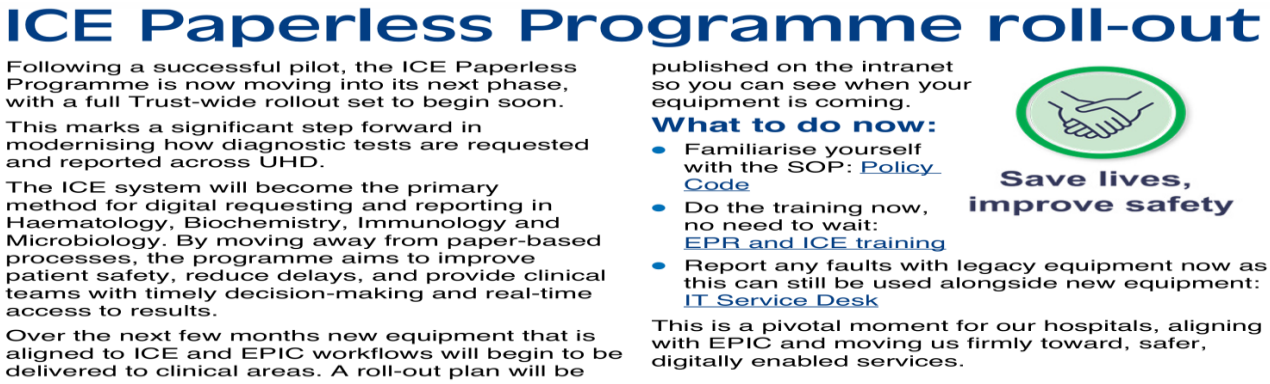
As part of our Patient Safety Incident Response Framework (PSIRF) we have developed a clear and organized approach to keeping patients safe, in line with national principles. This includes acting quickly when safety issues arise, learning from incidents in a way that matches their seriousness, involving people compassionately, and maintaining strong oversight. We track our progress using visual dashboards, regular checks, and thorough reviews to make sure we consistently spot and solve any risks related to the follow up of radiology or pathology results.



All reported incidents involving delays in the follow up of diagnostic results are reviewed in line with our PSIR Plan and Policy. For each incident, our responses matched the level of risk. Immediate safety steps were taken where required and open, honest communication was undertaken with those involved.

We've taken specific steps to improve system risks, such as:

- Introducing a new software system Integrated Clinical Environment (ICE) for secure, closed-loop reporting



ICE Paperless Programme roll-out

Following a successful pilot, the ICE Paperless Programme is now moving into its next phase, with a full Trust-wide rollout set to begin soon.

This marks a significant step forward in modernising how diagnostic tests are requested and reported across UHD.

The ICE system will become the primary method for digital requesting and reporting in Haematology, Biochemistry, Immunology and Microbiology. By moving away from paper-based processes, the programme aims to improve patient safety, reduce delays, and provide clinical teams with timely decision-making and real-time access to results.

Over the next few months new equipment that is aligned to ICE and EPIC workflows will begin to be delivered to clinical areas. A roll-out plan will be published on the intranet so you can see when your equipment is coming.

What to do now:

- Familiarise yourself with the SOP: Policy Code
- Do the training now, no need to wait: EPR and ICE training
- Report any faults with legacy equipment now as this can still be used alongside new equipment: IT Service Desk

Save lives, improve safety

This is a pivotal moment for our hospitals, aligning with EPIC and moving us firmly toward, safer, digitally enabled services.

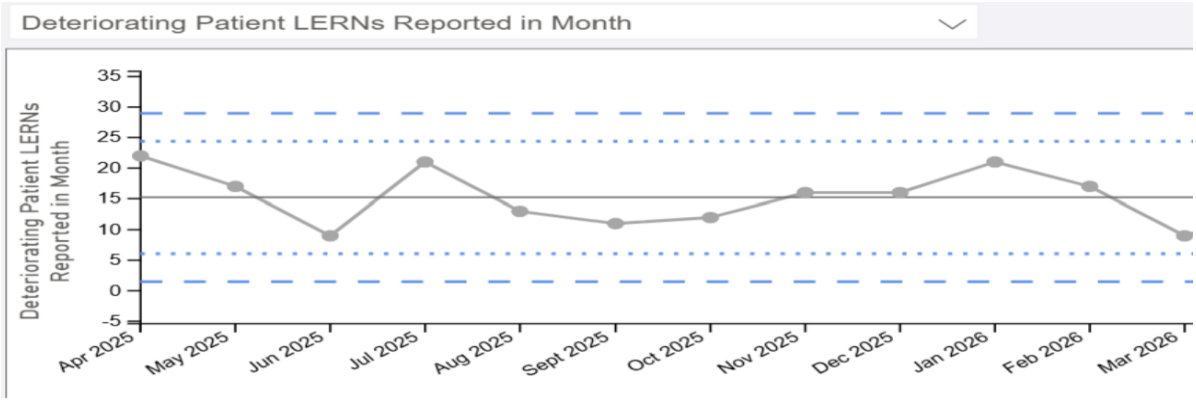
- Launching the Outpatients Diagnostic Improvement Project and rolling out the ORBIT computer system
- Auditing of diagnostic processes
- Improving the use of IT to improve information flows and reduce reliance on manual checks, paper processes and individual workarounds.

These efforts aim to make processes safer and more efficient, improve information sharing, and reduce manual tasks. More staff are using digital tools and audits show better adherence to protocols. However, we recognise that there is still more work to be done. Key priorities moving forward include making sure digital systems support prompt clinical action and cutting down on manual processes in outpatient care.

We also look forward to the implementation of a new Electronic Health Record (EHR) system in 2028, which will make data sharing, result tracking, and overall reliability much better. By following safety protocols and having strong leadership, we're committed to identifying and reducing risks in diagnosis to keep patients safe.

Deteriorating Patients:

We have established a clear Deteriorating Patient Safety Plan to establish clear steps, including immediate actions for safety, ways to assess what patients need, caring communication with families, and sharing lessons learned so we can keep improving.



