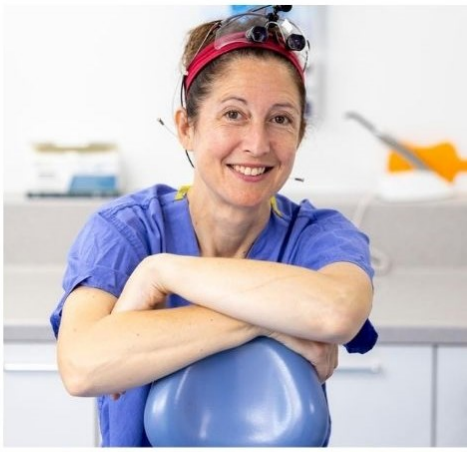
Dorset County Hospital
NHS Foundation Trust

Quality Account

2024 – 2025

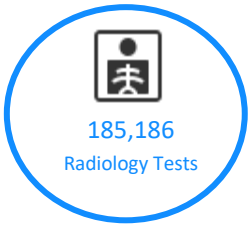




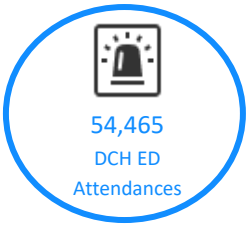

Healthier lives Empowered citizens Thriving communities

Our Year 2024 - 25

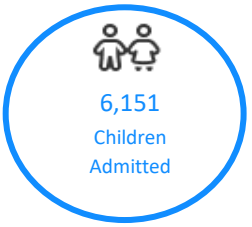
79,790
Patients Admitted



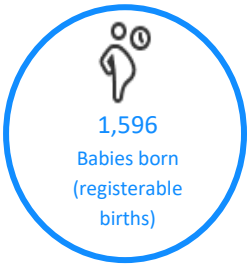
185,186
Radiology Tests



54,465
DCH ED Attendances



6,151
Children Admitted

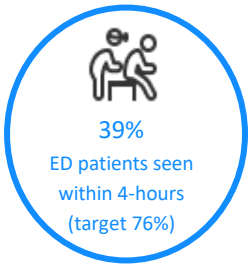


1,596
Babies born (registerable births)

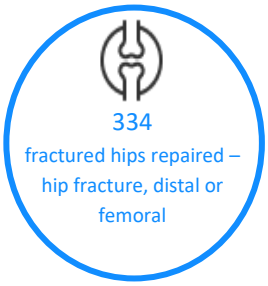
2,591
patients treated for cancer

60%
Referral to treatment within 18 weeks (target 96%)

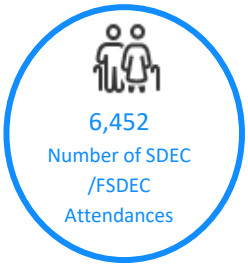
301
stroke patients treated



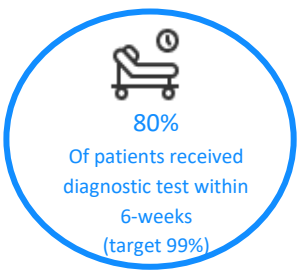
39%
ED patients seen within 4-hours (target 76%)



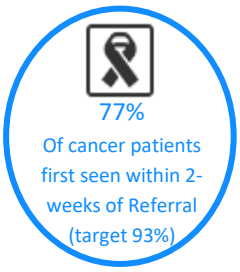
334
fractured hips repaired – hip fracture, distal or femoral



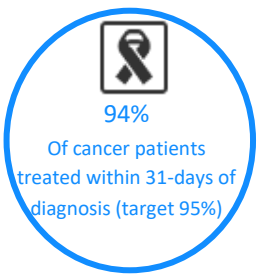
6,452
Number of SDEC /FSDEC Attendances



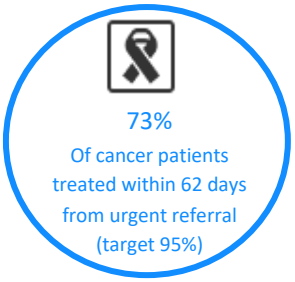
80%
Of patients received diagnostic test within 6-weeks (target 99%)



77%
Of cancer patients first seen within 2-weeks of Referral (target 93%)



94%
Of cancer patients treated within 31-days of diagnosis (target 95%)



73%
Of cancer patients treated within 62 days from urgent referral (target 95%)

180
New Doctors

118
New Nurses inc. Healthcare Support Workers & students

Quality Accounts 2024/25

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 2024-2025.

During this year a major transformation in the NHS has begun as the new Government set out its plans to make our health service fit for the future. With a backdrop of ongoing economic challenges and reduced resources available across public sector, we have started on a journey which will see the most significant changes to the NHS in well over a decade. Informed by a national engagement exercise, we will soon have a 10-year plan for the health service which will deliver a shift from care in hospitals to the community, analogue delivery to digital wherever possible and treatment to prevention This last shift is particularly important as we work together with partners to support our communities to thrive and individuals to look after themselves and stay well for longer.

