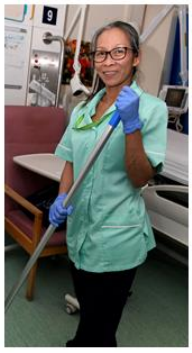
Respect
Integrity
Teamwork
Excellence

NHS
Dorset County Hospital
NHS Foundation Trust

Quality Account

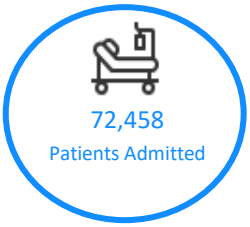
2023 - 2024

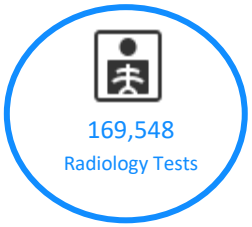


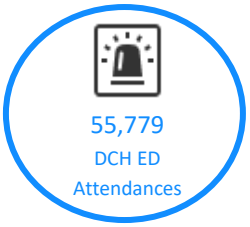



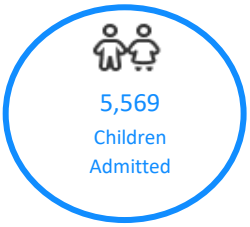
Outstanding care for people in ways which matter to them

Our Year 2023/24


72,458
Patients Admitted

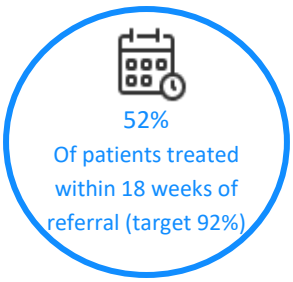

169,548
Radiology Tests

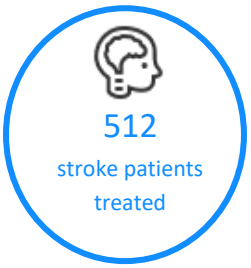

55,779
DCH ED Attendances

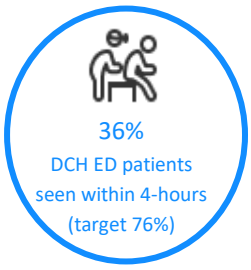

5,569
Children Admitted

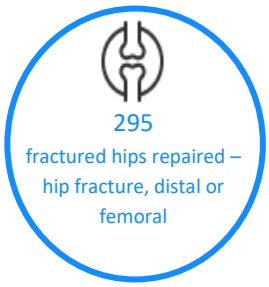

1,529
Babies born (registerable births)

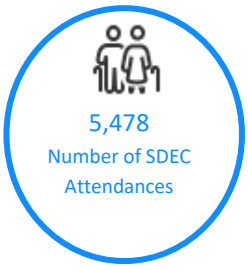

2,345
patients treated for cancer

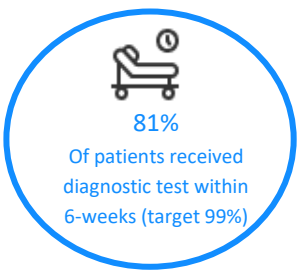

52%
Of patients treated within 18 weeks of referral (target 92%)

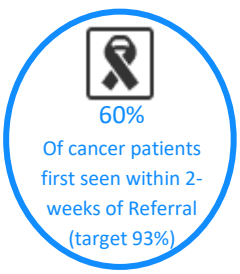

512
stroke patients treated

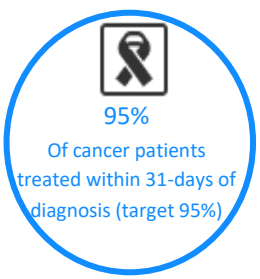

36%
DCH ED patients seen within 4-hours (target 76%)

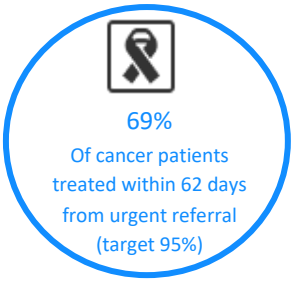

295
fractured hips repaired – hip fracture, distal or femoral


5,478
Number of SDEC Attendances


81%
Of patients received diagnostic test within 6-weeks (target 99%)


60%
Of cancer patients first seen within 2-weeks of Referral (target 93%)


95%
Of cancer patients treated within 31-days of diagnosis (target 95%)


69%
Of cancer patients treated within 62 days from urgent referral (target 95%)


157
New Doctors


216
New Nurses inc. Healthcare Support Workers & students

Quality Accounts 2022/23

Contents

PART 1

FOREWORD – Matthew Bryant, Joint Chief Executive Officer

It gives me pleasure to introduce the Quality Account for Dorset County Hospital NHS Foundation Trust (DCH) for the year 2023-2024

This year has continued to be a very challenging time in the NHS. I would like to say thank you for the tremendous contribution made by colleagues across Dorset County Hospital, who work hard to provide the best possible patient care, often in difficult circumstances. Throughout the year teams across the hospital have shown their commitment to bringing our values of integrity, respect, teamwork, and excellence to life in how we provide patient care – all of which is reflected in the achievements outlined in this report.

I would also like to thank our patients, their families and the local community for the patience and support shown to us during this period of continued recovery from the covid pandemic, and during the impact of continued industrial action, which we have seen throughout the past year. Despite all the pressures, I am proud that my colleagues have maintained our focus on quality improvement and safety, ensuring it is our number one priority.

Through a focus on quality improvement and new ways of working the Trust has continued to put the patient at the heart of everything we do, and this will continue into the new phase of hospital developments in the coming months, which we are committed to doing with the engagement of those people who use our services and our wider communities.

The following Quality Account details the progress made against the priorities set for last year; it will also detail the priorities set for the forthcoming year 2024-2025.

I am pleased to confirm that the Board of Directors has reviewed the 2023-2024 Quality Account and are assured that it is an accurate and fair reflection of the Trust performance.

The information contained within this report has been subject to internal review. Therefore, to the best of my knowledge, the information contained within this document reflects a true and accurate picture of the performance of the Trust.

Matthew Bryant
Chief Executive Officer

Part 2

Quality Improvement Priorities 2023/2024

In line with national guidance, Dorset County Hospital NHS Foundation Trust (DCH) developed priorities following engagement with DCH clinical staff, partners, the executive team, local community representatives and, of course, patients and their families.

DCH continued to work to deliver changes to improve
both the effectiveness and the quality of its services throughout 2023/24. For complete quality and performance data the public can access Trust Board papers
Below are listed the quality improvement priorities undertaken for 2023/24 with an end of year update:

Patient Safety

1. Reducing avoidable harm – deliver a continuous reduction in the overall number of patients in hospital with no criteria to reside and harms as a consequence of delays and deconditioning.

    a. As measured by the incidence of falls, incidents of harm and numbers of patients in hospital with no criteria to reside by length of stay.

Update: *Dorset County Hospital have now changed the way they respond to and investigate patient falls, in line with Patient Safety Incident Reporting Framework (PSIRF). Hot Debriefs and After-Action Reviews are now standard practice, and all groups are regularly reviewing our processes to ensure we are making the most of the learning which includes a new audit process for 2024/25. All inpatients now have a Multifactorial Risk Assessment, and the Trust believe this has contributed to a reduction of inpatient falls over the past 12 months. We have committed to reducing the volume of inpatient falls by investing in the new post of Fall Lead. Following recommendations through the 2022 National Audit of Inpatient Falls audit the Trust is reviewing its flat lifting equipment requirement.*

2. Implement the Patient Safety Incident Response Framework (PSIRF) to deliver and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

    a. As measured by the delivery of national programme milestones

Update*: PSIRF processes are now in place for Falls, Healthcare Associated Infections and there are pilot areas trialling the process for review of pressure damage. The Patient Safety Incident Response Policy and templates for Patient Safety Incident Investigation, After Action and Thematic Reviews have been approved and are in use. Weekly Patient Safety huddles are now in place together with Executive Huddles to review and validate decisions related to incidents of concern. Recruitment is underway for the Head of Patient Safety/Patient Safety Specialist and a review of job roles and job plans to ensure the responsibility for incident leadership and co-ordination, data analysis, family liaison and reporting arrangements are in place following retirements and changes within teams.*

3. Improve and sustain compliance with national guidance and local policy on consent, through the delivery of training and the implementation and use of a digital consent system.

   a. As measured by training numbers, audit of policy compliance, delivery of the e-consent implementation programme, related complaints, adverse incidents, litigation, and claims

Update: *Consent policies and processes are now included as a priority in the* ***Patient Safety Incident Response Plan.***

A Consent Task and Finish Group has been established under the leadership of the Associate Director for Quality, and there is focused effort on increasing medical representation. A review of the plan to implement a digital e-consent solution has commenced and a brief demonstration of Concentric Consent was provided to establish its usability and fit with existing systems and in line with current policies.

Patient Experience

1. In collaboration with the Dorset 100 Conversations programme, increase staff capacity through a Train the Trainer Programme and capture the patient voice to inform service delivery and quality improvement.

   a. As measured by training numbers, captured feedback and direct application to targeted programmes and QI projects.

Update: *The Trust continues to contribute to the overarching ICS work which looks at future focus for listening methodology and subsequent funding for staff training to deliver community conversations. This includes work being undertaken within NHS Dorset to develop an efficient and cost-effective AI solution for thematic analysis following community conversations. The data collected from the initial project in Portland is supporting the development of this. The Trust continues to link with the ICS engagement network on this work and subsequent opportunities for training and delivery of patient voice captured through the community conversation method.*

2. Deliver purposeful, therapeutic activity to patients through a planned programme of work developed by the Active Hospital Group and through the recruitment and delivery of a volunteer Activity Squad.

    b. As measured by progress against agreed action plan, training numbers, delivery of targeted activities and calendar of events, patient experience survey and overall incidence of violence and aggression against staff by patients who lack capacity (via Staff Survey)

Update: *The Active Hospital Project has been in discussions with the volunteer team and activity squad to provide training and resources to promote activity within the hospital. The training aims to improve volunteers' knowledge of physical activity and the importance of movement, the resources provide a variety of ways to help patients be active and address common barriers. Within the volunteer service we are continuing to build our team of Activity Squad volunteers. This includes supporting the Trusts Pathway Home Hub and social prescribing projects.*

2. Improve the experience of Children and Young People admitted to hospital with emotional, psychological, and mental health needs.

    a. As measured by local and national patient survey, progress against actions, related incidents, and complaints

Update*: Flagship programme underway and agreement to move through Gateway 2 in the Working Together Programme. Work is continuing with further workshops planned through April and May. Engagement is planned with Young People to capture their voice and feedback on plans for mental health support in ED. An initial workshop has also taken place in March to develop the Trust's 'Youth Voice'. The workshop focused on capturing ideas from Young People with lived experience of Youth Participation on how we could shape a Youth Voice offer within DCH. The development of a Youth Voice will directly support the flagship programme and ongoing work within this and other quality improvement projects*.

Clinical Effectiveness

1. Deliver continuous improvement in the Standardised Hospital Mortality Indicator (SHMI) to within expected limits.

Update: *The CMO, in conjunction with the Hospital Mortality Group (chaired by the Deputy CMO) and Divisional Directors, remains fully focused on understanding and improving the SHMI, whilst at the same time examining all other available local and national data to look for any evidence of unexpected deaths. The CMO has continued to report at Quality Committee which is then escalated to Board and published onto the Trust's internet site.*

The DCH SHMI has been within the 'expected range' for the 8 months to February 2024, against a background of gradual improvement. The internal predictions are that SHMI will slowly fall further over the coming months with the Trust coding backlog being cleared prior to the deadline for submission of HES data in mid-May.

Work continues to improve medical staff understanding of coding requirements and to ensure that the accuracy of coding is as good as possible. Depth of coding is now above the national average consistently. Bookmarks containing a 'guide to coding' for use within the paper notes have been provided to junior staff across the Trust. Coding is now included in all Trust induction sessions. The coding department still carries two staff vacancies, but two coding apprentices have been recently appointed and are being trained. Dorset Healthcare has provided 20 hours of additional coding from their staff who wish to broaden their experience of acute hospital work. These measures have given reasonable assurance that the end of year submission of Hospital Episode Statistics data will be on time.

2. Deliver the national target for Electronic Discharge Summaries of issue within 24hours of discharge.

Update*: Focused work is underway on data validation and mechanisms for discharge in radiology, day surgery unit and Emergency Department Assessment Unit. It is anticipated that Trust performance will improve and provide a more accurate reflection of discharge summary performance, as opposed to outpatient procedure/clinic letter communication. The latest performance is detailed below.*

3. Deliver full compliance with the Maternity Incentive Scheme (MIS), with emphasis on improving compliance with C02 monitoring at booking and audit of Transition.

Update: MIS action plan in place since January 2023 with successive iterations based on the finding through audit of missed cases.

New Transitional Care guideline has been created to incorporate 34-week babies in line with British Association of Perinatal Medicine guidance. The guideline outlines bespoke staffing model and audit schedule which provides evidence of compliance. Transitional Care (TC) Lead Role in place since June 2023. New pathway set for launch on 1st November 2023. This comprises strengthened governance around an already functional process of virtual TC. The new guideline provides clarity on roles and responsibilities and underpinning auditable standards and assurance of family centered care. The MIS has been subject to internal audit by BDO and against the Care Quality Commission findings from inspection in June 2023. The MIS was submitted for sign off in January prior to national submission. Further internal audit with BDO will be undertaken at periods throughout 24/25 to ensure progress towards full compliance for Year 6.

Quality Improvement Priorities 2024-2025

DCH continues to work to deliver changes to improve both the effectiveness and the quality of its services.

To ensure that improvement is monitored, and change can be observed over time, the Trust board has given approval to carry over 2023/24 priorities into 2024/25.

Patient Safety

1. Reducing avoidable harm – including a continuous reduction in the overall number of patients in hospital with no criteria to reside and harms as a consequence of delays and deconditioning.
    a. As measured by incidents of harm and numbers of patients in hospital with no criteria to reside by length of stay.
2. Implement the Patient Safety Incident Response Framework (PSIRF) to deliver and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
    b. As measured by the delivery of national programme milestones (PSIRF) and improvements against PSIRP priorities
3. Improve and sustain compliance with national guidance and local policy on consent, through the delivery of training and the implementation and use of a digital consent system.
    c. As measured by training numbers, audit of policy compliance, delivery of the e-consent implementation programme, related complaints, adverse incidents, litigation, and claims

Patient Experience

1. In collaboration with system partners, increase staff capacity through a Train the Trainer Programme and capture the patient voice to inform service delivery and quality improvement.
    a. As measured by training numbers, captured feedback and direct participation of people with lived experience to targeted programmes and QI projects.
2. Deliver purposeful, therapeutic activity to patients through a planned programme of work developed by the Active Hospital Group and through the recruitment and delivery of a volunteer Activity Squad.
    b. As measured by progress against agreed action plan, training numbers, delivery of targeted activities and calendar of events, patient experience survey and overall incidence of violence and aggression against staff by patients who lack capacity (via Staff Survey)
3. Improve the experience of Children and Young People attending and admitted with emotional, psychological, and mental health needs.
    c. As measured by local and national patient survey, progress against actions, related incidents, and complaints

Clinical Effectiveness

1. Deliver continuous improvement in the Standardised Hospital Mortality Indicator (SHMI) to within expected limits.
2. Deliver the national target for Electronic Discharge Summaries of issue within 24hours of discharge.
3. Deliver full compliance with the Maternity Incentive Scheme (MIS), with emphasis on delivering full compliance with the Safety Actions and Saving Babies Lives.

Progress against these Quality Priorities will be monitored and reported through the Trust sub-board Quality Committee and reported to the local commissioners.

Statements of Assurance from the Board

Review of Services

During 2023-24, DCH provided and/or
subcontracted 35 relevant health services.

The Trust has reviewed the data available to them on the quality of care in all these relevant health services.

The income generated by the relevant health services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant health services by the Trust in year.

The Trust income in 2023-24 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework. Although CQUIN schemes were included in contracting arrangements it was agreed that any unachieved CQUIN linked income would be reinvested in the Trust.

Clinical Audit

During 2023-24, 59 National clinical audits covered relevant health services that the Trust provides.

During that period the Trust participated in (53/59) 89.8% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2023-24 are as follows within the table.

The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2023-24 are as follows within the table:

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2023-24, 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

The NHS England-funded National Clinical Audit and Patient Outcomes Programme (NCAPOP) are a mandatory part of NHS contracts, and as such we are required to participate in those that relate to services provided by this Trust. The following table describes the audits we have participated in, and the relevant compliance.