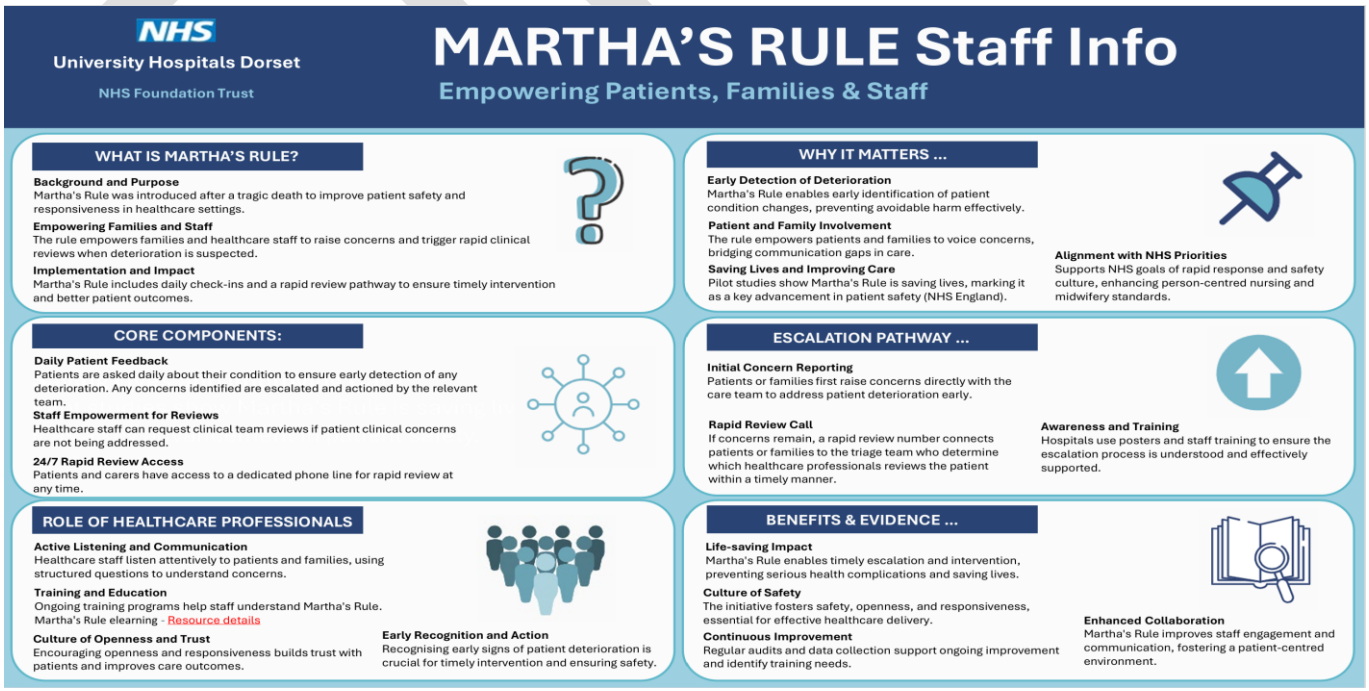
We carefully reviewed and responded to incidents, including detailed reviews and group discussions to understand what went wrong and how to prevent it next time. Some cases needed deeper investigation (thematic review), especially those involving challenges like finding a vein for IV access.

A new Deteriorating Patient Group has been established to oversee this work, focusing on four key areas:

- Sepsis (a serious infection)
- Kidney injuries
- Martha's Rule (patient rights and escalation)
- Prevention and early action

This group has cross site and cross Care group clinical and specialist engagement and looks closely at ensuring compliance with national and local standards. New policies have been developed for the management of a deteriorating patient, acute kidney injury, Martha's Rule and sepsis. We have developed new reporting tools and dashboards to monitor progress and are in the process of identifying routine audit processes.

We have also developed guidance for staff including this one for Marthas Rule:



The number of reported deteriorating patient incidents has stayed within expected levels. We are learning from each event, tracking progress with dashboards and oversight. However, we know we need better ways to measure our success and show improvement clearly.

For 2026–2028, we will:

- Set clear goals and measure how changes improve patient safety
- Turn lessons learned into practical steps
- Make sure incidents are managed the same way across the hospital
- Regularly check if recommendations are working

With strong leadership and careful monitoring, we aim to make sure that patients whose condition gets worse receive quick, safe, and reliable care every time.

Term admission to Neonatal Intensive care unit (NICU):

The term admission to NICU patient safety incident response plan focuses on thematic review and learning, immediate safety actions, staff support, compassionate engagement and escalating concerns when needed. Regular reviews and national oversight help spot and solve risks in maternity care.

All reported maternity related incidents were reported in accordance with the Trust PSIRF Policy and Plan. In most cases local reviews and learning were completed. Some cases needed more investigation, with one Patient Safety Incident Investigation (PSII) and one referral to the National Maternity and Neonatal Safety Investigation (MNSI) Team.

Oversight is provided through the Local Maternity and Neonatal System (LMNS), supported by internal maternity and neonatal safety leads.

The Maternity Safety Champions meeting, operating with Executive level oversight, provides assurance of leadership engagements, escalation and accountability. Monthly ATAIN (Avoiding Term Admissions Into Neonatal units) meetings ensure through review of all cases and support continuous learning and improvement.

Actions this year have included:

- Ensuring a multi-disciplinary team manages the ATAIN quality improvement program to ensure all admissions of term babies are thoroughly reviewed.
- Applying lessons from both local and national investigations
- Implementation of new practices like the provision and use of bedside CPAP (Continuous Positive Airway Pressure) machines to avoid babies having to go to ITU which causes mother/baby separation
- Improving ATAIN documentation and decision-making tools.

As a result of these measures, ATAIN figures for UHD are now below (better than) national targets.

Post Partum Haemorrhage (PPH):

Post-partum haemorrhage (PPH) – heavy bleeding after birth can become serious very quickly. When it happens, we need to respond immediately, support the people involved, and learn so we can reduce the chance of it happening again.

In 2025/26 we reviewed all reported PPH cases using our usual safety review process, including two After Action Reviews (team learning discussions) and one full patient safety incident investigation where deeper learning was needed. We also introduced weekly PPH case reviews so we can identify learning quickly and escalate concerns when needed. Immediate safety actions, staff support mechanisms and use of the PPH checklist were embedded in each response. Oversight is through our internal and external maternity governance forums.

Targeted improvement activity has focused on strengthening frontline response and reliability, including:

- Using a PPH checklist so the clinical response is consistent
- Weekly multidisciplinary review of PPH cases to identify learning early
- Identifying gaps in policies, training, medication availability and equipment so we can address them
- Reviewing events to improve recognition, response and team coordination during PPH events.

Actions and learning to date has included ensuring:

- consistent coding and data quality so themes can be easily identified
- updating and aligning policies relating to PPH management
- placing PPH medication cupboards in all labour rooms to support timely intervention
- undertaking multidisciplinary simulation training to improve team response
- clarity around the critical role during escalation and management of a PPH

Overall, the number of reported PPH cases over the last 12–18 months has been broadly stable.

Stillbirth:

We handle and review stillbirth cases in line with national guidelines. Our goal is to ensure every case is treated with respect, sensitivity, and thorough attention. For all cases, our maternity and neonatal teams met regularly to discuss what happened and how to improve care. We use the national Perimatal Mortality Review Tool (PMRT) and ensure cases are peer reviewed through established procedures. Oversight is provided through the Local Maternity and Neonatal System (LMNS).