This is reflected in our new joint strategy for Dorset Health Care and Dorset County Hospital – Working together, improving lives. The strategy was launched in October 2024 after extensive engagement across our organisations and with partners, patients and carers. It sets out our vision for our two Trusts for healthier lives, empowered citizens, thriving communities and details the four strategic objectives that will support us to deliver this - great quality care, vibrant and supportive communities, motivated and skilled colleagues and sustainability, both financially and environmentally.

Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best. We must do this in the context of significant financial challenges as a health and care system in Dorset and the need to ensure we make the most of our limited resources.

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 2024-2025 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 2024/2025

In line with national guidance, the Trust developed priorities following engagement with staff, partners, the executive team, local community representatives, governors together with patients and their families.

Dorset County Hospital NHS Foundation Trust (DCH) continued to work to deliver changes to improve both the effectiveness and the quality of its services throughout 2024/25. Achievement against the priorities are set out as follows:

. **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.

No criteria to reside
The number of patients who no longer meet the criteria to reside fluctuate through the year reflecting seasonal variation and system pressures. This information along with pathway data is include in the BI dashboard. The system workstream, Transfer of Care, supported by local quality initiatives such as Board Rounds, Criteria Led Discharge and Frailty Same Day Emergency Care are all aimed at reducing length of stay.

Falls prevention & management

Despite a 11% reduction in incidents in 2023/24, the total number of inpatient falls has remained consistent with 886 incidents in 2024/25, compared with 882 the year before. However, a reduction in levels of harm associated with falls, with a 25% increase in no harm events and a 45% decrease in low harm incidents being reported. Incidents resulting in moderate harm remained the same (14), with no severe or significant harm incidents reported.

Investigation of patient falls using Hot Debriefs and After-Action Reviews is now well embedded across the organisation and monitored through the Falls Action Group. An Occupational Therapy Lead / Falls Lead Role has been appointed, thereby strengthening clinical leadership. A mulit0factgorial falls risk assessment document has now been rolled out Trust wide and focus is being given to medicines management and the impact of anti-hypertensives, nighttime sedation and anti-psychotics and falls risk. Work is ongoing to replace bed frames with high-low beds as part of a rolling programme and the evaluation of products and equipment continue

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 (PSIRF)

The Trusts Patient Safety Incident Response Plan identified five initial local priorities for organisational PSIIs based on our reporting profile.

- Patient care – delay or failure to monitor a patient
- Medications
- Documentation Management
- Communication and consent
- Maternity and neonatal

These patient safety priorities were further underpinned by the development of local patient safety improvement plans:

- Diabetes management (reducing insulin errors)
- Consent
- Deteriorating patients (Martha's rule, sepsis, early warning scores)
- Patient falls
- Pressure ulcers (harm caused)
- Mental health patients – reducing delays in care pathway and support services
- Major obstetric haemorrhage
- ATAIN (Avoiding Term Admissions into Neonatal Units)

Diabetes management – thematic review of incidents has been completed and being reported back into the Safer Diabetes Group.
Deteriorating patients – Martha's Rule, roll out of the phases continues with the introduction of Call for Concern (adults and paediatrics), wellbeing assessment tool being piloted.
Mental Health patients – with support from DHC colleagues we now have a Mental Health triage practitioner embedded within our Emergency Dept.
Major Obstetric Haemorrhage – the focused Quality Improvement workstream has reduced the number of events to within national parameters and is now part of standard reporting in line with the perinatal quality surveillance model (PQSM) and included in the Maternity BI dashboard
ATAIN (Avoiding Term Admissions into Neonatal Units) – admissions to Special Care Baby Unit (SCBU) are reviewed to determine whether they were appropriate, number of avoidable admissions remain within national parameters

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

Liaising with colleagues at University Hospitals Dorset to review consent training and whether it can be introduced at DCH. An ongoing review of departments training records for medical and nursing staff continues. Leadership changes throughout the year has impacted on this workstream and will roll over to 2025/26.

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

This work is reported through the monthly NHS Dorset engagement leads network which brings together partners from across the system to discuss the engagement agenda and local projects in line with the statutory framework – Working in Partnership with People and Communities. This includes the recently developed, 'listening better' website which provides a toolkit on listening approaches: https://ourdorset.org.uk/listening/about/.

The next steps in this work is to develop an insight bank which will ideally sit alongside the listening or conversational approaches - to show how we are listening, what we are hearing and also the outcomes/impact.

The network is also involved in engagement work connected to the 10-year plan and have been busy delivering the 10-year plan 'Workshop in a box' to capture feedback on the government 3 main shift changes for healthcare.

Alongside the wider system engagement work, at DCH we have continued to deliver engagement activity across the Trust. This has included listening events in Ophthalmology, a 15 Step challenge in Maternity and a conversation cafe with the Deaf community. We have increased our community engagement activity attending events to hear from the public and hear their experiences of accessing healthcare. This has included attending Carers groups in Weymouth and Portland. The feedback from these events will be shared across the Trust and it is our ambition that we will continue to work with these groups to improve our support to Carers of patients accessing our services..