* Please note that in some cases the % of Registered Cases is above 100%; this is because the trust was able to identify additional cases than those identified by the HES (Hospital Episode Statistics) data

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Adult Respiratory Audit	Y	No: Trust does not have a Higher Respiratory Care Ward	no data available	

BAUS Nephrostomy Audit	Y	Y	2	100%
Breast and Cosmetic Implant Registry	Y	Y	no data available	
British Hernia Registry	Y	No: Lack of Resource	no data available	
Case Mix Programme	Y	Y	679	100%
Child Health Clinical Outcome Review Programme	Y	Y	no data available	
Elective Surgery: National PROMs Programme	Y	Y	no data available	
Emergency Medicine QIPs:				
a. Care of Older People	Y	N	no data available	
b. Mental Health Self Harm	Y	No:	no data available	
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	no data available	
Falls and Fragility Fracture Audit Programme 1:				
a. Fracture Liaison Service Database	Y	Y	no data available	
b. National Audit of Inpatient Falls	Y	Y	6	
c. National Hip Fracture Database	Y	Y	Fractured Neck of femur – 333 Peri-prosthetic fracture - 22 Femoral fracture - 12	
Improving Quality in Crohn's and Colitis (IQICC)	Y	Y	no data available	
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Y	Y	7	100%

Maternal and Newborn Infant Clinical Outcome Review Programme 1	Y	Y	no data available	
Medical and Surgical Clinical Outcome Review Programme 1 National Confidential Enquiry into Patient Outcome and Death	Y	Y	no data available	
National Adult Diabetes Audit				
a. National Diabetes Core Audit	Y	Y	1044	100%
b. National Diabetes Foot care Audit	Y	Y	no data available	
c. National Diabetes Inpatient Safety Audit	Y	Y	20	100%
d. National Pregnancy in Diabetes Audit	Y	Y	10	100%
National Respiratory Audit Plan (NRAP)				(Previously NACAP)
a. Adult Asthma Secondary Care	Y	Y	48 (3 opted out	100%
b. Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	159 (5 opted out)	100%
c. Paediatric Asthma Secondary Care	Y	Y	17 (1 opted out)	100%
d. Pulmonary Rehabilitation- Organisational and Clinical Audit	Y	Y	no data available	
National Audit of Cardiac Rehabilitation	Y	Y	no data available	
National Audit of Care at the End of Life (NACEL)	Y	Y	14 Staff Surveys 0 Quality Surveys 31 Case note Audits. To date 23/4/24	pause in 23/24 NACEL Audit Resumed Data collection from 1/1/24.
National Cancer Audit Collaborating Centre- National Audit of	Y	Y	no data available	

Metastatic Breast Cancer				
National Cancer Audit Collaborating Centre- National Audit of Primary Breast Cancer	Y	Y	no data available	
National Cardiac Arrest Audit	Y	Y	no data available	
National Cardiac Audit Programme				
c. National Heart Failure Audit	Y	Y	302 (15 opt outs)	
d. National Audit of Cardiac Rhythm Management	Y	Y	no data available	
e. Myocardial Ischaemia National Audit Project	Y	Y	no data available	
f. National Audit of Percutaneous Coronary Interventions	Y	Y	no data available	
National Child Mortality Database 1	Y	Y	no data available	
National Comparative Audit of Blood Transfusion:			no data available	
a.2023 Audit of Blood Transfusion against NICE Quality Standard 138	Y	Y	138=0	100%
b. 2023 Bedside Transfusion Audit	Y	Y	10	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	data being collected	
National Emergency Laparotomy Audit	Y	Y	80/92	87%
National Gastro-Intestinal Cancer Audit Programme (GICAP)				
a. National Bowel Cancer Audit	Y	Y	no data available	

(NBOCA)				
b. National Oesophageal-Gastric Cancer Audit (NOGCA)	Y	Y	no data available	
National Joint Registry Knees primary/Revision	Y	Y	295	
Hips primary +revisions	Y	Y	349	
Shoulder primary revisions	Y	Y	34	
National Lung Cancer Audit (NLCA)	Y	Y	no data available	
National Maternity and Perinatal Audit (NMPA)	Y	Y	no data available	
National Neonatal Audit Programme (NNAP)	Y	Y	no data available	
National Ophthalmology Database Audit	Y	Y	Medisight software installed 9/10/23 & Data uploaded since then	
National Paediatric Diabetes Audit 1	Y	Y	no data available	
National Prostate Cancer Audit (NPCA)	Y	Y	no data available	
National Perinatal Mortality Review Tool 1	Y	Y	no data available	
National Vascular Registry	N	N	no data available	
Perinatal Mortality Review Tool (PMRT)	Y	Y	no data available	
Perioperative Quality Improvement Programme	Y	N	No data available	Research Project. Governance through Research dept
Sentinel Stroke National Audit Programme 1	Y	Y	no data available	

Serious Hazards of Transfusion UK National Haemovigilance Scheme	Y	Y	15	100%
Society for Acute Medicine Benchmarking Audit	Y	Y	42	100%
Trauma Audit and Research Network (TARN)	Y	Y	1/4/23-1/6/23 30 submissions.	Audit interrupted June 2023. TARN closed down
UK Renal Registry				
a. *Acute Kidney Injury programme*	Y	N	no data available	Local Audit 5866
b. UK Renal Registry Chronic Kidney Disease Audit	Y	Y	Quarter 110 - Renal status 24/05/2023 - 840 patients Quarter 111 - Renal status 31/08/2023 - 829 patients Quarter 112 - Renal status 12/01/2024 - 844 patients Quarter 113 - Renal status 23/02/2024 - 844 patients	

National Confidential Enquiries into Patient Outcome and Death (NCEPOD)

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research. The following shows the National NCEPOD reports published and a precis of their findings:

Report Title	Report Precis
#5277 The Inbetweeners: A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services. June 2023	**Areas of good performance:** DCH 'Flag'' Young people going through transition on electronic records. Many young people are given the opportunity to be seen alone in clinics. DCH has established a multi-agency stakeholder group meeting monthly, Agreed a 3-year project plan for Transition Service, Agreed Trust Quality Statements aligning to NICE Guidance and raised the profile of Transition across the Trust – now presented at Care group and Divisional meetings. **Areas of concern:** Unable to provide keyworkers. Unable to provide equitable youth work service. No separate commissioning for transition care. Lack of (joint) transition clinics across services. Lack of unity with Primary care.

	DCH Electronic systems are a barrier to working across organisations and for empowering young people to manage their own healthcare. Lack of available/accessible information about adult services within DCH for young people and their parents/carers. No annual transition reviews. No transition page on website. Lack of holistic care documented. **What does this mean for DCH?** DCH is not compliant with National Guidance. DCH has employed a Transition Nurse Specialist who is leading on the development of a Transition and Young People's Service with a Consultant who is Clinical Lead for Transition with x1 PA, an Assistant Project Manager and a Youth Worker funded in the Diabetes Service.
#5419 NCEPOD Crohn's Disease Study: Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease. 13/7/23	Key Audit Results: **1.Provision of Holistic Support:** Basic psychoeducation provided on the effects of mental health on Inflammatory Bowel Disease (IBD) provided by staff and signposting/referrals made to Steps to Wellbeing or private fully accredited counselling services. Support services: The Community Front Rooms & The Retreat promoted. Good peer support- all our patients are signposted to Crohn's and Colitis UK for additional resources and support. We have also set up a Facebook DCH IBD Community Group with 60 patients where we share useful resources and are planning to set up a patient panel. Recent increase in Dietetic support including a 1x monthly clinic to accommodate referrals for newly diagnosed patients and pre-operative patients for nutritional optimisation, patients at high risk of malnutrition, Irritable Bowel Syndrome overlap and requiring low-residue diets. Limited time and resource to support mental wellbeing for our IBD patients given the increasing prevalence of mental health conditions such as anxiety, depression, trauma, and Obsessive Compulsive Disorder that have a direct impact on chronic health conditions. IBD UK recommend access to a Health Psychologist which we currently do not have as part of our service. 150 referrals were received by Steps to Wellbeing for clients with IBD in 2022 in Dorset. More Dietetic support required given our increasing patient cohort. **2.Medications for Crohn's should be managed effectively at all stages of the pathway**. We have a high standard of pharmaceutical, medical, and nursing oversight-regular medication reviews at scheduled appointments and Biologics and IBD MDT. Plans are made pre and post operatively in liaison with surgical team. **3.Consider surgery as a potential treatment option for patients with Crohn's Disease. Surgery should not be perceived as a failure of medical management and could be undertaken sooner.** Most patients considered as potentially suitable for resection are discussed at IBD Multi-Disciplinary Team in close liaison with the IBD Colorectal surgeons and Consultant Radiologist present. It is evident in the audit and historically that surgery is often perceived as a final option if medical therapy has failed and from reviewing case notes it has highlighted the need to address surgery as a viable option with patients early in their pathway alongside medical therapies. This is often not considered until patients have failed multiple medical therapies. This will help the patient to adjust their mindset to surgery earlier rather than later and feel more in control of the choices available to them. 4**.Perform surgery promptly once a decision to operate is made. Recommendation from the audit is that patients should be operated on within 1 month of entry onto the waiting list to avoid patient deterioration and emergency surgery.** We have a robust system in place for identifying and discussing Crohn's patients potentially suitable for surgery at IBD MDT. From review of 8 Crohn's resections performed between November 2021-September 2023 the time from referral to the Colorectal Surgeons to their initial outpatient review varied from 2-6 months. Time from waiting list entry to date of operation varied from 2-8 months. **5. Make sure that handover of care from the Surgical Team to Medical Team is robust to promote joined up care post operatively including**

	patient medication reviews. All post operative Crohn's resections are now reviewed at IBD MDT to plan future management including review of medical therapy and need for surveillance. We have set up an inpatient alert report with Business Intelligence which is emailed to the IBD Nurses inbox daily. This alerts us of elective admissions for surgery to prompt follow up. Nil concerns identified. **What does this mean for DCH?** Better Psychological support and Dietetic resource required. Crohn's patients identified as suitable for resection to be referred to the Colorectal Surgeons earlier in their patient pathway to discuss surgical verses medical treatment options. Crohn's patients referred to the Colorectal Surgeons should be seen urgently in clinic and discussed at the surgical planning meeting with an aim to be scheduled for surgery as soon as practically possible and should not be downscaled in favour of colorectal cancer patients. Report presented at Gastroenterology Business Meeting 6/12/23 & IBD MDT on 14/12/23**.** **Actions** 1.Employment of a Health Psychologist to cover Colorectal & Gastroenterology- Business Case to be completed. Data gathered to support the need from Steps to Wellbeing. Need to secure funding. 2. Increase in Dietician resource- Increase in Dietetic clinics for IBD required to accommodate increasing patient cohort - Pending replacement of new Lead Dietician. Once established to review benefits of IBD Dietetic involvement and source additional funding. 3.Crohn's patients suitable for surgical resection to be referred to the Colorectal Surgeons earlier in their patient pathway when treatment is required- Referrals completed by Gastroenterology Consultants and IBD Nurses in a timely matter on agreement with the patient when considering all treatment options. 4.For Crohn's patients to be seen by a Colorectal surgeon in clinic to discuss surgical options within 1 month. Plan made to email the Colorectal Secretaries when a referral is made to prioritise the appointment as urgent (to be seen within 4 weeks). 5.To reduce the waiting time to surgery for patients listed for surgical resection- New Crohn's referrals to be discussed at Surgical Planning Meetings 29/12/23 (Not always routinely discussed at Surgical Planning Meetings due to Cancer patients being prioritised). To aim to schedule in where possible in a timely manner to avoid patient deterioration
5585 NCEPOD Community Acquired Pneumonia	**Key Audit Results:** This was a national audit of community acquired pneumonia care in English hospitals. Of 767 cases included, 6 were from DCH. During 2022-23, we undertook ongoing audit of all Community Acquired Pneumonia admissions at DCH, performance was good in terms of getting a Chest X-Ray (CXR) done within 4 hours of admission and in terms of administering appropriate antibiotics within 4 hours. Reporting of inpatient CXRs generally takes longer than 24 hours at DCH – often up to 1 week. Whilst this is not optimal, it is good that CXR reporting is now happening, and the impact of this delay is likely to be minimal. At DCH, we have a robust system for following up repeat CXRs for people with CAP at 6 weeks. We were less good at assessing the CURB 65 severity score, but this audit recommends NEWS2 scores as an alternative to CURB 65 scores since they are also closely linked to mortality rates. At DCH, we routinely assess NEWS2 scores on all admissions. We do not have a named lead with specific time in their job plan for CAP and we do not employ a specialist pneumonia nurse (the recommendation is for 1 WTE per 400 admissions per annum) and we do not have any written patient information about pneumonia on discharge. **What does this mean for DCH?** Overall, not much in the way of action is required: Whilst it may be desirable to develop the use of Agyle in Emergency Department to prompt the use of CURB 65 scoring in patients with CAP, this is not essential since NEWS2

	scoring will probably suffice. These severity scores are used to guide the location of care (home, Intensive Care Unit etc), the use of antibiotics and subsequent investigations. Microbiological tests are indicated in our local CAP guideline in patients with more severe pneumonia, as recommended by this report. We are prompt in getting CXRs done and administering antibiotics. Our CXR reporting could be quicker but is adequate. Use of escalation plans is generally appropriate at DCH, in patients with CAP and in other patients. We have a smoke stop team who review any patients (CAP or otherwise) who smoke and offer nicotine replacement treatment. Our follow up of patients with 6-week CXRs is robust and more complex patients will receive face to face outpatient consultant review, based on individual clinical judgment. Whilst we have 6 specialist non-cancer respiratory nurses (only 2 of them spending significant amounts of time on inpatient care), we do not have a specialist pneumonia nurse. One study in 2020 (comparing clinical practice prior to and after 2013) demonstrated a significant reduction in overall CAP mortality in one NHS hospital associated with the introduction of a Specialist Pneumonia nurse who supported adherence to national guidance for CAP management. 6-month survival improved from 64% to 70%, with those seen by the pneumonia nurse having a survival of around 77%. Length of Stay was no different. However, whether a nurse at DCH would have such an impact in 2024 is debatable, given that our guideline adherence is good and now with the widespread use of NEWS2 scoring. There are nationwide plans to introduce ongoing CAP audit as part of the National respiratory audit programme which we will participate in and gain greater insight. 1.Discuss outcome at the respiratory clinical governance meeting- 29/2/24 2.Develop a CAP patient information leaflet (Draft done)- to discuss at governance meeting 29/2/24
5652; NCEPOD Testicular Torsion Study; Twist and Shout 8/2/24	**Key Audit Results:** Acute scrotum is always seen as a priority; In a case of suspected torsion, the consultant speaks to the anaesthetist and CEPOD team directly to avoid any delay, this at times may mean opening another theatre given the time critical nature of the procedure. At DCH the decision of exploration is always consultant led. We have a torsion pathway which is explained to the juniors at induction. The Junior Doctor contacts the surgical registrar on call and the urology consultant get notified immediately. Torsion may still be present despite reassuring doppler Ultra-sound scan (US); therefore, we do not ask for an US and offer urgent exploration when there is any doubt. **What does this mean for DCH?** The audit and its recommendations were discussed in urology departmental meeting. Our practices are in line with most of the recommendations, but we can certainly improve in providing public awareness. Adult urology service at DCH does not provide any paediatric urology work apart from acute scrotum as an emergency. Public awareness, however, is vital and we can involve the visiting paediatric urologist in public awareness programs and training at primary health care level.