In 2025/26 we have undertaken a number of improvement measures including:

- adding a special field in our records system to capture more accurate data
- updating our policies with the latest guidance
- providing targeted obstetric training to ophthalmology colleagues to improve the recognition of signs and symptoms of pre-eclampsia
- changing sample bottles to help staff follow collection procedures
- making patient information easier to find and understand for everyone

Our stillbirth numbers remain within expected levels and currently below the national average (Ref: Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK Report March 2026)

Looking ahead, we will:

- continue careful reviews with internal and external experts
- track how improvements affect patient care
- make information more accessible for patients and families
- follow best practices in maternity care
- keep executive oversight to spot risks early and keep improving

These steps show our commitment to reducing risks related to stillbirths and providing safe, sensitive care in line with national standards.

Never Events

Never events are patient safety incidents that should not occur because there is national guidance in place requiring the use of safe systems of work. The full list of Never Events is available on the NHS England website https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf

In 2025/26 we reported 5 Never events compared to 4 in 2024/25. All reported Never Events in 2025/26 occurred within the Surgical Care Group and related to retained foreign objects or wrong-site surgery. A substantial programme of work has been undertaken to review and strengthen use of the WHO Surgical Safety Checklist within Theatres, alongside enhanced monitoring of compliance. This work is now being rolled out more widely across the organisation.

Duty of Candour

The Duty of Candour requires healthcare providers to respond to patient safety incidents that result in moderate or severe harm or death in line with Statutory Duty of Candour as detailed in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Any patient safety incident meeting the criteria for statutory duty candour require organisations to:

- apologise
- inform patients that an investigation will be undertaken
- provide the opportunity for them to be involved in that investigation
- provide patients and their families with the opportunity, and support, to receive and discuss the outcomes of the investigation

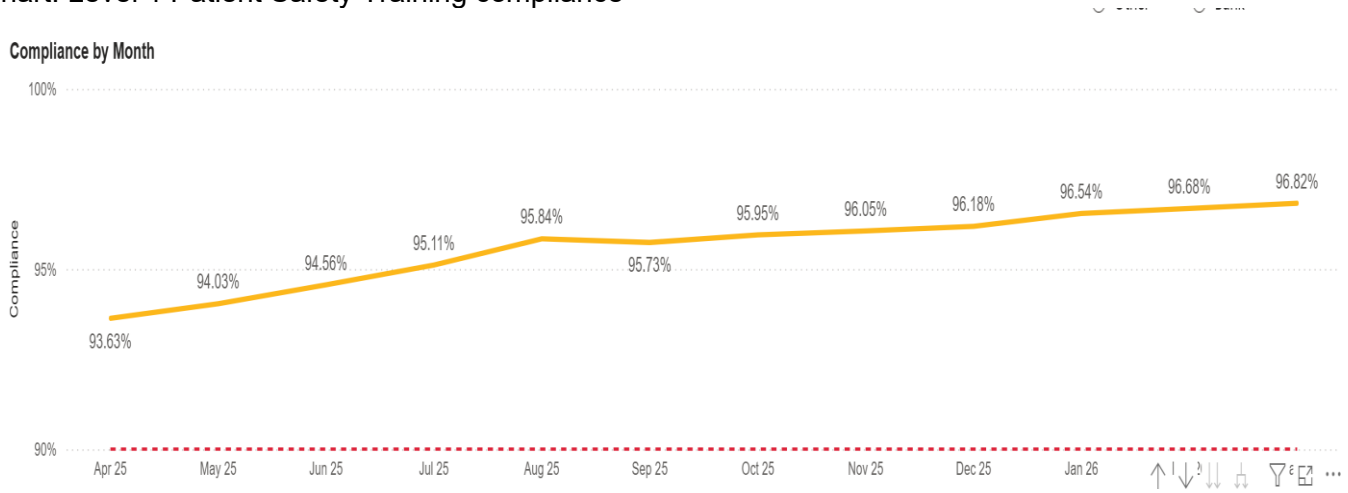
Duty of Candour is managed within the structure of the Trust's web-based risk management reporting system and is an integral part of the reporting and subsequent incident management process.

All investigation processes require consideration and undertaking of the Duty of Candour in accordance with national legislation. A Duty of Candour Toolkit is available to support staff.

Patient Safety Training

The National Patient Safety Training Level 1 is part of essential core skills training for all staff. At the end of March 2026 95.8% of staff had completed the online training.

Chart: Level 1 Patient Safety Training compliance



Sharing Learning - Patient Safety Events – Themes in 2025/2026

Learning from patient safety investigations is shared in several different ways including:

- Individual feedback (the LERN system provides an automatic response back to the reporter)
- Safety huddles
- Team, Care Group and Corporate newsletters
- Clinical governance, Quality and Safety meetings at various levels across the organisation
- The monthly Clinical Governance Group “Top 10” briefing
- Organisational Wide Learning (OWL) Patient Safety Alerts
- Core Brief articles e.g.

- Monthly Learn at Lunch sessions e.g.

  Other topics have included Security, Fire Safety, Mental Health, Clinical Audit, Simulation training for Safety and Adult Safeguarding.

- Training sessions, ½ audit days, presentations, and other learning forums
- An annual Patient Safety Conference

In September 2025 we held our first UHD Patient Safety Conference for over 200 staff. The event was also open to our ICB quality and safety colleagues and our UHD Patient Safety Partners. The event was an opportunity for staff to listen to some fantastic external speakers and join collective discussions on safety culture, system thinking and compassionate engagement. The event considered topical challenges for safety culture including:

- How can we move away from blame to focus on system learning and investigation?
- What are the practical steps needed to support patients, relatives and our staff during patient safety investigations?
- How can PSIRF support proportionate but effective learning
- How do we challenge ourselves to ensure that safety culture is a top priority for UHD?