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.
    a. 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)

We have continued to deliver therapeutic activity for patients across the Trust over the last quarter. Our Activity volunteers have continued to be supported by the dementia team, the activity co-ordinator in Purbeck Ward and the Creative Arts co-ordinator. Bournemouth Symphony Orchestra continue to offer weekly music therapy sessions to patients as well as our music volunteer who is continuing to entertain patients across four different wards each week. How we measure the impact of this activity continues to develop and though working in partnership with the dementia team we are exploring the best ways to do this

3. Improve the experience of Children and Young People admitted to hospital with emotional, psychological, and mental health needs. As measured by local and national patient survey, progress against actions, related incidents, and complaints.

Work continues across the system to establish a Youth Referral service to support Children and Young People admitted to hospital with SEMH needs. Alongside this work has also commenced to tackle the backlog of CYP waiting for appointments following a Neurodevelopmental assessment referral. We are supporting the CYP clinical lead with this providing data on complaints and enquiries linked to this and have engaged with Dorchester Youth Town Council to work through the challenges young people face whilst waiting and what we can do across the system to support them better whilst waiting for an appointment.

Clinical Effectiveness

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

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

Despite continued staffing challenges in the Clinical Coding Department all Clinical coding for 2024/25 is complete in order for annual refreshes to be included in the SUS upload. Two trainee clinical coders, recently recruited, are due to commence their Clinical Coding Standards Course in May 2025.

From September 2022 onwards there has been a steady trend of improvement in DCH's SHMI largely attributed to the heroic efforts of the coding department resulting in more accurate and timely coding returns to NHSE, and widespread implementation across the Trust of mortality "Structured Judgement Reviews".
The DCH SHMI is now at its best level for over 10 years.

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

A Task & Finish Group has been developed to work through the issues and identify possible solutions. The group includes medical and nursing colleagues along with colleagues from Coding, Digital and Business Intelligence. Whilst appreciating the current difficulties in the Digital workstreams, a decision was made to develop a Quality Improvement (QI) project for a group of resident doctors to complete as part of their curriculum. This project will concentrate on the Administration/Staff Process element of this work and information from initial discussions have been shared with the group of doctors. The QI group have been provided with QI training opportunities and QI tools; they will join the wider Task & Finish Group and present the outcomes of their project to the Quality Committee in Common.

3. Deliver full compliance with the Maternity Incentive Scheme (MIS), with emphasis on delivering full compliance with the Safety Actions and Saving Babies Lives.

DCH is in a position to declare full compliance against all 10 safety actions in MIS Year 6 following a comprehensive programme of work to collate and review the required supporting evidence in partnership with the LMNS/ICB and which has been internally audited by BDO

A BDO senior manager produced a final report (December 2024) concluding that the Trust has sufficient evidence to support its intended position on declaring full compliance with all 10 safety actions.

Ongoing liaison between BDO, Trust and ICB leads to ensure systems approach and compliance. Final BDO, Trust and ICB lead meeting undertaken (December 2024) concluded all evidence thresholds had been met

Quality Improvement Priorities 2025-2026

Dorset County Hospital NHS Foundation Trust (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 2024/25 priorities into 2025/26

Patient Safety

Reducing Avoidable Harm – deliver a continuous reduction in the overall number of patients experiencing hospital acquired pressure ulceration.

- **As measured by incidence of hospital acquired pressure ulcers.**

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

- **As measured by progress with implementation of this year's patient safety priorities**

Improve and sustain compliance with national guidance and local policy on recognition and rescue of the deteriorating patient - Implementing Martha's Rule .

As measured by progress with implementation of the three national components and audit of use of the escalation process and incidence of deteriorate.

Patient Experience

Build our Patient and Public engagement activity contributing to Trust strategic objectives and system wide engagement priorities supporting patient / public involvement in service developments.

Expand therapeutic activity support to patients, recognising and demonstrating the positive impact and benefits linked to specific measures including slips, trips and falls and violence and aggression incidents

Continue to deliver our Children and Young People programme to improve the experience of Children and Young People admitted to hospital with emotional, psychological, and mental health needs

Clinical Effectiveness:

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.

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

Deliver full compliance with the Maternity Incentive Scheme (MIS)

Deliver the Health Inequalities Action planning including EDS2 and CORE20Plus5 all age priorities

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 2024-25, Dorset County Hospital NHS Foundation Trust (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 2024-25 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2024-25.

The Trust income in 2024-25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Part 2

Clinical Audit

During 2024-25, there were 46 national clinical audits and 6 NCEPODS covered relevant health services that the Trust provides.

During that period the Trust participated in 100% 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 participated in, and for which data collection was completed during 2024-25, 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.