The reports of National Clinical Audits were reviewed by the provider in 2023-24.
The Trust intends to take the following actions to improve the quality of healthcare provided.
The table below summarises the audit outcomes and the actions taken as identified by the review undertaken:

Audit / Clinical Outcome	What this Trust learnt

<table>
<tr><th>Review Programme</th><th></th></tr>
<tr><td>#5051
National Lung Cancer Audit: State of the Nation Report 2023
Data period: 2021</td><td>DCH Results:
Data completeness:

<table><tr><td>Performance status (PS)</td><td>97%</td><td>Met standard</td></tr><tr><td>Ethnicity</td><td>96%</td><td>Met standard</td></tr><tr><td>Disease stage</td><td>95.5%</td><td>Met standard</td></tr><tr><td>Route to diagnosis</td><td>99.4%</td><td>Met standard</td></tr><tr><td>Lung Cancer Nurse Specialist (LCNS)</td><td>71%</td><td>Did not meet standard</td></tr><tr><td>Smoking status</td><td>94.2%</td><td>Met standard</td></tr></table>
85.2% (adjusted) of patients with stage I/II PS 0–2 NSCLC undergo curative-intent treatment in line with NICE guidance: Met standard. 58.9% (adjusted) of patients with NSCLC stage IIIB-IV and PS 0-1 receive systemic anti-cancer therapy in line with NICE guidance. This is only 34 patients: (65%) Did not meet standard. 92.9% of lung cancer patients are seen by a lung cancer clinical nurse specialist at diagnosis: Met standard.</td></tr>
<tr><td>#4829
Getting It Right First Time -
GIRFT Surgical Site Surveillance Audit 2019
01/05/2019 – 31/03/2021</td><td>An observational audit to measure Surgical Site Infections (SSIs). During the audit period, 241 index procedures were undertaken at DCH (appendicectomies, emergency laparotomies and elective colorectal resections). 4 SSIs were identified (2 each after emergency laparotomy and elective colorectal resection).
Areas of Good Performance: At 1.7%, DCH’s SSI rate is better than the national average (4%) and places the Trust in the top quartile of Trusts participating nationally (14th out of 57). Scrutiny of care of each patient who developed an SSI confirmed that perioperative antibiotic prophylaxis had been administered.
Areas of Concern: No specific concerns were highlighted using the nationally agreed GIRFT methodology.
Learning Points: This audit confirms local compliance with a nationally agreed standard of perioperative care. This audit also demonstrates a rate of SSIs is below the national average. Good record keeping facilitates subsequent audit of practice. Electronic prescribing facilitates validation of retrospective datasets.</td></tr>
<tr><td>#5042
National Bowel Cancer Audit Annual Report 2022
2020/21</td><td>Good performance- 0% risk-adjusted 90-day mortality. Data completeness for pre-treatment TNM status (99%) and performance status (87%). 100% seen by Clinical Nurse Specialist (85% national). Laparoscopic attempted in 90% (67% national). 12 or more lymph nodes excised 91% (86% national). Length of stay >5days 38% (56% national). Urgent or emergency surgery 5% (20% national)
Within expected range- 2-year post-operative mortality rate 13.5% (national average 17.7%). Risk-adjusted unplanned 30-day readmission rate 11.6% (national average 10.7%). Adjusted 18-month unclosed ileostomy rate 22.4% (national average 28%).
Areas for improvement- Case ascertainment “fair” (national aggregate N/A) Data completeness “fair” 74.1% (national average 89.4%).
Benchmarking- 90-day mortality rate, 2-year post-operative mortality rate, 30-day unplanned readmission rate trending downwards. No trend data for other variables
What does this mean for DCH? - this audit demonstrates good practice, especially considering a 0% 90-day post-operative mortality.
Improvement can be made in case ascertainment (target >80%) and data completeness (>70%, [age, sex, ASA grade, pathological T-stage, pathological N-stage, distant metastases, and site of cancer.]) improvement work to improve this commenced.</td></tr>
<tr><td>#5044
PROMS Elective Surgery 2020/21: Finalised Patient Reported Outcome Measures (PROMs) in England, for Hip and Knee Replacement</td><td>Key Audit Results: Nationally 97% and 94% of respondents reported an improvement in Oxford score for Hip and Knee replacements respectively.
In previous years DCH has reported similar or better outcomes compared to national outcomes.
Benchmarking: For the year 2020-21, DCH reported insufficient records to assess status. This is secondary to reallocation of duties to ensure we met urgent clinical priorities during the COVID pandemic.
What does this mean for DCH: Overall, little elective activity occurred during</td></tr>
</table>

01 Apr 2020 to 31 Mar 2021	this period, so few conclusions can be drawn. Presented at Ortho Meeting 12/5/23 – Service Manager will investigate the current process for obtaining patient PROMs data within the Trust. It appears an external company is paid to do this on the Trust's behalf.
#5308 National Joint Registry 2021: National Joint Registry 19th Annual Report 2022 Data period: 2021	**Key Audit Results:** DCH recorded 311 procedures with a 99% link ability during this period. We were not an outlier for 90-day mortality or revision rate for any type of joint implanted. **Benchmarking:** Over the last 5 years, 9 Total Hip Replacements (THRs) were revised for infection (against an expected 4). This has been investigated in a separate Consultant led process. Our unit has a significantly lower (better) periprosthetic fracture revision rate (4 vs 10.6 expected) than the National expectation. 92.8% of hip implants were Orthopaedic Data Evaluation Panel (ODEP) rated A*. 100% of knee implants were ODEP rated A or A*. **What does this mean for DCH:** Continue to use well-established implants. Adopt robust procedures to prevent infection (specifically true ringfencing of elective orthopaedic beds is planned imminently). Ortho Dept meeting 12/05/2023.
#5306 **National Asthma & COPD Audit Programme (NACAP) Children and Young People Asthma 2021-2022**	**Good:** All patients had clinical observations in a timely manner. Majority of patients received steroids with the date and time recorded for these. Inhaler technique checked and documented for high percentage of these patients. High proportion of patients received Personal Asthma Action Plans. Respiratory Nurse in post **Concerns:** Fractional Exhaled Nitric Oxide (FeNO) for diagnostic purposes unavailable in hospital setting Reviews post discharge could be improved. Hospital setting unable to provide all physiological tests at the hospital. Not always had a specialist review within 24 hours. Limited number of staff competent in performing spirometry testing **What does this mean for DCH:** Further work detailed below is required to meet national audit standards. Large gaps were found across the UK, and this is part of a national issue around diagnosis, access to expert advice, in patient management and follow up. **Recommendation 1:** For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care. Aiming to source and train in FeNO. We currently offer spirometry. Need to obtain funding and training. **Recommendation 2:** For care to be provided to people with asthma and COPD within the recommended timeframe after hospital admission, to support optimal outcomes; Liaising with Emergency Department (ED) to ensure early (<1hr administration of oral steroids) **Recommendation 3:** For people with asthma and COPD to receive care by appropriately trained healthcare professionals, at each stage of their care pathway; DCH now meet this standard fully. **Recommendation 4:** Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care. This is mostly met. (ePAAP's, smoking status). We started a transition clinic, but this needs formalising; Dorset wide work on how to implement an asthma discharge bundle. Work with transition team to establish transition clinic. Dorset wide plan to improve discharge bundle.
#5022 Epilepsy 12 Round 3 Cohort Epilepsy12 2022 Combined organisational and clinical audits: Report for England and Wales; Round 3, Cohort 3: (2019-December 2019 to 30 November 2020 (and subsequent year's	**Recommendation 1;** Epilepsy clinical teams should review the Epilepsy 12 data, and the criteria and implementation of, prescription of rescue medications for prolonged convulsive seizures in children and young people. All children at DCH with epilepsy have an individual seizure plan whether they have rescue medication or not. **Recommendation 2;** All females of child-bearing potential prescribed Sodium Valproate should have ongoing documentation regarding their status within the valproate Prevent Programme. DCH are 100% complaint with this and provide annual NHS benchmarking data. **Recommendation 3;** Ensure there is a process in place to ensure discussion of Sudden Unexpected Death in Epilepsy (SUDEP), and care planning for risks and participation, is achieved for children and young people with epilepsy. This is discussed and documented by epilepsy nurses at first home visit.

care) 21).	**Recommendation 4;** Review the waiting times for standard EEG in their services; ensuring sufficient capacity and pathways in place to achieve EEG within four weeks of referral. DCH waiting times are now back within the 4-week target**.** **Benchmarking:** This national audit does not have bench-marking standards available **Areas of concern for DCH:** Mental health support and screening: Nationally, very few children and young people with an identified mental health condition in cohort 2. (2%). Without widespread use of screening, opportunities for referral into the appropriate pathway for assessment could be missed. DCH does not use a specific screening tool and relies on the expertise of Clinicians and Epilepsy nurses to identify Autistic Spectrum Disorder (ASD), ADHD and mental health problems during clinic appointments, referrals are made, or patients signposted to support services. DCH now have an emotional and wellbeing psychologist. **Transition:** **DCH** does not have a separate Epilepsy clinic to support transition to adult services. The ready /steady /go model is started around age 13 years old. Formal referrals are made to adult clinic age 17, adult service will not see patients until 18 years old. Currently the adult service has no capacity to support a face-to-face transition clinic. We continue to work with transformation team in Dorset and the regional network on Epilepsy transition pathway.
5293 National Audit of Cardiac Rehabilitation (NACR) Quality and Outcomes Report 2021	**Areas of good performance:** Cardiac rehabilitation groups (CRG) restarted, tight infection control protocols in place, no transmission of infection occurred, giving confidence that the CRG could re-start in Spring 2022. The Project Lead presented the quarterly data for 2021 at the NACPR national conference with a poster display, also was involved in a national presentation with Mymhealth in October 2021 and Spring 2022.The Cardiac rehabilitation team (CRT) at Dorset County Hospital is already achieving the national uptake targets. The CRT, been a part of the team building the Myheart Cardiac Rehabilitation app and the Public Health England produced Active at Home exercise booklets. The variety of resources we have from The British Heart Foundation, Heart UK, Livewell Dorset and Steps2wellbeing, meant they were able to continue to offer a viable range of options which were able to accommodate patient's needs, post Myocardial Infarction (MI), Percutaneous Coronary Intervention (PCI) and or Heart Surgery, during a period of severe turmoil in the Covid19 Pandemic. **Areas of concern:** The team have **not achieved certification** due to financial and staffing limitations. **Benchmarking** National target of 85% uptake by 2027. 88.6% uptake of cardiac rehabilitation offered by the cardiac rehab team at Dorset County Hospital in 2021. **What does this mean for DCH?** **The impact of Venue location, budget restrictions and staffing:** 1.Restrict the patients to one 1 session of CRG exercise session per week per group-this should occur twice per week. 2.The team is unable to provide functional testing for patients following their clinic and completion of their 7-week cardiac rehabilitation programs to assess improvement. 3.The team hasn't been unable, for the past 12 years, to post the 10-page National Audit of Cardiac Rehabilitation (NACR) 2 questionnaires to patients at the end of their treatment to patients, with reply paid envelopes (only patients who attend a CRG, are offered the NACR 2 questionnaire,50% of patients who use home-based cardiac rehabilitation with telephone consultations do not receive these questionnaires). 4. At the end of the patients' CRG programs, they should have a holistic review and plan written for their next 12 months for secondary care-this has been

	impossible to establish. **These issues mean that not all NACR patient outcomes, have been able to be recorded within the NACR dataset meaning that the team are unable to meet all 6 of the requirements for Cardiac Rehabilitation Certification.** This is something the team would like to achieve. Although significant non-recurring funds have been offered to Dorset County Hospital by NHS England in March 2022 and March 2023, which could allow the service to develop and achieve certification, the management team have not felt able to take up this offer of ring-fenced funds. The team and service manager are planning to develop their service to meet these service deficits utilising funds from the speciality budget. A meeting regarding these developments is due to be scheduled for August 2023. **Actions** 1.Work towards certification. 2.Investigate and possibly establish cardiac rehab exercise sessions twice per week 3.Functional Testing to be investigated and established if beneficial to patients 4.Establish a system for NACR 2 Audit forms to be given to all patients at their end of program. 5.Investigate methods of providing end of cardiac rehab holistic review.
#5519: National Audit of Care at the End of Life (NACEL); Fourth round of the audit (2022/23) report	**Areas of good performance.** We performed as well as or better than the national average in 6 of 11 key performance indicators, including 3 new indicators based on the staff survey. **Where we performed less well** (in 5 indicators) we were not significantly below. Our performance trend over the last 4 audit cycles has been one of improvement in all indicators apart from "families' and others' experience of care". This reflects similar improvement nationally, but we have improved to a greater extent. Nationally performance in "assessing the needs of families and others" has reduced, but in our case it has increased. **Areas of concern**: Areas where it was identified that we could improve were: Communication with the dying person; Discussing possibility of drowsiness with medication; Discussing hydration and nutrition. Communication with families and others; Discussing possibility of drowsiness with medication, Discussing risks and benefits of nutrition. Involvement in decision making Discussing extent to which patient wishes to be involved in decision making. Discussing Cardio Pulmonary Resuscitation (CPR) with patient and family by senior clinician. Individualised plan of care; Nutrition status reviewed regularly, Benefit of starting/ stopping/ continuing blood sugar monitoring; Discussing anticipatory medications with patient and family. Needs of families and others Asking about their needs, Giving enough emotional support **From the staff survey areas of improvement were identified as:** Staff confidence All areas other than recognising dying and accessing the hospital palliative care team. Staff support Accessing specific training in End of Life (EOL) care and Managerial support to deliver EOL Care. Care and culture Able to raise a concern about end-of-life care, providing a peaceful and private environment, Deaths reviewed with action plan to improve end of life care. **Benchmarking;** Recognising the possibility of imminent death. National 87%, DCH 84.6%. **What does this mean for DCH?** Areas to focus on might include Communication; Discussions with family about Do Not Attempt CPR (DNACPR) decisions; Discussions around hydration and nutrition; Discussions around risks of drowsiness with EOL medications; Education; Asking about and supporting needs of families. These results will inform our EOL strategy for EOL care and the actions and from this. **Actions.** Reported at End-of-Life Care Committee June 2023 Hospital Mortality Group June 2023

	Improve communication and documentation around DNACPR and Treatment Escalation Plan decisions-1st meeting held and action plan developed. Education to ward staff- Additional nurse recruited to allow for increased EOLC facilitator role time.
#5514 National Audit of Dementia- Care in General Hospitals 2022-2023 Round 5 Audit Report	**Areas of good practice:** Increase in delirium screening. Tier 2 Dementia training (90%). Increase in initial assessment of pain. **Areas of concern:** Decrease in the use of a structured pain assessment tool. Decrease in positive feedback from carers. **Benchmarking** Contained within the national report. **What does this mean for DCH?** Increase use of structured pain assessment tool to be evidenced in case notes (Abbey pain scale). Try to increase and capture the positive feedback from carers. **Recommendations/actions:** Increase use of the Abbey pain scale for patients living with dementia- Discussed in the Dementia Action group 25/7/23 & discussed with the pain team to raise awareness. To Increase and capture the positive feedback from carers- Discussed in the Dementia Action group 25/7/23.
#5488- UK Parkinson's (PD) Audit	**Areas of good practice**: 1. Access to therapists with experience in Parkinson's: Meetings are organising weekly with neurology and elderly care to look at the individual patients as well as monthly meetings with HUB (Physiotherapist (PT), Occupational Therapist (OT), Speech and Language Therapist (SALT). 2.Standardised Practices; & 3. Communication and information sharing; - Brochures with Information, appropriate to patients with PD, about Parkinson's are given out. 4.Medication management; Aim to ensure PD patients get medication on time whilst in hospital. 5.Educating the workforce; Workforce currently 50% down on Parkinson's nurses. Impact of COVID on teaching student nurses, junior doctors. **Benchmarking**- From the UK full audit, compared with Parkinson's UK Recommendations for people with Parkinson's. **Areas of concern**: -1. Specialised multidisciplinary workings; There is a need for specialised physiotherapy (PT) and occupational therapy (OT). Training is available from Parkinson's UK web page for PT but not for OT. We want early referrals to therapy services so will be introducing newly diagnosed workshops to introduce people with Parkinson's to the therapists. Working with speech and language to know the best time for voice and swallow. Out of 265 patients, 136 Elderly Care and 129 Neurology, it was found: 34.7% patients were referred to therapists by Parkinson's nurses, 23.7% patients were referred to therapists by neurology consultants, 10.3% patients were referred to therapists by Elderly Care consultants. **What does this mean for DCH**- To meet national standards. **Recommendation's & Actions** Specialised multidisciplinary workings: By December 2023: 1. Monthly meeting with the local HUB to discuss what is on offer to people with Parkinson's as this is an ever-changing picture. 2.Weekly meetings with the neurologists to discuss individual patients are now being held and access to elderly care is consistent as in the same hospital 3. Newly diagnosed workshops to introduce the person with Parkinson's to therapy teams face to face. 4.Secure funding for newly diagnosed workshops for the future. Standardised Practices & Communication and information sharing: Give out information packs for newly diagnosed people with Parkinson's at nurse led clinic or sent by post once confirmation by consultant has been received. Use appropriate patient centred brochures. Telephone consultations to take place on receipt of confirmation so the patient is fully informed of their condition and correct information is sent (Information pack supplies regularly checked) Medication management: Monitor daily on JAC Pharmacy system by both pharmacy and Parkinson's team and check information is up to date. Get it on time campaign still being adopted to educate ever changing ward staff daily once PD nurse in post. Educating the workforce; Hold training sessions for new staff, awaiting a time when the hospital or local church will allow a group of people in for educational needs. Funding found for room in church
#5302- National	Benchmarking- we demonstrate much better rates of early contact with pregnant