The event was such a success we are planning a second one in September 2026

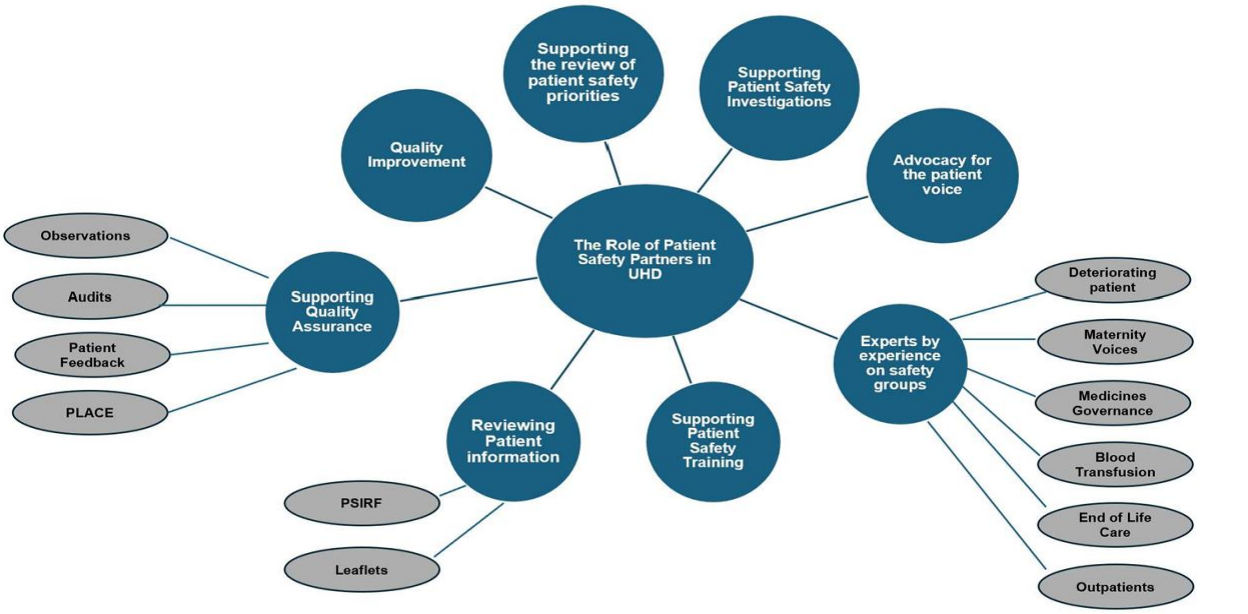
Patient Safety Partners

In UHD we are very lucky to have 4 wonderful volunteer Patient Safety Partners and two Staff Safety Partners – volunteers with lived experience as patients, carers or service users who collaborate with staff to strength safety.

Our volunteer Patient Safety Partners act as 'knowledge brokers' as they often have the insight of a user of services across different parts of the NHS and can therefore help inform learning and holistic safety solutions that cross organisational boundaries. They provide a different perspective on patient safety, one that is not influenced by organisational bias or historical systems. By reinforcing the patient voice at all levels in an organisation and across integrated care systems, PSPs can support a patient-centred approach to safer healthcare.

Examples of areas of collaboration include:

- membership of the Clinical Governance Group and Quality Committee
- involvement in patient safety improvement projects including fundamentals of care workstreams
- involvement in quality improvement projects and/or groups including deteriorating patient work
- supporting safety observations, audits and quality accreditation visits to clinical and non-clinical areas
- involvement in supporting safety training including compassionate engagement and duty of candour
- supporting the development of Patient Safety Incident Response Framework (PSIRF) plans



- supporting investigations e.g. reading draft reports, attending Oversight meetings, attending Terms of Reference meetings, undertaking PSIRF surveys with staff to support implementation and understanding.

National and Local Staff Survey

The **NHS Staff Survey** is the largest survey of staff opinion in the UK where staff are given the opportunity to share their views of experiences at work. It gathers views on staff experience at work around key areas, and including appraisal, health and wellbeing, staff engagement and raising concerns.

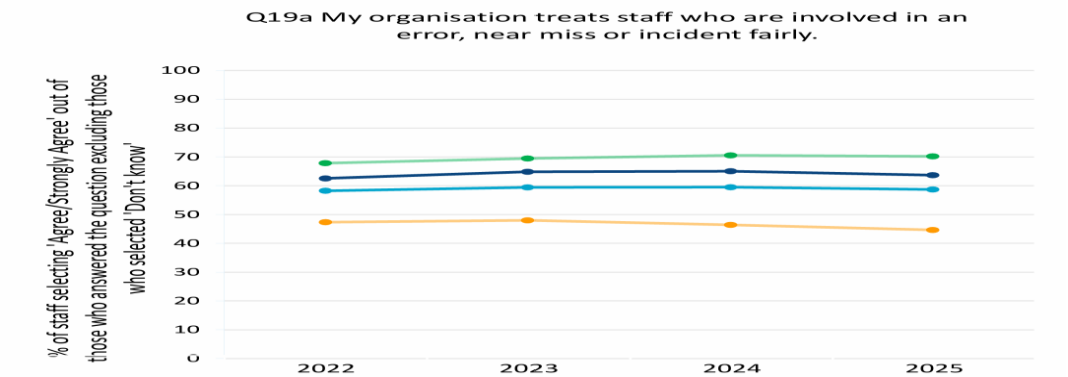
The questions in the NHS Staff survey are aligned to the NHS England People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience and is made up of seven elements:

The national survey centre publishes full and summary reports of core survey responses appropriately benchmarked against national data for all trusts in England. The survey provides valuable information about staff working conditions and practices, which are linked to the quality of patient care.

A number of the questions in the National Staff Survey are specifically relevant to safety culture.

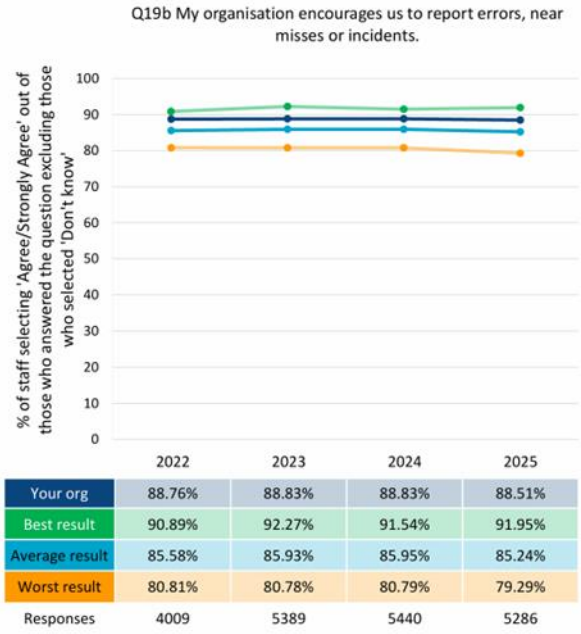
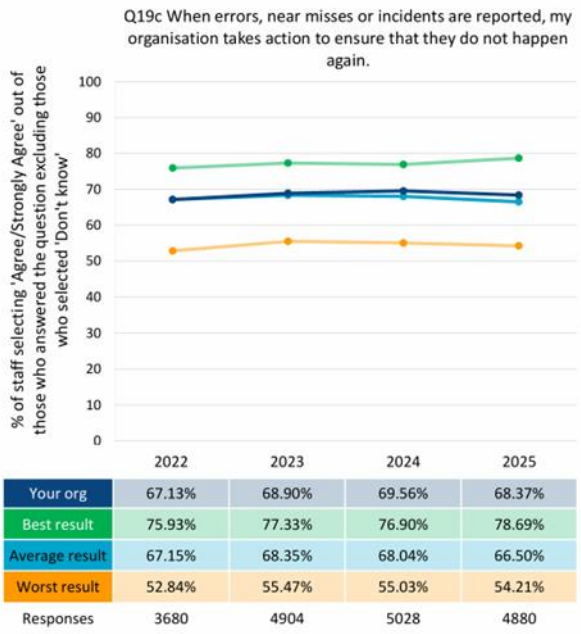
Although we were disappointed that our scores for 2025 were slightly lower than the previous year, we were really pleased to note that the results were still above the national average for all acute trusts.