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
National audit of patient outcomes from adult critical care - Case Mix Programme	Y	Y	692	-
Emergency Medicine QIPs:				
a. Time Critical Medications	Y	Yes	N/A	5 per week
b. Care of Older People	Y	Yes		5 per week
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Y	Y	12	N/A
Falls and Fragility Fracture Audit Programme:				
a. Fracture Liaison Service Database	Y	Y	1437	79%
b. National Audit of Inpatient Falls (NAIF)	Y	Y	4	100%
c. National Hip Fracture Database – Falls & Fragility Fractures Audit (FFFAP)	Y	Y	341	100%
National Cancer Audit Collaborating Centre (NATCAN):				
a. National Bowel Cancer Audit (NBOCA)	Y	Y	Continuous data	100%

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
			collection	
b. National Oesophago-gastric Cancer (NOGCA)	Y	Y	Continuous data collection	100%
c. National Audit of Metastatic Breast Cancer (NAoMe)	Y	Y	Continuous	100%
d. National Audit of Primary Breast Cancer (NAoPri)	Y	Y	Continuous	100%
e. National Lung Cancer Audit (NLCA)	Y	Y	Continuous	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Y	Y	All cases	100%
British Association of Urological Surgeons (BAUS):				
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit	Y	Y	13	100%
National Adult Diabetes Audit:				
a. National Diabetes Core Audit	Y	Y	2012	100%
b. National Diabetes Foot care Audit	Y	Y	All patients	100%
c. National Diabetes Inpatient Safety Audit	Y	Y	8	100%
d. National Pregnancy in Diabetes Audit	Y	Y	15	100%
e. National Paediatric Diabetes Audit (NPDA)	Y	Y	109	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:				
a. Adult Asthma Secondary Care	Y	Y	67	N/A Snapshot audit
b. Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	158	N/A- Snapshot audit
c. Paediatric Asthma Secondary Care	Y	Y	21	N/A Snapshot audit

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
d. Pulmonary Rehabilitation - Organisational and Clinical Audit	Y	Y	576	95%
National Cardiac Audit Programme (NCAP):				
a. Myocardial Ischaemia National Audit Project	Y	Y	Continuous collection	100%
b. National Audit of Cardiac Rhythm Management	Y	Y	Continuous collection	100%
c. National Audit of Percutaneous Coronary Interventions	Y	Y	Continuous collection	100%
d. National Heart Failure Audit	Y	Y	Continuous collection	100%
National Child Mortality Database Programme (NCMD)	Y	Y	Continuous collection	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	51	100%
National Emergency Laparotomy Audit (NELA)	Y	Y	15	-
National Joint Registry	Y	Y	692	98.42%
National Major Trauma Registry Network	Y	Y	611 (149)	24%
National Maternity and Perinatal Audit (NMPA)	Y	Y	Continuous annual collection	100%
National Neonatal Audit Programme (NNAP)	Y	Y	All SCBU babies	100%
National Audit of Cardiac Rehabilitation	Y	Y	550	100%
National Audit of Care at the End of Life	Y	Y	182	100%
National Audit of Dementia	Y	Y	80	100%
National Cardiac Arrest Audit	Y	Y	20	87.5%
National Ophthalmology Database Audit (NOD):				
a. National Cataract Audit	Y	Y	TBC	
b. Age-related Macular Degeneration Audit (AMD)	Y	Y	Awaiting data	

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
National Perinatal Mortality Review Tool	Y	Y	Awaiting data	
UK Renal Registry:				
a. *Acute Kidney Injury programme*	Y	Y	Continuous data flow	100%
b. *Chronic Kidney Disease Audit*	Y	Y	Continuous data flow	100%
Sentinel Stroke National Audit Programme	Y	Y	586	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Y	Y	N/A reported when occurs	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y	Y	N/A	Annual data collection June 2024

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.

Medical and Surgical Clinical Outcome Review Programme: **National Confidential Enquiry into Patient Outcome and Death (NCEPOD)**	*Rehabilitation following critical illness*	Y	Y	4	100%
	End of Life Care	Y	Y	5	100%
	Endometriosis	Y	Y	6	100%
	Blood Sodium Study	Y	Y	7	100%
	Emergency (non-elective) procedures in children and young people study	Y	Y	7	100%
NCEPOD: Child Outcome Review	Juvenile Idiopathic Arthritis	Y	Y	5	100%

The following shows an example of the National NCEPOD reports published and a precis of their findings:

Report Title	Report Precis
NCEPOD Endometriosis study Endometriosis: A Long and Painful Road	**Areas of Good Performance at DCH:** 1. A well-established referral pathway to the Southampton and Poole Endometriosis Centres for advanced cases. 2. Complex endometriosis cases are discussed in local consultant MDT meetings when needed, ensuring a comprehensive multidisciplinary approach. 3. Endometriosis management through hormonal treatment and laparoscopy is conducted as clinically indicated. 4. Endometriosis patients requiring additional support have access to the Dorset Pain Management Service. 5. Previous departmental teaching on endometriosis has been successfully delivered. 6. Patients are provided with clear, written consent information before undergoing laparoscopic diagnosis/treatment of endometriosis, detailing the procedure, risks, and benefits. 7. Discharge summaries include medication information for patients on long-term hormonal treatment. **Areas for Improvement:** 1. Provide patients diagnosed with endometriosis during laparoscopy with a quality of life questionnaire. 2. Update the current endometriosis guideline to reflect the latest recommendations outlined in the report. 3. Distribute the new NCEPOD endometriosis information leaflet to enhance patient awareness. 4. Implement an annual teaching session on endometriosis to maintain continuous education and knowledge dissemination. 5. Update the diagnostic laparoscopy consent form at DCH to incorporate the latest recommendations from the report. 6. Initiate a Patient-Initiated Follow-Up (PIFU) for patients with confirmed endometriosis diagnoses following laparoscopy.