Pregnancy in Diabetes Audit 01 January 2021 to 31 December 2022	women compared to nationally (England & Wales). **Local Actions**: 1.Continue to provide access to diabetes technologies (continuous glucose monitoring (CGM) and hybrid closed-loop systems (HCL) to all women with Type 1 diabetes of reproductive age – currently all women with Type 1 diabetes have access to CGM and eligible ones to HCL. 2.Continue and ensure women with Type 2 diabetes have access to appropriate dietary support, glucose monitoring and intensive insulin therapy. 3.Ensure there remains capacity for women to have regular clinic reviews (including monthly A1c checks, access to weight management programmes) for preconception care. 4.Outreach into community to improve preconception care, particularly in young onset type 2 diabetes but noting that this is currently outside of job plans and commissioning. Report presented 15 Nov 2023.
#5300 National Diabetes Audit (NDA): Care Processes and Treatment Targets 2021-22	We continue to work with our partners in Dorset Healthcare University Foundation Trust and primary care to support improvements in achieving treatment targets and provision of technology via the specialist DCH diabetes service. The DCH diabetes team is represented at the Integrated Care Board (ICB) Dorset Diabetes Programme Board and are involved in the treatment targets workstream. There are ongoing discussions across the Integrated Care System (ICS) regarding provision of diabetes technologies including CGM and insulin pumps which will be further developed following the anticipated NICE guidance for HCL technology. This is likely to require investment in additional DSN and specialist diabetes dietician staffing within the DCH specialist diabetes team to support improved access to these technologies and tackle inequalities. All the actions from the NDA report are for Commissioners of Care. There is no one person responsible for the work and the targets are very broad and vague so not easy to identify timescales.
#5060 Child Mortality Database; Deaths of children and young people due to traumatic incidents	Robust child death review processes leading to detailed evaluation of contributory factors and identification of key learning to underpin recommendations. 63% of deaths that have been reviewed at a Child Death Overview Panel (CDOP) had modifiable factors identified (much higher than all deaths where modifiable factors are found in approx. 1/3). This suggests that many of these deaths are preventable. Overall risk to children in the southwest of England is relatively high at 18.84 / 1 000 000 children per year (national range 13.49). Children with neurodiversity are disproportionately at risk. 11% of completed reviews for children aged 5-17yrs noted neurodiversity in the history while the population rates are reported as ASD 1.3% and ADHD 1.9%. The Report has 18 recommendations; Those of relevance to DCH and the local child death review team are – Recommendations; 3,4,5,6,12,13,14,15, 17 &18. The actions below relate to these. 1.Staff to know how to manage penetrating wounds; DCH to engage with work being led by the major trauma Operational Delivery Network ODN 2.Bleed control and resuscitation training for young people; DCH to consider how we may support 3.Ensure safe bathing techniques are being promoted; Maternity services to work with public health and primary care to update parenting programmes for antenatal and postnatal delivery 4.Sudden Unexpected Death in Infancy and Childhood (SUDIC) protocol to be updated; Local policy to be presented to the paediatric governance meeting, January 2024, Draft policy needs final revisions and will then be submitted 5.MOU with police and coroner to be developed to support multiagency working following an unexpected death; Draft to be circulated by the end of December 2023. Aim is for completion by February 2024.
#5309 NACAP Audit Programme COPD/Adult Asthma	A report of an ongoing continuous national audit into Asthma and COPD care. The data refers to January 2023, but we now have more up to date data (which show similar patterns). We are in the process of trying to improve our practice and monitoring that improvement.

2021 - 22	1.Improve use and capture of asthma and COPD discharge- Moreton Specialist nurses to liaise with Audit dept over capturing bundle data bundles 2.Improve recording of spirometry results in record for COPD- Moreton Specialist nurses to review patients early and capture DCR info 3.Improve access to and use of Peak Expiratory Flow (PEF) meters in asthma on admission- Discuss with ED about access and educate ED teams 4.Improve use of asthma and COPD admission bundles in ED and acute medicine- Discuss bundle use with ED and acute medical teams Monitor admission bundle use when patients reviewed for discharge. 5.Improve smoke stop use in asthma and COPD Review improvements with smoke stop team now in place 6.Discuss asthma and COPD discharges with community teams and monthly MDTs- Explore access to inpatient asthma and COPD DiiS for community nurses 7.Improve oxygen prescriptions through use of medical admissions bundle- Continue to feedback to juniors more regularly about medical admissions bundle use. Report presented at Respiratory department meeting 7/11/23
#5358 Outpatient Management of Pulmonary Embolism(PE)Audit 2021	**Key Audit Results:** This audit compares the management of acute PE by DCH (11 patients) compared to national records (1509 patients) in September 2021. With such small numbers, comparisons are unreliable. Our patients were all managed by ED or Acute medicine 45% were not admitted (48% nationally). 1.Improve Pulmonary Embolism Severity Index (PESI) recording-Discuss with Same Day Emergency Care (SDEC) team to implement change in practice 2.Ensure ST3+ senior review for all patients- Discuss with SDEC team to implement change in practice 3.Devise and provide written information about PE- Discuss with SDEC team to implement change in practice 4.Discuss a plan for 7-day review 5.Ensure administration of anticoagulation within 1 hour of clinical suspicion ((e.g., +ve d-dimer result) - Discuss with SDEC team to implement change in practice 6.Ensure CT reports contain evidence for Right Ventricular dysfunction, and this is recorded in the clinical record- Discuss with SDEC team to implement change in practice
#5388 National Asthma & Chronic Obstructive Pulmonary Rehabilitation Programme (NACAP); Drawing Breath 2021/22	**Key Audit Results.** ***Primary care teams offering referral to pulmonary rehabilitation for all people with COPD and a Medical Research Council (MRC) breathlessness grade of 3–5*** – Included on the template used for primary care during annual reviews for COPD patients. Recent update evenings have been held across the primary care networks highlighting the importance of pulmonary rehab and the patient pathway. ***Ensuring that pulmonary rehabilitation commences within 90 days of receipt of referral for people with stable COPD and within 30 days of leaving hospital for those admitted with COPD exacerbation*** – waiting times increased after covid lockdowns, now improving. The service is working towards achieving the national targets. ***Protecting time for pulmonary rehabilitation clinical leads to provide leadership to the team*** – since December 2022, we now have a clinical service manager in post who has designated leadership time. quality assuring pulmonary rehabilitation programmes for people with COPD, including the provision of discharge assessments and exercise plans – this is recorded on the separate National Respiratory Audit Programme data collection for pulmonary rehab. All DCH patients who complete the course and invited to a discharge assessment and ongoing exercise is discussed during this and written information given to the patients along with signposting to local community groups, LiveWell Dorset etc. **Benchmarking.** National Targets 90 days from receipt of referral for routine referrals – quarter 1 2023 - 24 weeks average, quarter 2 2023 - 15 weeks. **What does this mean for DCH:** We are meeting the recommendations in this report from a pulmonary rehab

	perspective and referral times are pointing to improvements.
#5500 National Audit of Inpatient Falls: Falls & Fragility Fractures Programme: Inpatient falls and fractures – one chance to get it right. The 2023 National Audit of Inpatient Falls (NAIF) report on 2022 clinical data	**Good performance.** Cases where patients were checked for injury before being moved. DCH 83% (improvement from 75% last year). NAIF Overall 77%. Cases that received a medical assessment within 30 minutes of a fall. DCH 83%. NAIF 67%. **Area of Concern**. Multi Factorial Risk Assessment (MFRA) quality score. DCH 33% (improvement from 25% last year). NAIF 34%. This will be addressed by changes that DCH implemented this year in July 2023 where we have changed our current PACT score to a Multi Factorial Risk Assessment called Fall Safe. Cases where a safe manual handling method was used to move a patient from floor. DCH 17%. NAIF 32%. **What does this mean for DCH.** In July 2023 DCH changed the falls risk assessment PACT score to a Multi Factorial Risk Assessment called Fall Safe. As a result of this, it is expected that the DCH audit data will be improved during the next audit. The slips, trips and falls policy was also reviewed in July 2023 and a new post fall assessment proforma was introduced as a guide to best practice for those undertaking checks for injury. This will be adapted to include the recommendation / prompt for analgesia. The procedure for a safe manual handling manoeuvre from the floor will need to be addressed by the Trust. The Falls Action Group is held bi-monthly, and the risk department provide a risk management data report which is discussed and analysed by the group. The Trust has advertised for a Falls Lead for the trust to lead on improvement projects. The Trust currently has good audit data for dementia and delirium screening and a team specifically focussed on this.
#0000 Epilepsy 12 National Clinical Audit of Seizures and Epilepsies for Children and Young People 2023 combined organisational and clinical audits: Report for England and Wales Round 4, Cohort 4 (2020-22	**Key Audit Results:** Overall, there has been improvement in care in 8/12 performance indicators within the Epilepsy 12 audit including timely access to key professionals, Investigations, treatment, and agreement of care plans. The main challenges remain access to mental health services and appropriate screening for learning disabilities and other neurobehavioral diagnosis. The purpose of the Epilepsy 12 audit is to demonstrate our compliance with the best practice tariff for our epilepsy clinic however we do not currently meet that (see page 76 and 78. 23-25NPS Annex DpC Guidance on best practice tariffs (england.nhs.uk) no agreed pathway for mental health concerns no agreed action plan describing steps towards integrating mental health provision in epilepsy clinics. **What does this mean for DCH.** DCH needs to be working with the ICB's within the 4 recommendations: Epilepsy12: Percentage of children with epilepsy and a mental health problem who have evidence of mental health support. Epilepsy12: Percentage of Trusts with agreed referral pathways for children with mental health concerns. Local Audit: evidence of the availability of specialist psychological advice and local pathways.
National Child Mortality Database (NCMD): **Infection related deaths of children and young people in England** **National Child Mortality Database Programme Thematic Report.** Data period: April 19 – March 22	In a 3-year study period there were 1507 infection related deaths in England, 4.2/100 000 / year. In 37% of these deaths; infection was a complete and sufficient explanation (accounts for 6% of all child deaths). **Benchmarking: NCMD child death data: year ending 31/3/2023.** Child death rates in the southwest of England are relatively low compared to other areas. This may reflect the demographics of the southwest and known relative risk factors for child deaths. **What does this mean for DCH?** **Ensure coherent and aligned guidelines on infections and treatments are developed and followed across service. This includes the use and development of tools to support the recognition of the sick child:** National Paediatric Early Warning Score (PEWS) tool not yet rolled out; a scoring system is included in the AGYLE ED system for neonates the Newborn Early Warning

	Track and Trigger (NEWTT2) screening tool is embedded in BadgerNet. Senior paediatric staff are trained in Advanced Paediatric Life Support (APLS) which includes the deteriorating child. This topic is covered at induction for paediatric trainees. Tools to support decision making re antibiotic treatment are used for children and neonates. **Ensure that recognition of infants and children who are at higher risk of death form infection is included within guidance and training:** High risk cohorts are identified by clinicians e.g. neonates and children with cardiac problems at increased risk from RSV infection. Children on immunosuppressive treatments have emergency treatment protocols. The sepsis screening tool used includes a question about whether the child is immunocompromised and this impacts on the scoring and recommendations. These are issues that are addressed on an individual patient level and in teaching about topics e.g. oncology. **Commission research to develop, evaluate and trial risk assessment tools:** staff should continue to participate in appropriate research studies. **Investigate further and gain better understanding of the barriers to accessing services by parents when their child may be presenting symptoms and signs of infection: C**onsidered at paediatric and neonatal mortality and morbidity meetings and child death reviews. Where learning is identified, actions are developed to address the issues. **Listen to and act on parental concerns about their baby's or child's health as per NICE Guideline194 and ensure timely escalation for senior review:** Martha's law has been discussed at Mortality & Morbidity meetings; clinicians are sensitive to the need to respond to parental concerns. The national PEWS chart includes a question about parental concerns which impacts on the score and the recommended action. There is an escalation pathway in place. When the national PEWS is in use in paediatrics it may be appropriate to audit compliance with this aspect. A Kingfisher app will be available from the end of January 2024 with information in many different languages. Development of this app will be ongoing, and it is anticipated that there will be a function linked to Martha's law in the 2nd version. Any child representing to the emergency department within 7 days for the same condition is seen for review by a SpR or consultant in accordance with guidance from the Royal College of Emergency medicine. **Increased public awareness of potentially significant symptoms and signs of infection particularly in infants e.g. by promoting the use of appropriate apps and websites for information:** Wessex healthier together is widely used by clinicians. It is accessible in many languages and includes the option to speak the text in each language. **Ensure that all children and families are offered all vaccinations their child is eligible for and are supported appropriately to consider and take up the offer. Increase awareness of the national children's vaccination schedule and green book guidance amongst child health services:** The pan Dorset and Somerset CDOP suggest all hospitals should consider the immunisation needs of patients with complex health needs at the point of discharge. For some people it may be appropriate to administer the vaccinations before they go home. This may help reduce the problem of missed vaccinations due to frequent admissions which has been seen to be a significant contributory factor to the death of a Somerset child. While there is no formal protocol in place about this it has been highlighted to all paediatric units across the CDOP area and has been discussed with the paediatric team at this hospital. **Ensure that any additional needs are identified prior to a child attending for vaccination so that person-centred reasonable adjustments can be accommodated where needed:** Action for primary care and immunisation services. **Ensure that any written and oral information and advice on immunisations is accessible to all groups and local communities and made available widely, and in multiple languages, to all parents, carers, and young people, in order that an informed decision can be made. Support from local immunisation services, children's health services, local community leaders and community outreach partners can be helpful in disseminating**

	information and providing reassurance to parents who may be hesitant in accepting any vaccination offer: This is a national recommendation. **Support and develop initiatives to improve health and reduce disparities and mitigate the social determinants such as housing, as well as risk factors such as smoking and obesity, all being associated with increased mortality risk from infection in children: S**taff should promote a healthy lifestyle. **Commission future research focusing on improvements in diagnosing specific causes and on the mechanisms underlying the much higher infection mortality rates in infancy. Further research should study the complex interaction of deprivation, ethnic disparities, and underlying health conditions, and inform maternal vaccine implementation work and future perinatal vaccine research:** Staff should contribute to appropriate research projects where possible. **Continue to develop data linkages between NCMD and other national datasets, including lab-confirmed infections within the Second-Generation Surveillance System (SGSS) dataset at the UK Health Security Agency:** This is a national recommendation. **Actions to be implemented.** 1.Listen to and act on parental concerns about their baby's or child's health- National PEWS to be adopted by DCH when the national roll out programme occurs. 2. Listen to and act on parental concerns about their baby's or child's health- When the national PEWS has been implemented consider auditing compliance with this aspect of the tool. This could include linking with ED for joint audit.
5499; Fracture Liaison Service Database February 2024	**Key Audit Results:** DCH – Patient capture rate achieved 92.2% which is 16% increase, with a 14% (65.9% against 51.8%) increase in spinal fracture capture. This represents a strong uptake for the service. Our time to DXA scanning has improved from 44.6% to 61.1%. This is well above the National Average of 29.2%. Patient Follow Up (F/U) rate at 16wks – 37.7% against 39.7%, is above the national average. All the F/U calls were made, although didn't meet the 16wk time reframe. Benchmarking Poole patient capture – 18.2% - Spinal 5.4% - DXA 27.4% - F/U 14.7% Yeovil patient capture – 97.6 % -Spinal 62.4% - DXA 47.8% - F/U 89.8% <u>National Averages</u> Patient Capture 40.6%, Spinal 22.5%, DXA 29.2%, F/U 27.1%. **What does this mean for DCH?** DCH have outperformed Poole and the Yeovil figures except Yeovil patient capture and F/U. All the DCH areas, are above the National Averages. Our DXA team have switched to the Radiology Department and has been allocated a well measured space with more resilience available for the service. **Actions** To identify the fracture risk as close to 100% as possible, follow up, scan dates and treatments in a timely manner. To ensure a smooth progression for Fracture Liaison Service practitioners to maintain continuity and consistency. To modify follow-up structure to include returnable questionnaires for patients not wishing to attend appointments to receive their feedback for auditing.