Question	2023	2024	**2025**	**Movement**	**UHD Comparison to national average (all acute Trusts) 2025**
My organisation treats staff who are involved in an error, near miss or incident fairly	64.71%	65.0%	**63.7%**	↓	↑



	2022	2023	2024	2025
Your org	62.55%	64.86%	65.03%	63.66%
Best result	67.83%	69.44%	70.55%	70.22%
Average result	58.23%	59.41%	59.50%	58.69%
Worst result	47.33%	47.99%	46.42%	44.65%
Responses	3253	4335	4444	4331

Question	2023	2024	**2025**	**Movement**	**UHD Comparison to national**

					average (all acute Trusts) 2025
My organisation encourages us to report errors, near misses or incidents	88.9%	88.8%	**88.5%**	↓	↑
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	69.1%	69.5%	**68.4%**	↓	↑
 Your org 88.76% 88.83% 88.83% 88.51% Best result 90.89% 92.27% 91.54% 91.95% Average result 85.58% 85.93% 85.95% 85.24% Worst result 80.81% 80.78% 80.79% 79.29% Responses 4009 5389 5440 5286			 Your org 67.13% 68.90% 69.56% 68.37% Best result 75.93% 77.33% 76.90% 78.69% Average result 67.15% 68.35% 68.04% 66.50% Worst result 52.84% 55.47% 55.03% 54.21% Responses 3680 4904 5028 4880		
We are given feedback about changes made in response to reported errors, near misses and incidents	60.1%	60.5%	**59.8%**	↓	↑
I would feel secure raising concerns about unsafe clinical practice	73.1%	73.7%	**72.2%**	↓	↑
Care of patients/service users is my organisation's top priority	76.3%	76.2%	**72.8%**	↓	↑

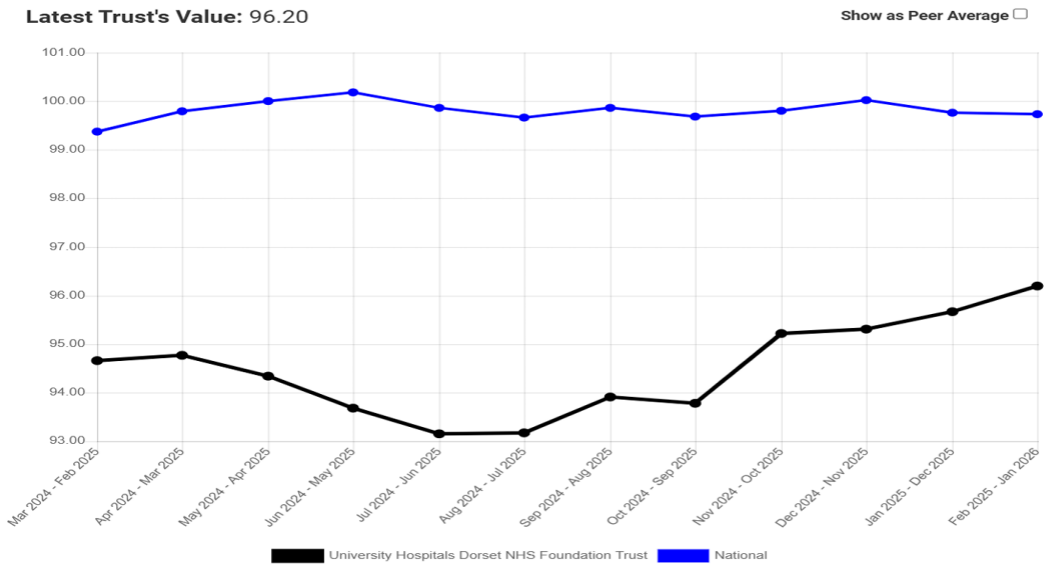
Reducing Mortality

Hospital mortality is normally assessed using two measures. The first is the hospital standardised mortality ratio or HSMR.

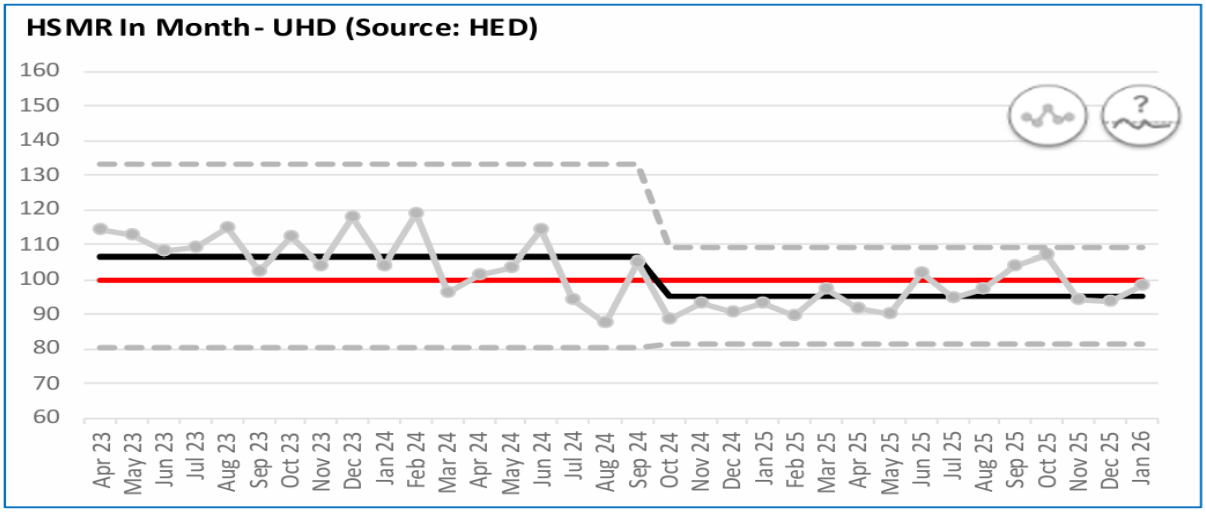
HSMR (Hospital Standardised Mortality Ratio) is the ratio of observed number of in-hospital inpatient deaths compared to the expected* number of in-hospital deaths. UHD report both the in-month and rolling 12-month positions and data is usually a few months in arrears. Data is extracted from HED (Healthcare Evaluation Data) and excludes the latest month which is not yet fully coded. The national average is 100.

HSMR Rolling 12 Month: February 2025 to January 2026 is 96.2. The below displays UHD (black line) against the national picture (blue line).

HSMR Rolling 12 Month: February 2025 to January 2026 is 96.20. The below displays UHD (black line) against the national picture (blue line).