The reports of National Clinical Audits are reviewed by the appropriate clinical leads and the Trust intends to take the identified actions to improve the quality of healthcare provided. The table below provides a summary of some of the National audit outcomes and the actions taken as identified by the clinical review undertaken:

Audit / Clinical Outcome Review Programme	What this Trust learnt	Recommendations
National Cardiac Audit Programme (NCAP) **Myocardial Ischaemia**	How does DCH perform in comparison with available national benchmarking? Or	Overall DCH compared to National average across many areas of Cardiology.

Audit / Clinical Outcome Review Programme	What this Trust learnt	Recommendations
National Audit Project (MINAP) **2024 Report**	Areas of good performance/ areas of concern ***Timeliness of PPCI treatment for higher-risk STEMI heart attack patients*** 1. Hospital emergency departments, PCI centres, neighbouring non-PCI hospitals and Ambulance Trusts should work together to reduce delays in the provision of primary percutaneous coronary intervention (PPCI) to higher-risk STEMI heart attack patients. This may include: • rapid offloading from ambulances directly into PCI facilities • rapid triage of patients who self-present with symptoms of heart attack • reviewing ambulance service responses to patients calling for help with symptoms of heart attack, especially the advice to patients if an ambulance is not immediately available • non-PPCI hospitals (particularly those remote from such services) considering immediate administration of intravenous thrombolytic drugs if it is anticipated that the Door-To-Balloon (DTB) target treatment time cannot be met (note: the latest audit data do not support the re-introduction of pre-hospital thrombolysis) ***Angiography for lower-risk NSTEMI heart attack patients***	DTB time achieved in 92% of cases. CTB time achieved in 64% of cases. Referral to cardiac rehab 88% (target 85%) Areas for review - % of patients discharged post MI on secondary prevention – the data suggests this is only 43%. This could be a data collection issue. An action has been agreed to conduct a deeper dive into this standard. DCH has rapid off-loading directly to the Cath lab Monday – Friday 0900-1700. Our DTB suggest that we are achieving well with 92% of cases within 90 mins. (73% within 90 mins and 63% within 60 mins). Our CTB time was achieved in 64% of cases (48% were within 150 mins and 33% were within 120 mins). Compared with nationally where the overall median time has risen to 158 mins. Longer delays are thought to be associated with the pressure faced by the Ambulance services and waiting times for emergency services. This was achieved in 66% of cases and continued to improve through out the first 2 quarters of 2024.

Audit / Clinical Outcome Review Programme	What this Trust learnt	Recommendations
	2. Hospitals and commissioners should ensure angiography following admission for NSTEMI patients does not take more than 72 hours to perform by: • identifying suitable patients • streamlining referrals and reliable transfer arrangements between (and within) hospitals • implementing weekend angiography lists for NSTEMI patients	In October 2024 we achieved 80%. This has improved since revising the cath lab rota and having more coronary lists on Monday's.
	Provision of specialist cardiac care 3. Hospitals with lower rates of heart attack patients admitted to cardiac wards should review their systems and bed allocations to maximise access to cardiac care and consider cardiac outreach services to those cared for elsewhere	70% of patients were cared for in cardiac ward. This does not reflect the patient who may have been on another ward, taken directly to cath lab for procedure and then discharged from there.
	4. Hospitals with lower rates of cardiology involvement in heart attack care should ensure their data reflects their practice. If the data are accurate, provision of cardiac care during admissions should be improved (e.g. by increased staffing or more flexible use of members of the cardiology team, including skilled nursing staff and physician specialists)	99% of patients were seen by specialist team – this would indicate that even though not all patients make it into a cardiac bed, they are still reviewed by the team and appropriate plans made.
	5. Hospitals providing echocardiograms to lower rates of heart attack patients should ensure the accuracy and completeness of their data. If the data are accurate, use of limited 'bedside' targeted echocardiographic assessments should be considered if there are difficulties obtaining timely tests	85% of STEMI patients underwent echocardiography pre discharge (target is 90% - need to understand where improvements can be made in this). 95% of all MI patient underwent echocardiography prior to discharge. (target is 90%). Great achievement in a service that is under a lot of strain.
	Prescribing of recommended medication	The data entry shows that we are only meeting this standard in 43% of patients. The data also suggests that we only prescribe aldosterone antagonist in