Local Clinical Audits

Local Clinical Audits Local audits are carried out by the specialties in relation to areas of their work where they are wishing to explore quality improvement or risks in services for improving. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 189 local audits and 28 National Audits were registered during 2023-24 and work will continue to see these through to completion. The reports of 89 local clinical audits were reviewed by the provider in 2023-24.
A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Reference number:5901.
Title: Compliance to Venous Thromboembolism (VTE) Risk Reassessment
Data Collection Period: 11/06/2023-20/08/2023
Intention of the audit
To comprehensively evaluate the current VTE prophylaxis practices for medical patients. To identify areas where improvements can be made in practice which can potentially lead to positive patient outcome and reduction in mortality rates.
Standards Source:
1. NG 89 1.1.2
2. Section 11 of Clinical Guideline 0984 – prevention of venous thromboembolism-VTE for adults:
How it was undertaken:
Random sampling of 30 Inpatients in acute and General medicine and Gastroenterology wards. VTE risk assessments on admission and 24 hours post admission for all these 30 patients reviewed and analysed using documentation on JAC, Vital Pac and Digital patient record. Analyse quality of VTE risk assessments on admission and the appropriateness of VTE prophylaxis prescription as per standards.
Findings.
Areas of good practice: Remarkable Initial VTE assessment completion ratio.
Areas of poor practice: Delayed completion of initial VTE risk assessment. Poor quality of VTE assessment. Complete Lack of VTE Re-assessment at 24 post-admissions. Insufficient recognition of the significance of VTE assessment. Lack of awareness of need for re- assessments.
Actions
1.To Understand Junior doctors' perspective regarding importance of VTE risk assessment, re-assessments, and impact of VTE on patient safety a questionnaire survey on VTE risk assessment-completed 30/09/2023.
2.Educating Junior doctors on significance of VTE assessment and prophylaxis by 'Grand Round' Teaching on VTE risk assessment, reassessment, and prophylaxis. - Completed 30/09/2023.
3.Simplifying VTE risk assessment and prophylaxis. - Flow chart and VTE bulletin in Junior doctor's mess and offices.
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Audit Reference number:5984.

Title: Dorset County Hospital (DCH) Quick fire A-E prompt cards for Foundation Year 1 Doctors Quality Service Improvement (2nd Cycle)

Dates: August to November 2023
Intention of the audit
The aim of this initial retrospective Quality Improvement Project (QIP) was to improve the confidence of dealing with deteriorating patients at the bedside, whilst under pressure, by having an easily accessible prompt.
Standards Source:
LeBlanc VR, McConnell MM, Monteiro SD. Predictable chaos: a review of the effects of emotions on attention, memory and decision making. Adv Heal Sci Educ [Internet]. 2015 Mar 6 [cited 2023 Mar 22];20(1):265–82. Kensinger EA. Remembering the details: Effects of emotion. Emot Rev [Internet]. 2009 [cited 2023 Mar 22];1(2):99–113. Available from: /pmc/articles/PMC2676782/
Leblanc VR. The effects of acute stress on performance: Implications for health professions education. Acad Med [Internet]. 2009 [cited 2023 Mar 22];84(SUPPL. 10). Keinan G. Decision Making Under Stress: Scanning of Alternatives Under Controllable and Uncontrollable Threats. J Pers Soc Psychol. 1987;52(3):639–44. Baradell JG, Klein K. Relationship of Life Stress and Body Consciousness to Hypervigilant Decision Making. J Pers Soc Psychol. 1993;64(2):267–73.
Sharkey SW, Berger CR, Brunette DD, Henry TD. Impact of the electrocardiogram on the delivery of thrombolytic therapy for acute myocardial infarction. Am J Cardiol. 1994 Mar 15;73(8):550–3. Weigl M. Physician burnout undermines safe healthcare [Internet]. Vol. 378, The BMJ. BMJ Publishing Group; 2022 [cited 2023 Mar 24]. Av DCH Management of the Deteriorating Patient Policy 1570:
How it was undertaken:
A questionnaire was developed and disseminated to the foundation year 1 Doctors, via presentation and QR code, during an early F1 teaching session. The A-E cards were distributed during this teaching period. Initial questionnaire responses were provided in August. F1s used the A-E cards.

Second questionnaire was disseminated at an F1 teaching session and the responses were provided in November.
Findings: The findings show; like the 1st cycle, overall, there appears to be a positive outcome from implementing the card. Proportionally people were more confident, less anxious and stated the card helped perform more thorough A-E assessments. The overwhelming majority of respondents think they would benefit from more simulation training. There were no issues with the robustness of the card which was a major drawback during the 1st cycle.
In conclusion, the second cycle of the QIP, suggests that implantation of a A-E card as a prompt may benefit incoming F1's when dealing with deteriorating patients as the results indicate proportional improvement in most domains. A major problem with the first cycle was the robustness of the card.
Action:
Prompt cards to be given to foundation doctors during induction.
More simulation training opportunities should be made available to doctors during foundation training specifically on deteriorating patients.

Audit Reference number:5866.
Title: Dorset County Hospital (DCH) Acute Kidney Injury (AKI) Co-Morbidities & Patient Recovery Audit
Dates: 04/05/2023 – 15/05/2023
Intention of the audit
The aim is to assess, retrospectively a range of parameters relating to AKI in patients admitted to the renal ward with AKI at DCH. The sample included all patients admitted to the renal ward between 01/05/21 - 30/04/22 who had AKI. Management, mortality, and renal outcomes of these patients were tracked until 12 months post admission.
Standards Source:
How it was undertaken:
Findings.
The audit showed that patients with Type 2 Diabetes Mellitus (T2DM) or chronic kidney disease (CKD) have poorer outcomes (death or renal replacement therapy) following AKI than those without, suggesting these co-morbidities are significant risk factors for poor renal outcomes after AKI. It also showed that not all patients are receiving urine dip investigations or timely renal tract USS in the context of AKI investigation and management.
Action
Recommended the use of sick day rule cards for patients with co-morbidities at risk of poor outcomes following AKI.
Further analysis of why renal USS and urine dip investigations were not always performed as per guidelines and further in-depth analysis of patient outcomes following AKI in those with other co-morbidities.

Audit Reference number; #5992;
Title**:** Pre-operative Tranexamic acid (TXA) administration to eligible patients with a hip fracture treated surgically.
Intention of the audit
The aim of this retrospective audit is to identify if 27 patients (over age 65; between September and October 2023) with hip fracture who are eligible are receiving TXA prior to hip fracture surgery following the original audit no. 5553. To help us identify if there has been any improvement in practice.
Standards Source:
How it was undertaken:
Findings.
The audit shows that at DCH a greater number of eligible patients receive pre-operative TXA than Nationally (as shown in the PATHS study). Following the initial audit and poster displayed post audit there was an improvement in compliance to 85.2%, meeting the gold standard of eligible patients having TXA pre-operatively.
Actions
To discuss the results in January 2024 and for a formal multidisciplinary guideline use of TXA pre-operatively in eligible patients; and document when TXA in, In-patients is inappropriate in the operative notes/anaesthetic charts.

Audit Reference number; Title dates
#5835: Audit on Caesarean Sections at full Cervical dilatation and impacted fetal head (IFH)

Intention of the audit
Aim: To audit caesarean sections performed at full cervical dilatation and impacted fetal head (IFH).
And evaluate:
(i)The incidence of caesarean deliveries in the second stage of labour.
(ii)Risk factors of impacted fetal head (IFH) at caesarean section (CS).
(iii)The indication for delivery.
(iv)Associated fetal and maternal morbidity.
with a view to suggesting strategies for improvement in the future.
Standards Source:
How it was undertaken:
Findings.
This audit identified that IFH is a serious complication that can occur at c-section. There is a need for additional training and a local guideline to help identify women at risk of IFH and to manage IFH.
Use of the fetal pillow helped reduced haemorrhage, surgical complications, and improved neonatal outcomes. The audit highlighted the need to improve documentation during labour and c-sections and to document the debriefing patients are given following delivery.
Learning points
There is an increasing incidence of IFH at CS and this will continue as CS rates increase.
Management of IFH is extremely important, it has serious and significant neonatal and maternal outcomes. Currently there are no clear guidelines on the best way to manage IFH.
Our audit identified that use of the fetal pillow was associated with easier delivery of the IFH, reduced blood loss and better neonatal outcomes.
While the fetal pillow is helpful with second stage CS, it is not clear what is the best method for IFH for a first stage CS or management of an unexpected IFH at CS.
Actions
1.Creating local guidelines in the management of IFH.
2.More training in the management of IFH e.g., incorporating an IFH station at PROMPT training.
3.Better documentation.
4.Improving debriefing patients following CS
5.Re-audit.

Clinical Research

The Research department at Dorset County Hospital delivers clinical research and has been operational since 2001. The Department currently has around 23 whole-time equivalent substantive staff as well as a consistent group of bank staff based at Trust Headquarters. The Department receives good support from an active volunteer group of Patient Research Ambassadors. It is part of

the Corporate Service of the Trust, under the executive leadership of the Chief Medical Officer. The Research Department appointed a new Clinical Director for Research who started in May 2023 and has undergone a complete governance review now with the bimonthly Research Steering Committee which gives assurance to the Quality Committee on a quarterly basis.

Delivering clinical research opportunities to patients continues to be a key priority for Dorset County Hospital, a service fundamentally supported by our long-standing collaborative relationship with the NIHR. Over the past 12 months the strategic focus of the Research Department has been responding to the national review of commercial clinical trials as outlined in the 2023 O'Shaughnessy report and this has included successfully launching the Weymouth Research Hub as a new, innovative facility to support high-throughput commercial research jointly hosted with Dorset Health Care.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2023-24 that were recruited during that period to participate in research approved by a research ethics committee was 473. The Weymouth Research Hub also supported 46 health volunteers to participate in commercial research trials under the Wessex Research Hub model. The Trust actively recruited to 37 projects which were open to recruitment during the financial year - four of these open projects were commercially funded and sponsored representing a 25% increase from the previous year.

Of the active, open studies which recruited participants, two were in Paediatrics, five in Maternity, three in Critical Care, two in Renal Disorders, four in Gastroenterology, two in Anaesthesia, four in Surgery, one in Cardiovascular, three in Stroke, six in Oncology, one in Trauma and Emergency Medicine, one in Respiratory Medicine and one in Diabetes. The most active recruitment areas were Surgery and Gastroenterology recruiting 97 participants followed by Anaesthetics which recruited 92 participants and then Respiratory Disorders and Stroke who recruited 86 participants into open studies. Commercial trials were supported in Cardiovascular, Renal, Oncology and General Surgery with a team of experienced clinical staff supporting strong portfolios in these areas. The Weymouth Research Hub recruited 46 healthy volunteers into a Covid-19 vaccine study which took DCH's overall commercial recruitment activity to 76 participants.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registered in full without any additional conditions.

During this reporting period, CQC inspected the maternity service at Dorset County Hospital as part of a national maternity inspection programme which took place in June 2023. Dorset County Hospital provides maternity services to the population of west and north Dorset, including Dorchester, Weymouth and Portland, and Purbeck. Maternity Services were inspected, looking at how safe and how well led this service is.

Under section 29A of the Health and Social Care Act 2008, CQC issued a warning notice in relation to governance and oversight of services.

Areas of concern raised by the CQC included:

1. The service does not have effective governance processes or accurate data collection to monitor, gain assurance, and work to reduce the incidence and severity of post-partum haemorrhage.

2. The service does not have effective governance processes to monitor and improve the quality of services in relation reducing neonatal mortality and morbidity.

3. The service and trust board does not have effective governance processes to monitor and improve clinical outcomes for babies over time.

4. The service does not have an effective program of regular audit to ensure the quality and safety of services is monitored.

The Trust welcomed the opportunity to receive feedback from CQC and is committed to ensuring safe effective and patient centred care for our patients. In response to the notice and inspection report, the Trust developed and shared an action plan with the CQC and continues to make improvements including robust policies and processes. The rating for Maternity Services dropped as a result of this inspection.

The CQC has continued to virtually attend the ICS System Quality Group to provide further scrutiny of quality in the trust, with wider regulatory and non-regulatory partners. Throughout the year the trust has continued to be monitored under 'routine surveillance', meaning that no concerns were raised or escalated for further scrutiny.

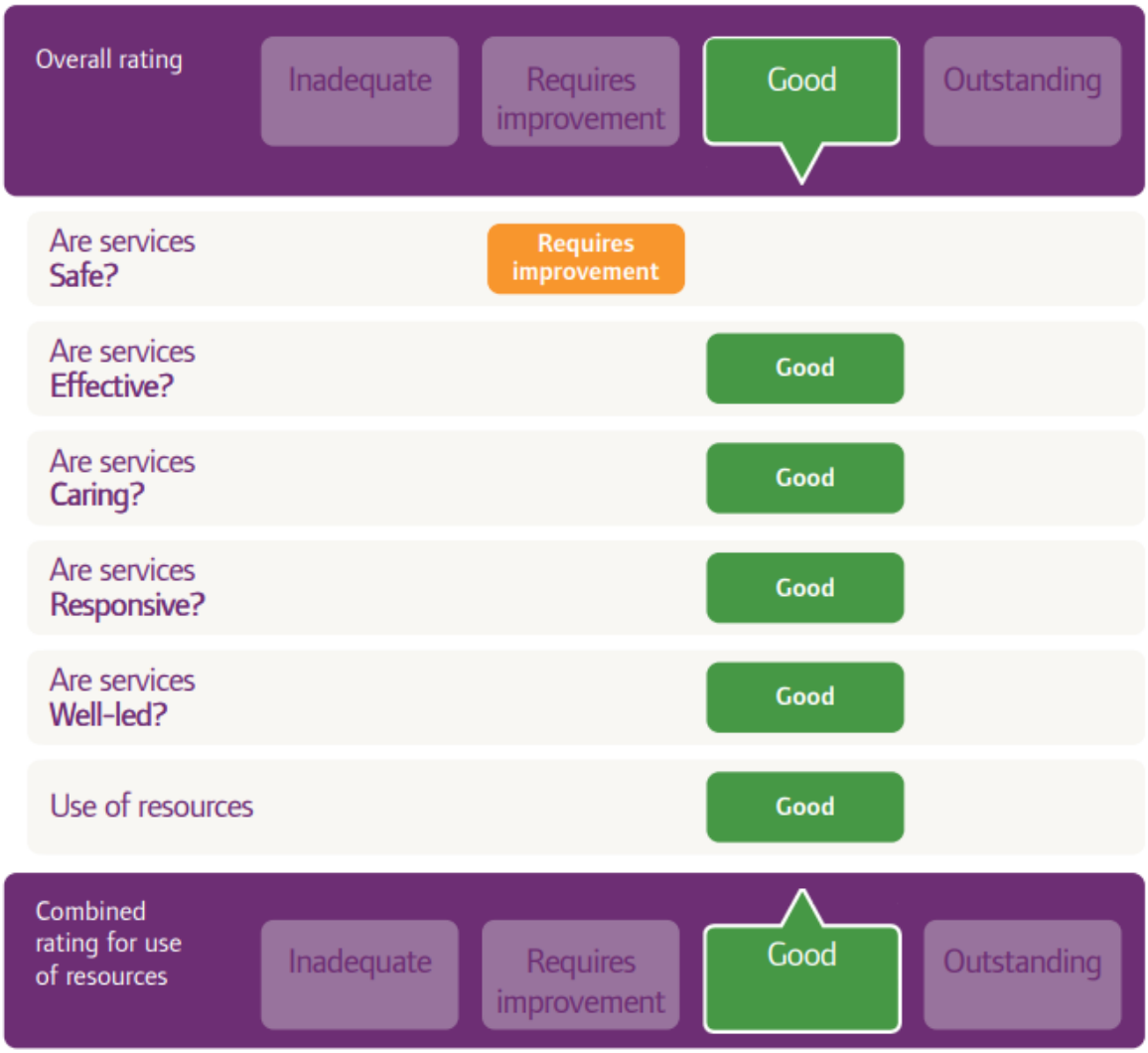
The trust continues to self-assess itself and continues to strive to provide outstanding quality service

The Trust is currently rated as 'Good' overall, with Dorset County Hospital rated as 'Requires Improvement' for the location. The Trust continues to undertake engage meetings with the local and regional CQC inspection team as well as engages with any enquiries received via the CQC.
The ratings grid below, as published by the CQC on its website, shows the current ratings given to the core services and five key questions for both The Trust and the hospital as a location.