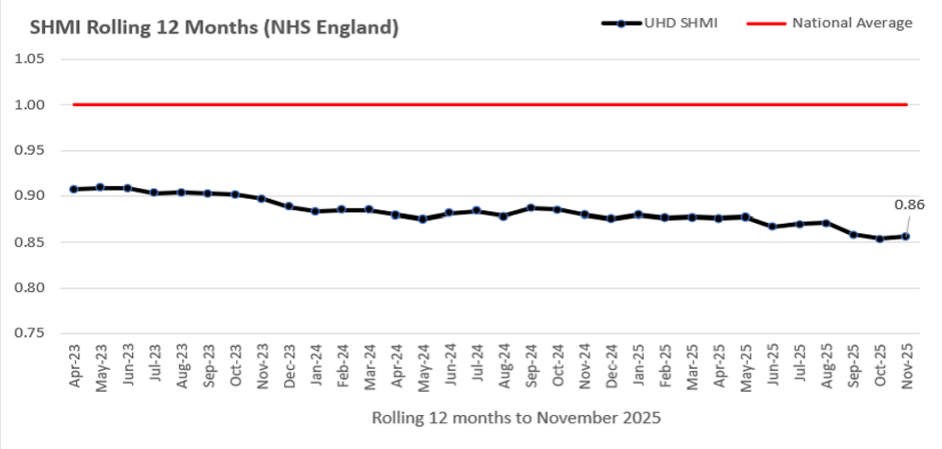


HSMR In Month : Latest fully coded position is January 2026 at 98.0, which is below the national average of 100 and remains within expected variation.



SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the number of patients who die up to 30 days following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. Data is provided for rolling 12 months and always in arrears. Hospices are excluded. The national average is 1.

UHD's SHMI is in the 'lower (better) than expected' range at 0.86 for the 12 months to November 2025.



NHS England calculate SHMI values and bandings for 10 of the SHMI diagnosis groups. Below is for the latest rolling 12 month period to November 2025;

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
Cancer of bronchus; lung	15	370	105	100	1.0727	As expected SHMI
Septicaemia (except in labour), Shock	2	650	175	175	0.9988	As expected SHMI
Fluid and electrolyte disorders	37	845	55	55	0.9620	As expected SHMI
Pneumonia (excluding TB/STD)	73	2,975	465	490	0.9443	As expected SHMI
Secondary malignancies	30	840	120	130	0.9233	As expected SHMI
Acute myocardial infarction	57	960	70	80	0.9218	As expected SHMI
Gastrointestinal hemorrhage	96	725	45	45	0.9104	As expected SHMI
Fracture of neck of femur (hip)	120	920	65	80	0.7878	Lower than expected SHMI
Urinary tract infections	101	1,860	70	90	0.7654	Lower than expected SHMI
Acute bronchitis	74	1,905	50	85	0.6055	Lower than expected SHMI

For the 12 months to November 2025, all diagnosis level values are either as expected or lower than expected. NHS England publish the latest statistics on a monthly basis. UHD has a SHMI of 'as expected'. UHD is in the top 10 trusts of the 119 trusts included. For more detail please see this report published by NHS England; https://digital.nhs.uk/data-andinformation/publications/statistical/shmi

Each month we receive Mortality Alerts from HED (Healthcare Evaluation Data), these are triggered when there is a higher than expected value above and beyond a given threshold. For 'red' alerts, this threshold is the upper control limit. There were no mortality alerts for the latest data published (Jan 2025 to Dec 2025) for the rolling 12-month SHMI position.

Meeting National Institute for Health and Care Excellence (NICE) Guidance

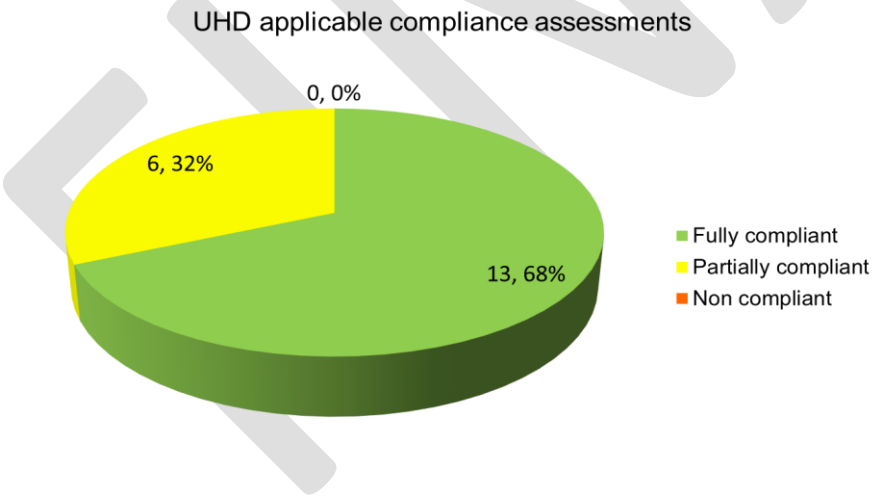
This section covers the NICE process at UHD including the NICE procedure. The report provides: an overview of guidance published by NICE; the status of all new guidance published in 2025/26; developments undertaken in 2025/26; developments planned for 2026/27.

The Trust position in relation to NICE Guidance published from 1 April 2025 to 31 March 2026 is as follows:

Care Group	Compliant	Partially Compliant	Non-Compliant	Not applicable	Grand Total
Medical	6	3	0	11	20
Surgical	1	0	0	5	6
WCCSS	5	2	0	7	14
Operations	0	0	0	0	0
Nursing and Quality	1	1	0	2	4
Grand Total	**13**	**6**	**0**	**25**	**44***

*This figure does not include Technology Appraisals (TAs), Health Technology Evaluations (if they have been disseminated for information only), guidance awaiting review of compliance or updates to guidance that was previously published.

Of those that were rated as applicable to UHD as per the table above (published from 1 April 2025 to 31 March 2026), the compliance status is recorded as follows:



*These figures exclude NICE Technical Appraisals

Of those that were rated as partially compliant for UHD the reasons for partial compliance and corresponding action plans are listed in the following table:

Partially compliant NICE				
Guidance	**Title**	**Specialty**	**Overview of the situation for elements of non-compliance:**	**Monitoring of action plans**
NG 249	Falls: assessment and prevention in older people and in people 50 and over at higher risk	Nursing and Quality	As a Trust, we are not yet fully compliant with all aspects of the guidance. Improvement workstreams are in place to review current risk assessment tools and care plan requirements. The work is being delivered through the Fundamentals of Care Steering Group.	Fundamentals of Care Steering Group
NG 252	Rehabilitation for chronic neurological disorders including acquired brain injury	Neuro Rehab	Partial compliance with standards relating to capacity and supporting behavioural change around physical activity.	Recruitment is in progress to support a full compliance rating.
NG 253	Suspected sepsis in people aged 16 or over: recognition, assessment and early management	Emergency Department	This has been recorded as partial compliance pending the provision of audit or training records to evidence full compliance. A refreshed Sepsis Policy has been implemented, and a new Sepsis Group is being established. A Sepsis lead post and a Sepsis Nurse post are currently out to advert. The sepsis nurse post will lead on relevant audit data.	Deteriorating Patient Group
NG 254 and QS213	Suspected sepsis in under 16s: recognition, diagnosis and early management	Acute Paediatrics	As above	Deteriorating Patient Group
NG 255	Suspected sepsis in pregnant or recently pregnant people:	Obstetrics	As above	Deteriorating Patient Group

Case studies of improvement following implementation of NICE Guidance include:

NG248 Gambling-related harms: identification, assessment and management - UHD are now compliant with this guidance. Posters providing QR codes for self-referral to the Southwest Gambling Service and for mental health support are now on display in ED waiting rooms across UHD. In addition, staff education has also been completed to raise awareness around asking patients about gambling and giving information on available support for patients, where appropriate. This forms part of the ongoing departmental improvement program.