Audit / Clinical Outcome Review Programme	What this Trust learnt	Recommendations
	6. Hospitals not meeting the standard for prescribing secondary prevention medication prior to discharge following heart attack should assess the quality of their data and, if suboptimal performance is confirmed, consider the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists and 'ACS' nurse specialists ***Referral to rehabilitation*** 7. Hospitals not meeting the standard for referral to cardiac rehabilitation following heart attack should ensure early identification of suitable patients (e.g. through routine distribution of information about cardiac rehabilitation within discharge leaflets given to all patients).	25% of patient who are eligible. This is a clear area for improvement, and the data collection process will also be reviewed to ensure this is a true reflection of practice. We are currently giving consideration to other roles within the team, for example Cardiology ACP. 88% of patients were referred to Cardiac rehab. Target is 85%. This is also reflected in the NACR data.
5899: **National Audit of Metatastic Breast Cancer** **State of the nation report 2024: An audit of care received by people diagnosed with metatastic breast cancer in England and Wales during 2019 - 2021** **Publication date: 12/09/2024**	How does DCH perform in comparison with available national benchmarking? Or Areas of good performance/ areas of Concern 1. Ensure the care for people newly diagnosed with MBC (either de-novo or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting. 2. Examine biopsy rates for MBC and aim to increase this where feasible if the results may have therapeutic implications. 3. Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness	Good results comparing to the benchmark. Standard data collected well, in line with national standards. Of note is specific demographics with one of the oldest population in the country. As a result generally higher ASA, CS, PS. The main concern is now delay starting the chemotherapy in view of shortage of Aseptic Pharmacists. Breast MDT has special part designated to discuss metastatic patients. MDT is generally well attended also by Metastatic Breast Nurse (full time). We have x2 Breast Nurses with skills to work with metastatic patients. Biopsy for MBC managed through the MDT process and MDT recorded. No data for DCH but likely close to the national benchmark of 34%. Available and performed if clinically indicated. Compliant

Audit / Clinical Outcome Review Programme	What this Trust learnt	Recommendations
	within breast MDTs should include full tumour characterisation, ER13 and HER213 status (for invasive breast cancer), performance status, the NABCOP fitness assessment14 data items (for people aged 70+ years) as well as data on Triple Diagnostic Assessment (TDA) and contact with Clinical Nurse Specialists (CNS). *(Recommendation aligned with the report for the National Audit of Primary Breast Cancer 8.)* 4. Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: a) Education on the recording of recurrence, sharing the NAoMe Guide to collecting COSD data for breast cancer recurrence20 with NHS organisations. b) Reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. *(Recommendation aligned with the report for the National Audit of Primary Breast Cancer14.)*	Compliant
5812: National Respiratory Audit Programme NRAP Pulmonary Rehabilitation **Publication date: 11/07/2024**	1. Integrated care boards and local health boards should ensure that they achieve 100% service participation and that services achieve a minimum 50% case ascertainment in NRAP audits by May 2026. This will require all hospitals having named NRAP clinical leadership and dedicated audit support. 2. All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	Pulmonary rehab team submit data form all clinical activity to NRAP for inclusion in reports. Smoking status recorded during all pulmonary rehabilitation assessments and current smokers signposted, with their consent, to LiveWell Dorset for ongoing support.

Audit / Clinical Outcome Review Programme	What this Trust learnt	Recommendations
	In England, the Department of Health and Social Care, NHS England and integrated care boards should work together to provide increased resource to all acute, mental health and maternity services in England, so that every provider develops and implements a comprehensive inpatient tobacco dependency service. 3. 3. All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management. In England, integrated care boards should work with providers to ensure that there is adequate resource to support frontline clinicians in the delivery of patient's discharge bundles. 4. All patients requiring pulmonary rehabilitation should have timely access to the intervention, in line with recommendations from NICE and the British Thoracic Society's clinical statement on pulmonary rehabilitation. Where that's not achieved, services should work towards a target of 70% of patients starting a PR programme within 90 days of referral, and 70% of patients with acute exacerbation of COPD starting within 30 days of referral, by May 2026. In England, integrated care boards should be resourced to create increased pulmonary rehabilitation capacity.	DCH Pulmonary rehab activity for non acute exacerbation referrals over the last year is 86.9 days against the national target in this report of 90 days from receipt of referral to starting programme. Waiting time for referrals received post acute exacerbation over the last year is average 52.4 days. Urgent slots are available in our clinics to start the assessment process for these patients but given their recent hospital stays, the patients often choose to delay their treatment beyond the 30 day national target. This may be due to going home with package of care, further investigations required as an out-pt or patient choice.

Local Clinical Audits

Local Clinical 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. 198 local audits were registered and 130 completed during 2024-25 and work will continue to see these through to completion. The reports of local clinical audits were reviewed by the provider in 2024-25. An example of these is provided below, and the Trust intends to take the identified actions to improve the quality of healthcare provided:

Audit Number & Title:	Audit Findings/ How this Audit Improves patient care	Actions agreed and complete
6009 **Referral efficiency for Cardiac surgery** Data Collection Period: November 2022- June 2023	This audit was for Clinical Concern, Patient Safety and Patient Journey. This quality improvement project was designed to identify the average time for a patient to be transferred to SGH and which part of the patient pathway was impacting on this. The aim to review all patients that were transferred to Southampton for Cardiac surgery in a 3-month period and establish the length of time taken for each investigation to be performed, and how long the patients stay at DCH was impacted based on several variables outlined below. The findings showed on average patients are listed on whiteboard 48hrs after admission; The median transfer time from admission to transfer is 12 days; The median time to acquire all relevant data for acceptance of the referral is 5 days; and the median time for transfer once the decision is made is 2 days. Overall, this pathway is performing adequately The findings showed 31% of patients transferred for surgery were Female. The median age of patients in the data set were 69; The biggest proportion of patients referred were for Valvular issues, and the second was a combination of coronary and valvular issues; On average patients are listed on whiteboard 48hrs after admission; The median transfer time from admission to transfer is 12 days; and the median time to acquire all relevant data for acceptance of the referral is 5 days. The median time for transfer once the decision is made is 2 days.	It is recommended for In house Max Fax / dental assessments; a re-audit; Education for the new cohort of junior doctors starting August 2024 regarding the required investigations depending on the surgery required and show the most streamlined way to request these including education around the use of the whiteboard system.
6038 **Improving the Molecular Sampling Pathway across**	The aim of this audit is to ensure that the Dorset Lung cancer Teams were meeting the National Optimal Lung Cancer Pathway turn-around-times for molecular testing. This will include analysing the time taken to obtain results of 27	It is recommended to continue to engage with the programme and the development of the