CareQuality Commission

Last rated
6 November 2018

Dorset County Hospital NHS Foundation Trust



CareQuality Commission

Last rated
2 November 2023

Dorset County Hospital NHS Foundation Trust

Dorset County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Not rated	Good	Good
Critical care	Good	Good	Good	Requires Improvement	Good	Good
Diagnostic imaging	Good	Not rated	Good	Requires Improvement	Good	Good
End of life care	Good	Requires Improvement	Good	Good	Good	Good
Maternity	Requires Improvement	Good	Good	Good	Inadequate	Requires Improvement
Outpatients	Good	Not rated	Good	Good	Requires Improvement	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Urgent and emergency services	Requires Improvement	Good	Good	Good	Good	Good

Data Quality

The Trust submitted records during 2023-24 to the Secondary Uses Service 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 patient's valid NHS number was:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	National Average 2023/24
Admitted Patient Care	99.9%	99.9%	99.9%	100%	99.9%	99.9%	99.9%*	99.7%*
Outpatient Care	100%	100%	100%	100%	100%	100%	100%*	99.8%*
Accident and Emergency Care	99.1%	99.0%	99.2%	99.7%	99.7%	99.6%	99.6%	97.0%

The percentage of records which included the General Medical Practice Code was:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	National Average 2023/24
Admitted Patient Care*	100%	100%	100%	100%	100%	100%	100%*	99.8%*
Outpatient Care*	100%	100%	100%	100%	100%	99.9%	100%*	99.5%*
Accident and Emergency Care	100%	99.8%	100%	100%	99.7%	100%	100%	98.9%

***Please note that these figures cover the period April 23 to February 24 inclusive only. The figures for March 24 should be available from 10/05/24**

The Trust will be taking the following actions to improve data quality:

- The Information Assurance Manager will continue to work with the Business Intelligence Team to validate the data held in the Patient Administration System to provide improved assurance to the end users of reports.

Data quality metrics and reports are used to assess and improve data quality. The Data Quality Maturity Index (DQMI) and the CDS Data Quality Dashboards are monitored, and reports run on a daily/weekly/monthly basis via the PAS system and the Data Warehouse to highlight and address areas of concern.

The Trust was not subject to the Payment by Results clinical coding audit during 2023 – 2024.

Data Security

On 29th February 2024, the Trust submitted the interim Data Security and Protection Toolkit (DSPT) baseline submission to NHS Digital to demonstrate that, to date, it was compliant with 73 of the 108 mandatory assertions and 2 of the 10 national standards.

The internal audit performed by BDO LLP in February 2022 confirmed that the evidence provided for 39 of the 45 mandatory sub-assertion included in the sample were found to be satisfactory, and in line with the requirements of the Independent Assessment Framework. They conclude MODERATE assurance over the design and operational effectiveness of the Trust's data security and protection controls, and they rated confidence in the Trust's DSP Toolkit return as HIGH because the work completed on the DSP Toolkit has been in line with the requirements of the DSP Toolkit.

The Data Protection Officer continues to gather the evidence needed to complete the 2023/24 Data Security and Protection Toolkit, which is due for submission on 30 June 2024.

Learning from Deaths 2023/24

The Trust has a full complement of Medical Examiners who perform brief reviews of every in-patient death and identify those cases that require further in-depth reviews, using the Learning from Deaths national guidance. ('*National Guidance on Learning from Deaths*', National Quality Board, March 2017).

During April 2023 – March 2024 1,163 of DCH patients died in hospital or within 30 days of discharge from hospital (previous reports have not included deaths after discharge). This compromises the following number of deaths which occurred in each Quarter of that reporting period:

- 256 First Quarter
- 325 Second Quarter
- 298 Third Quarter
- 284 Fourth Quarter

By 01/04/2024 315 case record reviews and 4 investigations have been carried out in relation to the 1,163 deaths included in the previous section
In 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 70 First Quarter
- 89 Second Quarter
- 76 Third Quarter
- 80 Fourth Quarter (Completed Structured Judgment Review (SJR)

2 representing 0.17% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 1 of 256 representing 0.08% for the first Quarter
- 0 of 325 representing 0% for the second Quarter
- 0 of 298 representing 0% for the third Quarter
- 1 of 284 representing 0.08% for the fourth Quarter

These numbers are derived from the judgement score for whether it is felt that the death was 'more likely than not' to have resulted from a problem in healthcare. All such cases are referred to, and reviewed by, the Hospital Mortality Group (HMG).

The HMG publishes a summary of outcomes from all reviews via its quarterly report to the Trust's public Board papers which are available via the Trust's internet site. Reports are shared internally by email newsletters. Any common themes identified feed into the quality improvement plans in the Trust, as part of the overall trust objective to deliver outstanding services every day. The notes of any patient who suffers a cardiac arrest are automatically subject to an SJR to examine whether it might have been preventable, regardless of the outcome.

An additional audit of 65 deaths was carried by the Chief Medical Officer during Q3 and submitted to the DCH Quality Committee as well as a review by NHSE SW CMO – Dr. Michael Marsh.

This reporting period was again less affected by the covid-19 pandemic than the previous year, although some nosocomial covid-related deaths occurred. These were all subject to an SJR. Many comments within SJRs related to the quality of documentation which has been noted in previous

years. DCH has invested in a fully electronic patient record which was introduced in ED and Acute Medicine in 2022, and which has improved documentation standards in these areas. It is expected to also resolve most of these problems as it is rolled out to other parts of the Trust during 2024/25. Identified issues continue to be communicated across the Trust via a newsletter, and cases of suboptimal care are forwarded to departmental Morbidity & Mortality meetings and Divisional, Care Group and Specialty Governance meetings for further discussion and learning.

- During December 2023 it was apparent that readmissions within 30 days of discharge had increased to a peak of 19.6% (compared to the average of around 12%). An audit has been carried out by Dr. James Metcalfe and will report to Quality Committee in June 2024.
- AGYLE (Electronic Patient Record) software introduced 2022 to be rolled out to Acute Medicine 2024.
- 'Deaths of patients in hospital but awaiting more complex discharge plans' (no criteria to reside) are now monitored on a monthly basis using a continuously updated PowerBI dashboard. Figures are scrutinised regularly by the Quality Committee and escalated to Board if necessary.
- Discussion around completeness of DNAR forms led the HMG to suggest mandatory completion of such forms for all patients before, or within 24 hours of, admission. Since the paperwork is 'pan-Dorset' this idea has been raised at an ICS level meeting in Q1 2023.
- The redesigned patient record note paper containing printed watermark reminders to date, time, sign and record their PIN number with each entry remains in use across the Trust where AGYLE is not yet in use.
- VTE assessment recording was changed to a different IT system (EPMA) from mid-July 2020 and resulted in immediate achievement of the 95% recording target. A subsequent audit has shown that prescription of thromboprophylaxis is in line with this figure, but a separate twice-yearly audit of readmissions as a result of VTE occurrence demonstrated that such patients are more likely to have been prescribed prophylaxis incorrectly or not at all. This problem has now been referred on to the VTE committee for monitoring and action. The latest audit has shown significant improvement.

The following is an assessment of the impact of the actions described above during the reporting period.

- Timing & signing of notes entries – Introduction of a partial Electronic Case Note Record (AGYLE) occurred in 2022 and has resolved these problems within ED specifically. As its coverage is increased across the Trust it is expected that the same improvement will be evident during 2024.
- Identification of deaths among patients awaiting discharge began in April 2023 and data is now published within a Power BI dashboard. This allows regular monitoring by the Quality Committee. Numbers of such in-patients have reduced significantly during Q4.
- Identification of a deteriorating patient is under constant review by the Trust's sepsis group, and the 'All Cause Deterioration' documentation is in use since 2020/21 Q4. The introduction of PSIRF reviews is now established within DCH and is replacing the need for multiple RCAs. The new approach is better able to document and act on trends as opposed to individual events.
- All case notes involving the End-of-Life Care pathway are reviewed by the EoLC group, chaired by a palliative care consultant, and with a review of DNAR orders and appropriateness of escalation of care decisions. Readmission of such patients at end of life was highlighted in the CMO's Q3 audit, suggesting that if staffing and facilities- were adequate the readmissions may have been avoidable. Results and readmissions are reported back to HMG on a regular basis.
- Surgical admission clerking/differential diagnosis remains a taught session as part of FY1 education – usually delivered by the Trust Medical Director. A second session examining lessons from SJR is also included in the Grand Rounds each year.

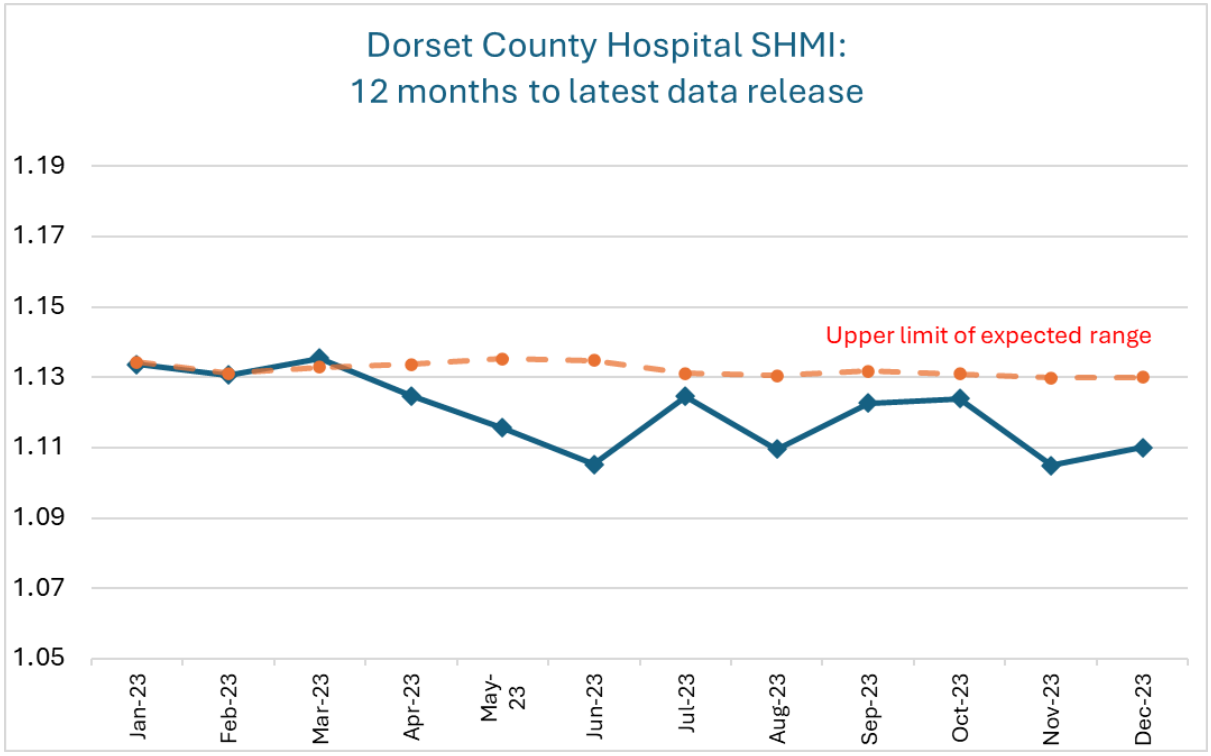
Mortality Outcomes Data - Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

It covers all deaths of patients who were admitted to non-specialist acute trusts in England, and who either died in hospital or within 30 days of discharge.

A lower score indicates better performance. In addition to individual scores, trusts are categorised into one of three bandings: 1 (SHMI higher than expected); 2 (SHMI as expected); 3 (SHMI lower than expected). The DCH SHMI has been within the expected range (banding 2) for 11 of the previous 12 reporting periods.

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
DCH SHMI 2023	1.134	1.131	1.136	1.125	1.116	1.105	1.125	1.120	1.123	1.124	1.105	1.110
DCH SHMI Banding	2	2	1	2	2	2	2	2	2	2	2	2



Summary Hospital-level Mortality Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24*	Trend
Banding	**2**	**2**	**2**	**1**	**2**	**1**	**1**	**2**	**1**	**1**	**1**	**2**	
Value	**1.07**	**1.11**	**1.10**	**1.16**	**1.12**	**1.17**	**1.19**	**1.13**	**1.14**	**1.13**	**1.13**	**1.10**	
% of patient deaths with palliative care coded at either diagnosis or speciality level	**12.0%**	**13.5%**	**15.7%**	**24.9%**	**35.6%**	**32.3%**	**33.0%**	**39.0%**	**42.0%**	**45.0%**	**47.0%**	**50.0%**	
National Average	*19.9%*	*23.6%*	*25.7%*	*28.5%*	*30.7%*	*32.5%*	*35.0%*	*37.0%*	*38.0%*	*40.0%*	*40.0%*	*42.0%*	
Lowest	*0.1%*	*0.0%*	*0.0%*	*0.6%*	*11.1%*	*12.6%*	*12.0%*	*9.0%*	*8.0%*	*11.0%*	*14.0%*	*16.0%*	
Highest	*44.0%*	*48.5%*	*50.9%*	*54.6%*	*56.9%*	*59.0%*	*60.0%*	*58.0%*	*63.0%*	*66.0%*	*66.0%*	*66.0%*	

Latest publication up to November 2023. Full year 2023/24 data published August 2024

The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of 'as expected'. For the SHMI, a comparison should not be made with the highest and lowest trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, **it is inappropriate to rank trusts according to their SHMI**.

Source - Click link and find latest financial year report, scroll down to the SHMI palliative card coding contextual indicators and select the Excel Doc called % of deaths with palliative care coding. The data tab shows the England % as national, find DCH Trust then filter on column to get lowest and highest %

Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS Digital

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

Patient Reported Outcome Measures (PROMs)	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18^	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Trend
Groin Hernia													
Dorset County Hospital	**0.076**	**0.076**	**0.066**	**N/A**	**0.068**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	
National Average	*0.085*	*0.085*	*0.084*	*0.088*	*0.086*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest													
Highest													
Hip replacement													
Dorset County Hospital	**0.461**	**0.445**	**0.466**	**0.471**	**0.462**	**0.506**	**0.501**	**0.453**	**N/A**	**N/A**	**N/A**	**N/A**	
National average	*0.438*	*0.436*	*0.437*	*0.438*	*0.445*	*0.458*	*0.457*	*0.453*	*0.467*	*N/A*	*N/A*	*N/A*	
Lowest													
Highest													
Knee replacement													
Dorset County Hospital	**0.304**	**0.297**	**0.305**	**0.341**	**0.299**	**0.356**	**0.361**	**0.35**	**N/A**	**N/A**	**N/A**	**N/A**	
National average	*0.318*	*0.323*	*0.315*	*0.320*	*0.324*	*0.337*	*0.337*	*0.334*	*0.317*	*N/A*	*N/A*	*N/A*	
Lowest													
Highest													
Varicose Vein													
Dorset County Hospital	**N/A**	**N/A**	**0.099**	**0.127**	**0.043**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	
National average	*N/A*	*0.093*	*0.095*	*0.096*	*0.092*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest													
Highest													

Provisional publication for 2020/21. Data for 2021/22 and 2022/23 not published

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

^NHS England discontinued the mandatory varicose vein surgery and groin-hernia surgery national PROM collections from October 2017

A higher number demonstrates that patients have experienced a greater improvement in their health.

Emergency Readmissions

The table below shows the percentage of emergency readmissions to the Trust within 28 days of a patient being discharged.

A readmission to hospital within 30 days may suggest either inadequate initial treatment or a poorly planned discharge process. The following funnel chart below shows number of readmissions within 28 days during 2021 for all acute, non-specialist Trusts. The large blue dot shows DCH's rate exactly on the average line (relative risk 100), demonstrating no increased risk of readmission within 30 days compared with other Trusts.

Readmissions within 28 days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24*	Trend
Aged 0 to 15 years													
Total Spells	5,147	4,749	4,676	4,948	4,975	4,778	4,677	4,568	3,165	4,260	4,702	N/A	
Of which, readmitted as an emergency within 28 days	456	393	442	471	488	478	508	573	372	527	584	N/A	
Dorset County Hospital	**8.9%**	**8.3%**	**9.5%**	**9.5%**	**9.8%**	**10.0%**	**10.9%**	**12.5%**	**11.8%**	**12.4%**	**12.4%**	**N/A**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Aged 16 years and over													
Total Spells	16,832	16,103	17,567	18,263	18,837	17,957	17,920	18,196	14,439	17,081	15,588	N/A	
Of which, readmitted as an emergency within 28 days	1,741	1,695	1,994	2,222	2,295	2,142	2,316	2,504	2,087	2,204	1,787	N/A	
Dorset County Hospital	**10.3%**	**10.5%**	**11.4%**	**12.2%**	**12.2%**	**11.9%**	**12.9%**	**13.8%**	**14.5%**	**12.9%**	**11.5%**	**N/A**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	

2023/24 data not published.