NG137 Twin and triplet pregnancy - UHD are now compliant with the recommendations around cervical length scanning and associated progesterone pathway for all multiple pregnancies. This may reduce the risk of pre-term deliveries.

Learning from complaints and concerns

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

Complaints made to the Trust are managed within the terms of the Trust's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion. The number of formal complaints received and investigated can be seen below.

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

The Trust has implemented an early resolution of complaints which forms part of the formal complaint process and reported as such. Early resolution is intended to provide a quicker response usually within 10 working days.

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

PALS concerns	**2025/26**	**2024/25**	**2023/24**	**2022/23**	**2021/22**
	UHD	**UHD**	**UHD**	**UHD**	**UHD**
	7041	6624	5982	5530	5200

Subjects of complaints

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

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 & cancelled appointmen	**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%)
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%)
Prescribing	**17 (1.87%)**	0 (0.0%)	37 (2.5%)	43 (2.2%)
Privacy, dignity & wellbeing	**23 (2.53%)**	154 (18.7%)	41 (2.7%)	22 (1.1%)
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 & 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. Themes from complaints feed into relevant governance meetings including Fundamentals of Care, Falls steering group, Clinical Governance Group and the Deteriorating Patient Group.

Changes resulting from Complaints

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

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 have rectified this. The team will also be auditing the lighting provision during the darker months to ensure that there are safe, well-lit paths to and from the car parks
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 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 since 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.
You Said: Concerns regarding storage of medicines in the locked storage in patient 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 e-learning medication management package as well as Trust wide via senior leadership teams.
You Said: Concerns raised regarding congestion in the car park and feedback regarding the speed humps on the Bournemouth site
We Did: Our external car park company have 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: 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.

Plans for the year ahead will focus on promptly addressing issues to limit formal complaints, providing clear process updates and notifications of delays to complainants, and consistently working to shorten response times for all concerns.

Performance against national priorities 2025/26

National Priority	2025/26 Actual	2025/26 Standard	2024/25	2023/24	2022/23
18 week referral to treatment waiting times – admitted (31/03/2026)	**49.3%**	92%	46.1%	46.0%	49.8%
18 week referral to treatment waiting times – non admitted (31/03/2026)	**74.5%**	92%	65.3%	66.1%	54.6%
18 week referral to treatment waiting times – patients on an incomplete pathway (31/03/2026)	**67.5%**	92%	60.9%	62.0%	53.8%
Proportion of patients staying for over 12 hours in Emergency Departments	**8.5%**	<2%	7.5%	7.0%	7.3%
62 Day General Standard (all cancers)	**71.3%**	85%	72.0%	68.9%	67.8%
31 Day General Treatment Standard (all cancers)	**96.2%**	96%	96.6%	96.1%	97.1%
28 Day General Faster Diagnosis Standard (FDS - all cancers)	**75.8%**	75%	79.8%	67.1%	67.4%
% waiting under 6 weeks (1% std) for diagnostic procedures (31/03/2026)	**92.7%**	>99%	92.5%	89.3%	93.0%

Appendix A – Comments from stakeholders

Healthwatch Dorset welcomes the opportunity to provide a comment for the University Hospitals Dorset NHS Foundation Trust Quality Account report for 2025-2026.

Healthwatch Dorset exists to provide a strong voice for local people. Being separate from the NHS and central government has helped us build trust with communities and our independence means people feel more confident sharing their experiences with us. We want everyone in Dorset to be included in the conversation, so we strive to hear from as wide a range of people as possible from our diverse communities. We share those views with University Hospitals Dorset and others who provide local health and care services, to help create positive change.

This year we've worked with University Hospitals Dorset NHS Foundation Trust to report on carers experience of the Hospital at Home service:
https://www.healthwatchdorset.co.uk/report/2025-09-30/hospital-home-service-understanding-impact-family-carers-dorset
We visited the A&E department at Bournemouth Hospital to see what impact the new building that opened in May 2025 has had on people's experience of care:
https://www.healthwatchdorset.co.uk/report/2025-11-25/enter-view-report-emergency-department-royal-bournemouth-hospital
We also met with members of the Addiction Care and Treatment Services team at University Hospital's Dorset to find out how they support inpatients:
https://www.healthwatchdorset.co.uk/blog/2026-01-06/addiction-care-and-treatment-services
https://www.healthwatchdorset.co.uk/blog/2025-09-29/nhs-addiction-services-supporting-patients-dorset

We look forward to working with the Trust over the coming year to share people's views and improve services. In light of the proposed changes in the recent Health Bill, we will also be working hard to urge decision-makers to ensure that there remains a strong, independent mechanism for public feedback across health and care — one that is accessible, trusted and accountable.

www.healthwatchdorset.co.uk

Governors statement for the Quality Account 2025/26:

'The Council of Governors welcome the Trust's open and transparent Quality Account, with clear and honest reflection on areas for improvement alongside evidence of a strong and positive patient safety culture. The Quality Account demonstrates a clear strategic direction through the "Patient First" approach and a commitment to focusing on key priorities to deliver meaningful care to our patients.

The Council of Governors would like to thank Jo Sims and her team for providing such a comprehensive report.'

Statement from NHS Dorset Integrated Care Board on University Hospitals Dorset NHS Foundation Trust Quality Account for 2025/2026

NHS Dorset Integrated Care Board welcomes the opportunity to review and comment on University Hospitals Dorset NHS Foundation Trust Quality Account for 2025/2026. Insofar as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate and is consistent with information presented to the Integrated Care Board through monitoring discussions and established quality governance routes during 2025/26. The ICB also notes that the Account appears to address the expected NHS England Quality Account requirements.

NHS Dorset notes the comprehensive overview of the Trust's achievements, challenges and future priorities, aimed at continuing the delivery of high-quality care. It is the view of the ICB that the Quality Account reflects University Hospitals Dorset NHS Foundation Trust's ongoing commitment to continuous improvement in patient care and safety, and recognises the Trust's key achievements and areas of progress in the following areas:

- Sustained achievement of the national mandated standard for venous thromboembolism risk assessment, with the Trust reporting achievement of the 95% compliance standard in each quarter of 2025/26. This provides important assurance in relation to the systematic identification and management of VTE risk, while recognising the Trust's continued focus on improving timely prescribing of prophylaxis and learning from thematic review.