Audit Number & Title:	Audit Findings/ How this Audit Improves patient care	Actions agreed and complete
Dorset Within Lung Cancer. Data Collection Period: 01/09/2023 - 31/10/2023	biopsy samples; understand the delays and to implement the national optimal lung cancer pathway guidelines. The key findings showed that there were delays in programmed death-ligand 1 (PDL-1) testing at DCH compared to UHD, due to the fact UHD performs this in house. Anomalies are noted in individual cases.	genomic hubs; and to have close links with the pathology service.
6147 **Compliance to the Universal Safety Checklist for Interventional Procedures for the Same Day Emergency Care (SDEC)LocSSIP 2024** Data Collection Period: 01/09/2023 – 29/02/2024	The aim of this audit is to identify compliance with the LocSSIP Universal Safety Checklist for Interventional Procedures; identify any amendments to be made to the LocSSIP Universal Safety Checklist for Interventional Procedures; and to address any non-compliance through training and reflective practice for all staff involved. It sampled 53 patients who underwent an Interventional Procedure within SDEC. The findings showed that every standard achieved 100% of the required compliance.	It is recommended to continue to educate clinical staff in the completion of the checklist and to reaudit in 6 months.

Mandatory Statement 4

Commissioning for Quality and Innovation CQUIN Framework

The 2024/25 Commissioning for Quality and Innovation (CQUIN) programme was paused by NHS England **whilst a wider review of quality incentives takes place.**

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 a number of active 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 has a Clinical Director as well as an Associate Clinical Director for Research who joined the team in June 2024 coming from a General Practice background. Research Steering Committee receives escalation reports from three sub-groups and gives assurance to the newly formed Quality Governance Group on a quarterly basis. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2024-25 that were recruited during that period to participate in research approved by a research ethics committee was 526. The Weymouth Research Hub supported 76 healthy volunteers to participate in commercial research trials under the Wessex Research Hub model.

Maximising opportunities for patients to take part in clinical research continues to be a key priority for Dorset County Hospital, a service fundamentally supported by our long-standing collaborative relationship with the NIHR, now through the Southwest Central Regional Research Delivery Network hosted by University Hospitals Bristol and Western. Dorset County Hospital continues to co-host the Weymouth Research Hub as part of the federation with Dorset Healthcare and a partner in the strategic alliance of Wessex Health Partners. This collaboration has seen the teams working with local communities to foster Trust and build a research culture in a previously research naive population evidenced by the successful delivery of two large-scale commercial vaccine studies.

Over the past 12 months, responding to the national review of commercial clinical trials by Lord O'Shaughnessy, the Research Department have nearly quadrupled the number of commercial trials offered to patients in clinical specialities such as cancer, cardiology, renal and surgical services. A business plan aimed at developing the Trust's capacity and capability to engage with Industry and build positive, fruitful relationships has enabled the Research Department to achieve financial recovery and sustainability post-Pandemic. Importantly, this will support future growth of the Trust's overall research capabilities including nurturing grass-roots potential and clinical academic pathways for all healthcare professions.

Key highlights which have had a positive impact for our patients include being the trial site for a colorectal cancer vaccine study and taking regional referrals for this study as part of the Cancer Vaccine Launch Pad. Dorset County Hospital have also been recognised as the highest recruiting NHS site for a commercial observational lung cancer study which was embedded into the targeted lung cancer screening programme. Finally, the Trust has been awarded its first successful NIHR capital funding bid for over £200,000. This award will fund a state-of-the-art Heidelberg SPECTRALIS® retinal OCT scanner which will enable the Ophthalmology service to build their research portfolio and offer innovative treatment opportunities for conditions including age-related macular degeneration.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008.