Information is available in Emergency readmissions to hospital within 30 days of discharge : indirectly standardised percent trends broken down by age bands and sex (I02040 / I00712) - NHS England Digital but only up until March-23

https://digital.nhs.uk/data-and-information/publications/statistical/compendium-emergency-readmissions/current/emergency-readmissions-to-hospital-within-30-days-of-discharge

Responsiveness

The indicator is a composite, calculated as the average of five survey questions taken from the annual national inpatient survey.

Responsiveness to the personal needs of patients	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	2022/23*	2023/24*	Trend
Dorset County Hospital	**66.9**	**69.9**	**71.1**	**69.6**	**70.2**	**69.0**	**68.2**	**67.0**	**76.7**	**N/A**	**N/A**	**N/A**	
National average	*68.1*	*68.7*	*68.9*	*69.6*	*68.1*	*68.6*	*67.2*	*67.1*	*74.5*	*N/A*	*N/A*	*N/A*	
Lowest	*57.4*	*54.4*	*59.1*	*58.9*	*60.0*	*60.5*	*58.9*	*59.5*	*67.3*	*N/A*	*N/A*	*N/A*	
Highest	*84.4*	*84.2*	*86.1*	*86.2*	*85.2*	*85.0*	*85.0*	*84.2*	*85.4*	*N/A*	*N/A*	*N/A*	

2021/22,2022/23,2023/24 data not published.

Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators.

As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made in due course.

As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding scoring regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years.

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals. NHS OF will be published on an annual basis from March 2022 onwards. The August 2021 release was the final quarterly publication.

Source

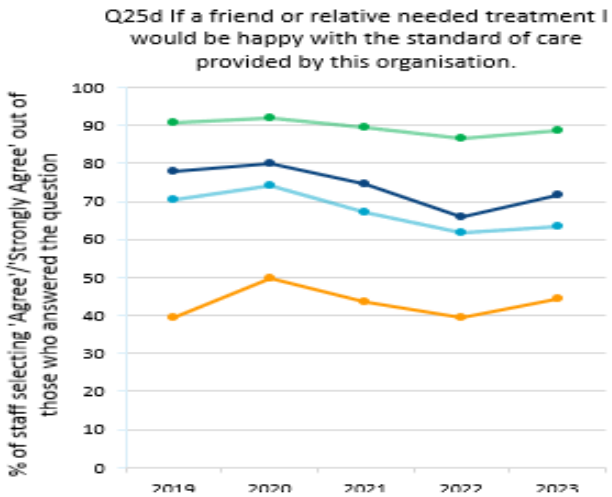
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/may-2020/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

The overall score can range from 0 to 100, a higher score indicating better performance. If all patients were to report all aspects of their care as 'very good' this would equate to an overall score of 80. A score of approximately 60 would indicate 'good' patient experience.

Staff Friends and Family Test (SFFT)

This test forms part of the national NHS Staff Survey undertaken in quarter 3 of each year. These figures are taken from the 2023 survey.

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2017	2018	2019	2020	2021	2022	2023
Dorset County Hospital	76%	**80%**	**78%**	**80%**	**66%**	**66%**	**72%**
National Average (median)	71%	**71%**	**69%**	**74%**	**58%**	**62%**	**63%**



	2019	2020	2021	2022	2023
Your org	77.80%	80.05%	74.55%	65.79%	71.71%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	1206	1346	1506	1397	1402

Venous thromboembolism (VTE)

Venous thromboembolism (VTE) is an international patient safety issue and a clinical priority for the NHS in England.

VTE is a collective term for deep vein thrombosis (DVT) – a blood clot that forms in the veins of the leg; and pulmonary embolism (PE) – a blood clot in the lungs. It affects approximately 1 in every 1000 of the UK population and is a significant cause of mortality, long term disability and chronic ill-health problems.

There is no year end data since 2019/20 as collection and publication was suspended in line with national guidance to release capacity within providers to support and manage the Covid-19 pandemic

Rate of admitted patients assessed for VTE	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20*	2020/21*	2021/22*	2022/23*	2023/24*	Trend
Admissions	24,026	87,426	91,462	96,063	96,797	98,692	99,443	59,516	N/A	N/A	N/A	N/A	
Of which, VTE risk assessed	22,077	85,211	87,371	92,847	92,813	94,793	94,133	52,933	N/A	N/A	N/A	N/A	
% VTE risk assessed	**91.9%**	**97.5%**	**95.5%**	**96.7%**	**95.9%**	**96.0%**	**94.7%**	**88.9%**	**N/A**	**N/A**	**N/A**	**N/A**	
NHS Standard	*92.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*N/A*	*N/A*	*N/A*	*N/A*	
National Average	*94.0%*	*95.8%*	*96.1%*	*95.8%*	*95.6%*	*95.3%*	*95.6%*	*95.5%*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	***80.2%***	***66.7%***	***88.6%***	***76.9%***	***0.0%***	***75.1%***	***0.0%***	***71.8%***	***N/A***	***N/A***	***N/A***	***N/A***	
Highest	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*N/A*	*N/A*	*N/A*	*N/A*	

2019/20 nationally published data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic

Source
https://www.england.nhs.uk/statistics/statistical-work-areas/vte/
https://improvement.nhs.uk/resources/vte/

Clostridium difficile C-Diff

Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea. People who become infected with C. difficile are usually those who have taken antibiotics, particularly the elderly and people whose immune systems are compromised. For each HOHA – hospital onset healthcare acquired care (stool sample taken after day 2 of admission, day one being day of admission) and COHA -community onset hospital associated case (inpatient in

previous 28 days prior to sample being taken) a full route cause analysis is performed to identify any learning or lapses in care with particular attention on sampling in a timely manner, isolating patients with new onset of diarrhoea and justification of prior antibiotic use.

C-difficile rates per 100,000 bed-days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24*	Trend
Bed-days	101,156	102,674	98,654	105,719	99,883	98,908	98,845	100,903	77,905	107,280	119,522	N/A	
C-difficile cases	22	27	15	24	13	10	10	10	15	41	39	N/A	
C-difficile rate	**21.7**	**26.3**	**15.2**	**22.7**	**13.0**	**10.1**	**10.1**	**9.9**	**19.3**	**38.2**	33	N/A	
National Average	*17.4*	*14.7*	*15.0*	*14.9*	*13.2*	*13.6*	*12.2*	*13.6*	*15.4*	*16.2*	*18.3*	*N/A*	
Lowest	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*N/A*	
Highest	*31.2*	*37.1*	*62.6*	*67.2*	*82.7*	*91.0*	*79.7*	*51.0*	*80.6*	*53.6*	*73.3*	*N/A*	

2023/24 data currently not published
Source
NHS Outcomes Framework Indicators - March 2022 release - NHS England Digital

Incidents

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

The trust actively encourages staff to report incidents and 'near-miss episodes. Incident reporting is a positive culture of open transparency on safety within The Trust. All reporting is disseminated to ensure that key learning points are shared throughout the organisation.

Patient safety incidents reported	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	2022/23*	2023/24*	Trend
Number of patient safety incidents reported to NRLS	2,945	1,736	2,116	4,609	4,493	4,838	4,997	5,542	5,552	N/A	N/A	N/A	
Admissions	51,184	50,530	98,666	105,413	99,883	99,491	98,845	100,903	77905	N/A	N/A	N/A	
Incident rate per 100 admissions	**5.8**	**3.4**	**2.1**	**4.4**	**4.5**	**4.9**	**5.1**	**5.5**	**7.1**	**N/A**	**N/A**	**N/A**	
National Average	*7.1*	*7.7*	*3.6*	*3.9*	*4.1*	*4.3*	*4.5*	*4.9*	*5.8*	*N/A*	*N/A*	*N/A*	
Lowest	*2.5*	*3.0*	*1.7*	*1.6*	*1.9*	*1.6*	*2.1*	*2.1*	*1.5*	*N/A*	*N/A*	*N/A*	
Highest	*27.8*	*30.4*	*10.2*	*13.0*	*14.8*	*16.7*	*14.2*	*18.1*	*18.5*	*N/A*	*N/A*	*N/A*	
Incidents resulting in severe harm or death	25	3	19	25	24	22	25	28	23	N/A	N/A	N/A	
Percentage of incidents resulting in severe harm or death	**0.85%**	**0.17%**	**0.90%**	**0.54%**	**0.53%**	**0.45%**	**0.50%**	**0.51%**	**0.41%**	**N/A**	**N/A**	**N/A**	
National Average	*0.65%*	*0.55%*	*0.49%*	*0.41%*	*0.37%*	*0.34%*	*0.32%*	*0.30%*	*0.44%*	*N/A*	*N/A*	*N/A*	
Lowest	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*N/A*	*N/A*	*N/A*	
Highest	*3.34%*	*3.90%*	*4.18%*	*1.74%*	*1.58%*	*1.76%*	*1.35%*	*1.31%*	*2.80%*	*N/A*	*N/A*	*N/A*	

2021/22,2022/23, 2023/24 data not published.
Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators.
As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made in due course.
Source

5.6 Patient safety incidents reported (formerly indicators 5a, 5b and 5.4) - NHS England Digital

Part 3

Quality Performance Information

This section of the report provides further detail on the quality of services provided or subcontracted by the Trust in the period 2023/24. Information on Patient Safety, Patient Experience and Clinical Effectiveness can also be found within the Quality Priorities end of year update section.

Patient safety – All Cause Deterioration

The Deteriorating Patient Group [DPG] has reviewed its terms of reference and (multi-professional) attendance list in line with the workstream requests of the Patient Safety Committee to whom it reports and escalates concerns. The Patient Safety Committee takes a broad overview of patient safety issues including feedback from subgroups, learning from incidents and monitoring any action plans. They also have input into the Patient Safety Incident Response Framework (PSIRF) plan.

The DPG is leading on the following workstreams (to include Maternity and Paediatrics):

- Monitoring Trust compliance with national scores (NEWS, PEWS, MEOWS).
- Monitoring compliance of Sepsis 6.
- Observe and monitor the delivery of the AIMS programme.
- Monitor risks and incidents relating to All Cause Deterioration.

In addition, the group continues to monitor and encourage the use of the All-Cause Deterioration Pathway [ACD] and the Clinical Deterioration Episode [CDE] proforma. Use of the CDE form is not only beneficial for patient management but is also helpful data as part of our CQUIN Quality Improvement work. The Deteriorating Group is exploring the scope for adding a trigger for this to the Agyle system as it is rolled out.

The DPG is also working on the implementation of Martha's Rule, to include a call system enabling patients and their loved ones to report concerns around deterioration. This system will provide the Trust with added assurance for safety netting the deteriorating patient, as well as empowering patients and relatives within their own care journey.

Clinical Effectiveness – Promoting the Health and Wellbeing of staff

The health and wellbeing of staff is imperative for ensuring safe, high-quality care for Trust patients. In order that DCH can support care quality and mitigate risk, reduce waiting lists, and support elective recovery, they must support people recovery. The evidence shows that when the staff feel well and satisfied with their work, the experiences of patients improve. It makes sound business sense to ensure all staff can access timely, relevant, and evidence-based support to maintain and improve their health and wellbeing.

DCHFT Wellbeing Visual Identity

Work has continued to embed the DCH Wellbeing offer by using the visual identity, which uses a bright green recognisable pallet and logo that appears on pop ups and in all communications including the intranet, it is also highly visible via recently circulated Health & Wellbeing folders which have been placed in prominent locations across the trust.

The Trust offers the current initiatives and support:

Health & Wellbeing Group The Health & Wellbeing Steering Group which started during 2024 brings together key stakeholders from across the organisation to work together to support the improvement of staff health & wellbeing at DCH. This group will enable a central opportunity to create opportunities, to influence and to coordinate change for staff.	**Financial Wellbeing** DCH is partnered with Money and Pensions Service for staff advice and support and the Serve & Protect Credit Union for salary deduction-based consolidation loans and savings. Staff have access to confidential foodbank referral and can receive a £25 shopping voucher support for those in need, as well as this staff in financial need are able to utilise food that would otherwise go to waste from Damers restaurant.
Health and Wellbeing Coaches	**Wellbeing Conversations**

Our network of staff Health & Wellbeing Coaches (HWCs) continues to grow, with over 60 participants and an additional intake during June 2024 that will join the community of practice. HWCs help signpost and support colleagues. The HWCs form an internal Community of Practice and receive training opportunities including Mental Health First Aid, Suicide Awareness, Trauma Risk Management and Behaviour Change	All new HWC's and Managers, or prospective Managers are offered the NHS Safe & Effective Wellbeing Conversations course to develop skills and approaches to further support staff as part of the Management Matters Programme. This ensures a culture of Wellbeing conversations with staff both formally and informally.
Trauma Response (TRiM) Following its launch in February 2024 staff are supported by a trauma response network across the Trust. TRiM (Trauma Risk Management) is a peer delivered assessment tool, used to determine by what degree, if any, a colleague has been affected by a potentially traumatic incident, and to ascertain whether they would benefit from further support. The network of trained TRiM practitioners and managers are currently receiving refresher training to help them maintain their role for the good of staff wellbeing. Work will continue around a cultural shift to embed the TRiM process at DCH.	**Charity Funding Support** Charity funding has continued to support the work of Health & Wellbeing at DCH, approval for a Health & Wellbeing Coordinator post for two years was supported by NHSCT and additionally funding will support DVR Virtual Reality Headsets for staff which can be issued in a prescription style basis for staff who need help with mindfulness, grounding or are generally struggling with their mental health. Funds have also been used to support staff who would like to provide free classes for colleagues such as yoga and Pilates, to pay for venues. Additionally, funding will support the work in Menopause and training for staff in bereavement support
Menopause Support Following the formation of a Menopause forum in 2022 work has progressed to include the development of Menopause policy, information days, stands and during April/May the recruitment of Menopause Advocates in the trust who will be identifiable via a badge or a fleece who will be available to support colleagues and, or would like to influence the organisational position on Menopause.	**Your Care** Launching in May 23 staff will have access to an online website portal called Your Care which will enable staff to take assessments against their holistic health, it will advise and support staff to self-help, or signposting where needed. Statistical measures of staff activity and wellness will be accessible for the development of organisational responses to need.

Patient Experience - Learning Disability Benchmarking

The improvement standards were launched in 2018 by NHS Improvement to ensure the provision of high quality, personalised and safe care from the NHS for the estimated 950,000 adults and 300,000 children with learning disabilities as well as the 440,000 adults and 120,000 children with autism across England. These standards were designed together with people with learning disabilities, autistic people, family members, carers and health professionals, to drive rapid and substantial improvements to patient experiences and equity of care.
The NHS Long Term Plan, published in 2019, pledged that over the next five years, the national learning disability improvement standards will be implemented by all services funded by the NHS to ensure people with learning disabilities and/or autistic people can receive high quality, personalised and safe care when they use the NHS.

The four improvement standards against which trust performance is measured cover:

- Respecting and protecting rights
- Inclusion and engagement
- Workforce
- Specialist learning disability services

The first three ‘universal standards’ apply to all NHS trusts, and the fourth ‘specialist standard’ applies specifically to trusts that provide services commissioned exclusively for people with a learning disability and/or autistic people.

The exercise consists of organisational data collection, staff survey and patient survey.

Sample results from Patient Survey:

	DCH results	National results
Did staff treat you with dignity and respect?	Yes: 100%	Yes: 91%
Did staff explain things in a way you could understand	Yes: 95%	Yes: 79%
Do you feel like staff listened to you?	Yes: 91%	Yes: 81%
Did you feel safe	Yes: 95%	Yes: 87%
Do you have any concerns regarding your care?	Yes: 19%	Yes: 22%
	No: 76%	No: 68%
If you needed to be seen in an emergency, were you seen quickly?	Yes: 80%	Yes: 63%
	No: 20%	No: 26%

Sample results from Staff Survey:

Staff feel able to identify what reasonable adjustments are needed for children, young people, adults with a learning disability or autism	DCH results	National results
Disagree	17%	7%
Neither disagree nor agree	6%	18%
Agree	67%	50%
Strongly agree	11%	21%
Patients receive the reasonable adjustments they need	DCH results	National results
Disagree	22%	15%
Neither disagree nor agree	28%	27%
Agree	50%	42%
Strongly agree	13%	0
Staff always feel able to deliver safe care	DCH results	National results
Neither disagree nor agree	24%	24%
Agree	71%	51%
Strongly agree	6%	15%

The benchmarking enables DCH to explore areas of work and improvement to help address any health inequalities experienced by our local community.