- Continued clinical engagement in eMortality and learning from deaths reviews, with the Trust reporting 94% compliance in March 2026 and some specialties achieving 100%. The ICB notes the importance of this work in supporting clinical learning, strengthening mortality governance and ensuring that learning from completed reviews is shared through specialty, directorate and Trust-level governance routes.
- Evidence of improvement in moderate and above harm falls during the year, with the Trust reporting statistically significant improvement from mid-2025. The ICB welcomes the establishment of a new Falls Steering Group and the reorganisation of the Falls Team to provide greater support for Trust-wide and ward-based quality and safety programmes.
- Ongoing implementation of the Patient Safety Incident Response Framework, with a continued focus on learning and improvement, supported by clinical audit, governance and patient safety processes. The ICB recognises the importance of PSIRF maturity in strengthening thematic learning and the use of safety intelligence to inform improvement.
- The Trust's response to the 2025 Care Quality Commission maternity inspection at Royal Bournemouth Hospital, which identified both strengths and areas requiring improvement. The ICB welcomes the immediate assurances provided by the Trust and will continue to monitor delivery of improvement actions through established quality and governance routes.
- Strong participation in national and local clinical audit, research and clinical effectiveness activity, including participation in 91% of eligible national clinical audits and 100% of eligible national confidential enquiries, alongside the review of 359 local clinical audits during 2025/26. The ICB welcomes the Trust's investment in a new Audit Management and Tracking System, which should strengthen oversight, action tracking and the translation of audit findings into measurable improvement.

The ICB recognises the Trust's 2026/2027 plan to improve the quality of care through the continued implementation of the 'Patient First' strategy. This provides a clear and focused direction for improvement, aligned to the Trust's wider strategic themes of population health and system working, our people, patient experience, quality outcomes and safety, and sustainable services. Specific areas identified for further development during 2026/2027 are:

- Reducing mortality and avoidable harm, including continued focus on falls, pressure ulcers, mortality review, infection prevention and wider patient safety priorities. This remains central to improving outcomes for patients and sustaining a culture of learning and improvement.
- Improving VTE risk assessment and prescribing within 24 hours, building on strong VTE risk assessment compliance while addressing variation in timely prescribing. The ICB welcomes the Trust's commitment to reviewing barriers to compliance and using the findings to drive targeted improvement.
- Reducing hospital-acquired E. coli infections, reflecting the continued importance of infection prevention and control, antimicrobial stewardship and the reduction of avoidable healthcare-associated infection.
- Improving incident closure and sign-off rates, supporting more timely review, learning and action following patient safety events. This will be important in ensuring that learning is identified, shared and embedded across services.
- Strengthening patient experience through timely complaints responses and action on feedback, including the Trust's focus on closing 90% of complaints within 35 days and ensuring that 95% of Friends and Family Test responses are rated good or very good. The ICB welcomes this continued focus on listening to patients, families and carers and using feedback to improve care.
- Continuing to strengthen quality governance, clinical effectiveness and improvement infrastructure, including the use of audit, research, patient safety intelligence and quality improvement methodology to support evidence-based improvement across services.

We look forward to seeing progress with the quality priorities identified in this Quality Account. This will be supported by the continued maturity of the Patient Safety Incident Response Framework, the Trust's contribution to learning and improvement across Dorset, and ongoing delivery of the 'Patient First' strategy.

NHS Dorset Integrated Care Board is committed to sustaining strong working relationships with University Hospitals Dorset NHS Foundation Trust and, together with wider health and social care partners, will continue to work collaboratively to achieve our shared priorities as an Integrated Care System in 2026/2027.

Yours sincerely,

Shelagh Meldrum,

Cluster Chief Nursing Officer

NHS Bath and North East Somerset, Swindon and Wiltshire, NHS Dorset and NHS Somerset

Annex B

Glossary of Terms

AAR – After Action Review (a type of learning response)

BEAT- Blended Education and Training team

CA UTI - Catheter Associated Urinary Tract Infections

CEPOD – Confidential Enquiry into Perioperative Deaths

Clostridium difficile, -also known as C. difficile, or C. diff, is a bacterium which infects humans, and other animals. Symptoms can range from diarrhoea to serious and potentially fatal inflammation of the colon. ... C. difficile is generally treated with antibiotics

CQUIN The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care

CT - A CT (computed tomography) scan uses specialized X-rays and computer technology to produce detailed, cross-sectional, 3D images of bones, organs, and soft tissues.

ECG - An ECG (electrocardiogram) is a simple, painless, and fast test that records the electrical signals of your heart to check for rhythm, rate, and structural problems. It is used by doctors to detect arrhythmias (irregular beats), coronary heart disease, and signs of a heart attack by mapping heart activity using sensors placed on the skin

ED – Emergency Department

eNA – Electronic nurse assessments

eMortality - Electronic Mortality review form

GIRFT Get It Right First Time is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice

ITU – Intensive Care Unit

LERN – Learning Event Report Notification system

LFPSE – Learning from Patient Safety Events Service

MRSA - Methicillin-resistant staphylococcus aureus. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MUST – Malnutrition Universal Screening Tool

NEWS - National Early Warning Score - An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six

cardinal vital signs (Respiratory rate, Oxygen saturations, Temperature, Blood pressure, Heart rate, Alert/Voice/Pain/Unresponsive scale). This gives a numerical score.

National Institute for Health and Care Excellence (NICE) – NICE is sponsored by the Department of Health to provide national guidance and advice to improve health and social care. NICE produce evidence based guidance and advice and develop quality standards and performance metrics for organisations providing and commissioning health, public health and social care services.

Never Event - Never Events are patient safety that are deemed to be wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Never Events include incidents such as wrong site surgery, retained instrument post operation and wrong route administration of chemotherapy. The full list of Never Events is available on the NHS England website.

NCEPOD - National Confidential Enquiry into Patient Outcome and Death

NIHR - National Institute for Health Research (NIHR)

OPS coding – OPCS Classification of Interventions and Procedures is a World Health Organization measurement for all patient procedures.

PSIRF Patient Safety Incident Response Framework

R&I – Research and Innovation

RCP – Royal College of Physicians

SPC – Statistical Process Control. Statistical process control (SPC) is defined as the use of statistical techniques to control a process or production method.

VTE – VTE stands for Venous Thromboembolism, a serious medical condition encompassing blood clots, specifically deep vein thrombosis (DVT) and pulmonary embolism (PE). It occurs when a blood clot forms in a deep vein, usually in the legs or pelvis (DVT), which can dislodge and travel to the lungs (PE)

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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