Key areas for work moving forward include:
Accessible information (this forms part of the work of the Accessible Information Standard group)

Exploring the provision of a Changing Places facility (As part of the New Hospital Development programme)

Patient Experience - **15 Step Challenge**

Last year we completed our first 15 Step Challenge with Young People, (https://www.england.nhs.uk/wp-content/uploads/2017/11/15-steps-children-young-people.pdf). Commissioned by our Transition service and supported by the Patient Experience and Learning Disabilities teams, the challenge saw 10 Young People aged from 11 to 18 assess 12 departments around the Trust with a focus on answering the following questions:

- Is it welcoming?
- Is it a safe place?
- Will it care for me?
- Is it well organised and calm?

Split into groups of 3 to 4 and supported by one of the Executive / Management team each group visited 3 departments before coming back together for a discussion and debrief. The group then met in the weeks following to compile a report and recommendations, which was then brilliantly presented to Trust board in December by some of the Young People who took part.

The Challenge recommendations included the following:

- All staff should take a child centred approach to younger individuals, meaning the use of less jargon, etc.
- Patients should be welcomed when they arrive by a kind and friendly person.
- There should be more friendly and welcoming spaces for visitors.
- There should be separate areas for young people for if they feel overwhelmed.
- All of the lifts across the hospital should be working properly.
- Greater attention should be given to checking patients' allergies.
- There needs to be clearer signage that can be separated and understand from noticeboards. The signage should be regularly checked to make sure it is correct.
- Signs about patients' allergies need to be clearer, eg - "nil by mouth"
- Patients should be given the choice to have a sign that says, "Do Not Disturb" and/or "Please come back later."
- Hoists need to be easily accessible on all wards.
- The counter at the pharmacy needs to be lowered to cater for people in wheelchairs and those who aren't very tall.

The Trust are now looking at the recommendations above and will provide an update later in 2024, to those who took part in the challenge, on improvement actions undertaken.

Youth Council (Youth Voice)

As part of our Power of Youth charter pledge, (https://www.iwill.org.uk/organisations/the-power-of-youth/), with the #Will movement to support Youth Social Action, the Trust have made progress over the last year with plans to set up a dedicated Youth Council (Youth Voice). This will form part of the wider Patient and Public Voice Partner work within the Trust enabling us to work closer with our community in gaining feedback and collaboration on service improvement. In March 2024, following some initial work up, a planning meeting took place with Young People involved to start to shape what Youth Voice could look like in the Trust. We are working closely with colleagues in Dorset Healthcare's participation team on this work with a view that we can build a network of Youth Voice across our two Trusts and with link up further across the ICS in the future.

Patient Experience – Trust renovations and upgrades

Green Spaces

The Trust is committed to improving the environment for staff and visitors and to enrich the experience they have from being at the hospital.

The Trust has developed a wildflower meadow funded through the Hospital Charities application.

The area is cut less that the rest of the site allowing wildflowers to blossom, new seating was installed in May 2023 and new sightings board, was installed during autumn 2023. A welcoming gate sign and interpretation board are to be installed imminently. Funding enabled the addition of native varieties of honeysuckles to be planted along the trellis that edges the wildflower meadow.

Through careful management of an area adjacent to William's Avenue entrance, we have been rewarded with a whole bank of cowslips this spring. 130 tree whips from an NHS Forest application of a native 'urban bundle' were 'dug in' as individual trees and hedgerows during February 2024. We are planning more changes to greenspaces based on anecdotal feedback from staff at a 'Sustainability Day' July 2023, plus a survey with South Walks House regarding adding plants to the terrace there.

At South Walks house we are adding a livestream 'Window to Arne' based on studies that show images of nature can reduce stress and anxiety and improve wellbeing. We have been successful with an application for a Sensory Courtyard Garden for 2024/2025 with comments cards collected in Special Care Dentistry for design ideas we are developing with Kingston Maurward College, supported by Little Green Change and Mens Shed Dorchester, this will be funded by Greener Communities Fund supported by Hubbub and Starbucks, to improve and create greenspaces for those with limited access to green spaces or with health inequalities.

Prayer Room/Quiet Space (formerly known as the Chapel)

The Prayer Room (formerly the Chapel) had not been decorated for many years. It is important that the room should be a comfortable, inclusive space, open to people of any or no faith.

Heavy rainfall had caused damage to the carpet and ceiling, the chairs were stained and worn. The recent refurbishment has made the space more welcoming, the new colour scheme giving it an atmosphere of peacefulness and the replacement chairs, in an uplifting colour and including a sofa, have provide more comfort. We have had very positive feedback from staff, who use the room for their own quiet time and often for one-to-one discussions. The room is used for individual prayer by staff and visitors (as the prayer requests left in our prayer quilt demonstrate) and is often used by family members wishing to have some quiet time. Once the new sound system is Sunday services and other events are to be reintroduced, the first of which is to host a 'Tea and Cake' event during the Dying Matters week. Another suggestion has been to offer afternoon tea and entertainment for the patients on Mary Anning. In the past few years, we have hosted emergency weddings in the room – it will now be a much more pleasant environment for these types of events. It is intended to publicise the Prayer Room and what it can offer staff, patients and their families.

The Vestry

This room is used to store books, communion vessels and vestments. Our male Muslim colleagues use this room for daily prayer (the Muslim females use the Prayer Room). The Vestry has two sinks, one especially low to accommodate the washing of feet necessary before Muslim prayer. After decoration and the installation of new lighting and new flooring this room is a much more pleasant space.

The Chaplains' Office

This room was very cramped and, as with the Prayer Room, had suffered water damage. To achieve more space the 'over-large' corner desk has been removed and replaced with a 'fitted' workspace giving much needed room to accommodate visitors (staff or family members) who wish to speak to us confidentially. The walls have been painted, a new ceiling, new flooring and new lighting have been installed.

General

As a team the chaplaincy team are excited at the prospect of the variety of uses the newly refurbished Prayer Room gives, and at knowing that we are welcoming people into an inviting, safe and inclusive space.

Damers Restaurant Refurbishment

The Trust had a series of improvement works take place in our main restaurant – Damers, which will be complete at the end of May 2024. The upgrades all play in to strategies within the trust to develop our staff wellbeing spaces, improve the overall customer experience in Damers and maximise our commercial performance.

The new space has an updated design and feel that makes the area more spacious and calmer with furniture and signage which brings a modern and refined edge to the dining experience that reflect the quality of DCH catering.

An additional 'grab and go' area and clearer retail space have made for a much more enjoyable and efficient customer experience. We believe once complete these improvements will also show in the commercial performance of our restaurant.

Staff were involved with the process from start to finish with regular opportunities to offer feedback and ideas on development stages. The Trust collaborated with a local school on the design aspect of the project and many of the motifs were incorporated in the design. Although the main design for the

structural changes came from the catering and capital projects teams, the staff have been given every opportunity to be an integral element to the project as a whole.

Funding for the project came from the charity team and had been earmarked for staff wellbeing and improvement. Damers is a key space within the trust where staff gather and socialise over a meal, or a coffee and a dedicated staff area has been incorporated into the plans. Frosted screening means that staff can relax and decompress away from patients and visitor.

Freedom to Speak Up

It is a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian (FTSUG). The Guardian's key role is to support the creation of a positive, open learning culture where people feel listened to, and feedback is welcomed, and acted on. The Trust have designated FTSU roles including the FTSUG, Executive Director, Senior Independent Officer who holds a Non-Executive Director (NED) position on the Trust Board, and over 30 FTSU Champions across the Trust. All have received either in-house training with the FTSUG or completed training recommended by the National Guardians Office (NGO). The holders of these roles ensure all methods of raising concerns are promoted, including Line Managers/Supervisors and colleagues, Human Resources, Patient Safety & Risk Team, Trade Unions, Occupational Health and Chaplaincy Services, Professional Regulators and the NGO. The FTSUG reports directly to the Chief Executive Officer (CEO) and holds monthly one to ones with the Chief People Officer and Chief Nursing Officer. The FTSUG meets quarterly with the CEO and NED and reports monthly to the People & Culture Committee and bi-annually to the Trust Board, as recommended by the NGO.

Staff are encouraged to Speak Up if they have concerns including but not limited to, patient safety or quality, staff safety or wellbeing, bullying and harassment and other inappropriate behaviours within the Trust. Concerns relating to patient safety are dealt with immediately. The Guardian works closely with the Risk Manager and sits on the Patient Safety Incident Response Framework (PSIRF) working group.

At Dorset County Hospital (DCH) the FTSUG role is primarily a facilitator and enabler rather than 'fixer' of issues, following up with line managers on progress in resolution and identification of trends to support organisational learning. There are several enabling factors that support 'speaking up' throughout the Trust, including a visible leadership culture that supports and encourages the raising concerns at all levels in all parts of the organisation. The FTSUG ensures that those raising concerns are listened to, feel valued and that their concerns receive the appropriate level of review and response. Embedding a restorative and just culture lies at the heart of our philosophy.

Between 1st April 2023 and 31st March 2024, a total of 287 contacts were made to the service. Most contacts to the FTSU service are initially by email as the contact details are shared widely across the organisation in posters, cards, on the intranet and through contact during raising awareness sessions or attending team meetings. Once a contact is made this is logged and next steps are agreed with the individual. The Freedom to Speak Policy (2023) is aligned to the national policy and outlines how

staff raising a concern will be supported. The FTSUG also explores barriers to speaking up and is an ally of the Staff Network groups.

The FTSUG feeds back directly to those who raise concerns or ensures feedback is provided by others involved in cases such as HR Managers and Line Managers. Where staff are concerned they will suffer detriment for speaking up, their confidentiality is protected (unless required to disclose it by law) and there are options to raise concerns anonymously via either our Incident Reporting System (Datix) or the FTSU post-box.

The FTSU Guardian attends both regional meetings and national conferences. Attendance enables the Guardian to network, share and learn from best practice. Local Dorset & Somerset network meetings have developed where high-level themes are shared and support/supervision is accessed in addition to the support from within the Trust. In light of the federation arrangement between DCH and Dorset HealthCare, the Guardians work very closely and share ideas and workstreams where appropriate.

Rota Gaps

The Trust recognises that gaps in medical staffing rotas are a potential threat to the quality of patient care, and the sustainability of the medical workforce. Mechanisms remain in place to identify and monitor Rota Gaps and their impact of safe working. A detailed breakdown or vacancies within trainee rotas is provided as an appendix to the Guardian's quarterly and annual report. Trainees are encouraged to exception report instances when they have needed to work beyond allocated hours. Analysis of exception reports by specialty provides an insight into the most stressed clinical areas. This can be considered alongside vacancies when considering what constitutes minimum safe staffing, where recruitment is most need, and where an expansion of trainee numbers should be focused.

The impact of rota gaps is specifically discussed at regular meetings of the Junior Doctors Forum, with representatives of the Trust, divisional leadership, the Guardian of Safe Working Hours, and junior doctor representatives.

Risk Assessment Framework and Single Oversight Framework Indicators

The following indicators are a pre-requisite of the Risk Assessment Framework and the Single Oversight Framework to be included by Acute Trusts. More up-to-date data and fuller analysis and narrative is available on the Trust website in the Trust Board papers.

RTT - In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

ED 4 hour target - A four-hour target in emergency departments was introduced by the Department of Health for National Health Service acute hospitals in England to state that at least 95% of patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours.

62 days wait - All patients who have been referred by their GP or by a dentist on a suspected cancer pathway should receive their first definitive treatment within 62 days of referral receipt or a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer. NOTE: Change to a combined metric for cancer 62 Day Performance.

Indicator	Standard	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Trend
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	92%	95.5%	94.9%	93.7%	92.1%	87.6%	85.3%	81.6%	70.6%	47.9%	55.9%	57.0%	52.1%	
Maximum ED waiting time of 4 hours from arrival to admission/transfer/discharge (ED Only)	95%	96.5%	94.7%	94.9%	94.1%	93.2%	95.0%	90.5%	82.9%	87.6%	64.1%	53.4%	60.8%	
Maximum ED waiting time of 4 hours from arrival to admission/transfer/discharge (Including MIU/UCC from November 2016)	95%	96.5%	94.7%	94.9%	94.1%	95.2%	97.6%	95.5%	91.8%	92.8%	75.2%	71.9%	78.4%	
62 day wait for first treatment from an urgent GP referral for suspected cancer	85%	93.4%	88.4%	85.5%	81.7%	86.2%	80.5%	77.9%	78.4%	72.9%	72.2%	70.4%		
62 day wait for first treatment following a NHS Cancer Screening Service referral	90%	96.8%	96.0%	98.2%	94.9%	83.2%	96.2%	93.8%	72.8%	63.1%	71.7%	65.4%		
Cancer 62 day performance													69.5%	
C-Difficile infections^	16	22	27	8	10	7	8	3	13	22	47	41	36	
SHMI	1.00	1.07	1.11	1.10	1.16	1.12	1.17	1.19	1.13	1.14	1.13	1.13	1.10	
Maximum 6 week wait for diagnostic procedures	99%	99.3%	93.9%	94.8%	98.8%	93.0%	91.2%	86.2%	91.5%	64.7%	86.9%	70.3%	84.5%	
VTE Risk assessment~	95%	91.9%	97.5%	95.5%	96.7%	95.9%	96.0%	94.7%	88.9%	N/A	N/A	N/A	N/A	

Target achieved
Target not met

^pre 2019/20 criteria based on hospital acquired cases (post 72 hours) due to lapses in care, from 2019/20 onwards hospital onset healthcare associated cases defined as those detected in hospital three or more days after admission

~2019/20 nationally published VTE data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. This is due to be restarted for Q1 24/25

Source of Nationally published information - https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Annex 1 Statement from Trust Partners

I am pleased to have had the opportunity to review and comment on this Quality Account for DCH. It is clear from reading it that considerable effort has gone in to making DCH a safe environment for patients and that they are provided with the highest quality of care. It also highlights that there is more to do, and I am pleased to see that this is recognised with a particular focus on creating a culture where staff are able raise concerns, be honest about things that have gone wrong and enable learning to make a better future for both staff and patients.

As Governors one of our roles is to represent the public and I know I speak on behalf of my Governor colleagues when I say that the majority of feedback we receive about the care people receive at DCH is overwhelmingly positive. The reputation of the staff as being kind, caring and continually striving for the best possible outcomes for their patients goes a long way to reach this high standard of quality and I would like to take this opportunity to record our thanks and appreciation.

Kathryn Harrison
Lead Governor
DCHFT Lead Governor

NHS
Dorset

24 June 2024

PRIVATE AND CONFIDENTIAL
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Email: Debbie.Simmons@nhsdorset.nhs.uk

Dear Dawn,

Re: Quality Account 2023/24

Thank you for asking NHS Dorset to review and comment on your Quality Account for 2023/2024. Please find below the ICB statement for inclusion in the final document:

NHS Dorset welcomes the opportunity to provide this statement on Dorset County Hospital's Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of information we have received during the year as part of monitoring discussions during 2023/2024.

In 2023/2024 Dorset County Hospital NHS Foundation Trust set priorities focusing on patient safety, patient experience and clinical effectiveness. The trust has seen progress in all areas. There has been a reduction in falls during 2023/2024 which has been supported by the Multifactorial Risk Assessment process for all inpatients. The trust is continuing to expand the new approach to incidents following implementation of the Patient Safety Incident Response Framework. Ensuring patient voices are heard through the community conversation method has been adopted by the trust and there has been a focus on capturing youth voices. Coding has improved in the trust which is resulting in an improving Standardised Hospital Mortality Indicator which has remained within the expected range for eight months..

NHS Dorset supports the three key strategic priorities of patient safety, patient experience and clinical effectiveness continuing into 2024/2025 and supporting the detailed actions that follow these to improve the quality of care being delivered. We look forward to receiving regular updates on the progress in these areas, whilst recognising that the NHS continues to face a challenging backdrop from increased demand alongside recovery of services from the impacts of the Covid-19 pandemic. NHS Dorset remains committed to work with Dorset County Hospital NHS Foundation Trust, over the coming year to ensure all quality standards are monitored.

Please do not hesitate to contact me if you require any further information.

Yours sincerely,

Debbie Simmons
Chief Nursing Officer

Annex 2 Statement of Directors' Responsibility for the Quality Report

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the board:

Chairman
David Clayton-Smith

Chief Executive
Matthew Bryant