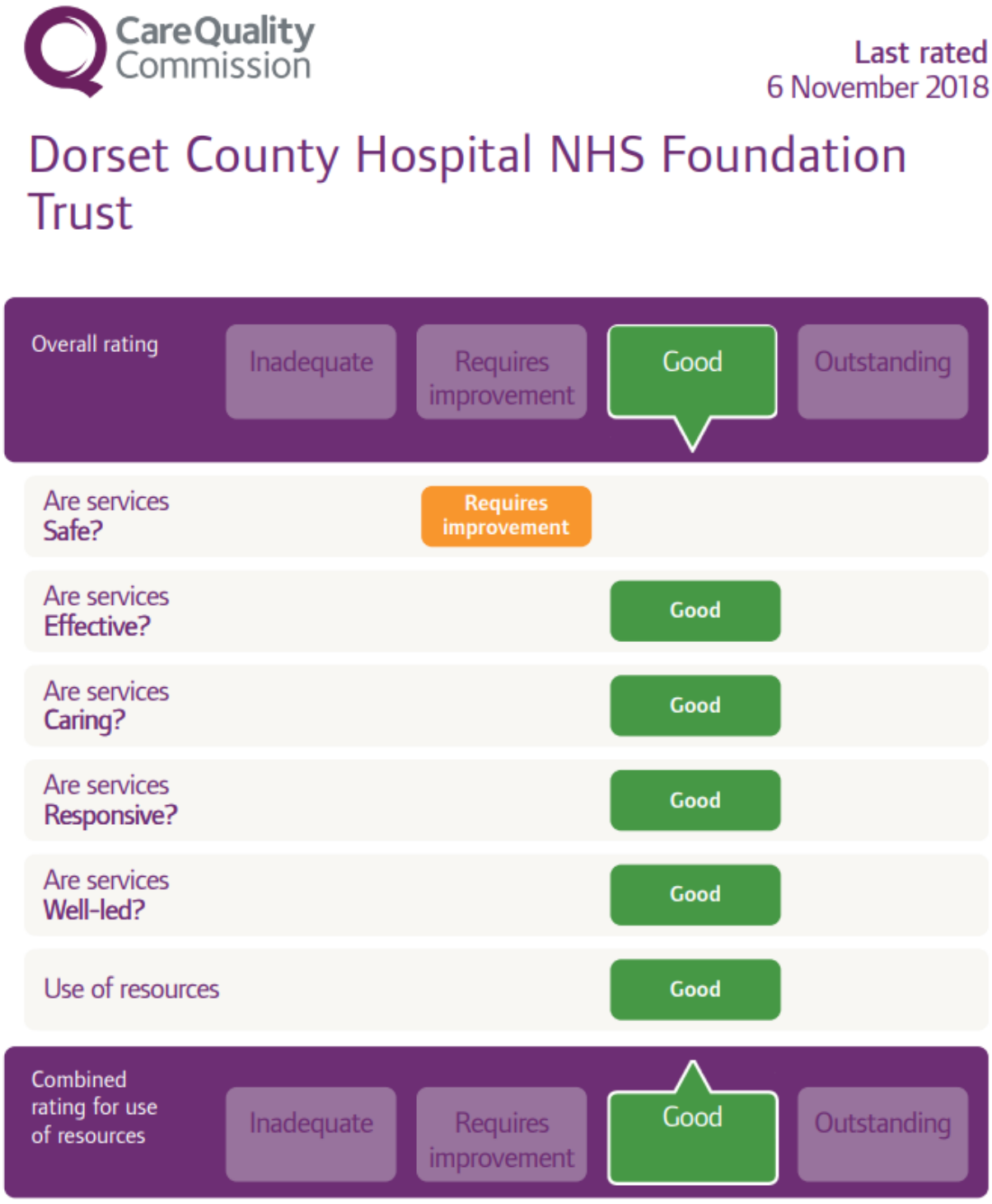
Following the CQC inspection of maternity services at Dorset County Hospital in 2023/24 which resulted in the Trust receiving a rating of Requires Improvement, the Trust commissioned an independent Maternity Improvement Advisor to complete a full diagnostic assessment. This assessment delivered recommendations to improve leadership structures, governance and oversight and compliance with the Maternity Incentive Scheme (MIS). The Trust is committed to ensuring safe effective and patient centred care for our patients and in response to the inspection report, and independent diagnostic, the Trust has progressed with identified areas for improvement and is fully compliant with the Maternity Incentive Scheme.

The Trust engages with the CQC inspection team to report on progress with action plans and to respond to enquiries as and when received.

The CQC continues with a risk-based approach to regulation through their Single Assessment Framework, which is driven through a regular review of data and information available to the CQC through national and regional reporting, engagement with people who use the services and engagement meetings with the Trust. Throughout the year, the Trust has continued to be monitored under 'routine surveillance', meaning that no concerns were raised or escalated prompting additional inspection.

The Trust has a current overall rating of 'Good' with a location rating of 'Requires Improvement'.

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
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 2024-25 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:

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	National Average 2024/25
Admitted Patient Care	99.9%	99.9%	100%	99.9%	99.9%	99.9%	99.9%	99.7%
Outpatient Care	100%	100%	100%	100%	100%	100%	100%	99.7%
Accident and Emergency Care	99.0%	99.2%	99.7%	99.7%	99.6%	99.6%	99.8%	98.2%

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

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	National Average 2024/25
Admitted Patient Care	100%	100%	100%	100%	100%	100%	100%	99.4%
Outpatient Care	100%	100%	100%	100%	99.9%	100%	100%	99.3%
Accident and Emergency Care	99.8%	100%	100%	99.7%	100%	100%	100%	99.2%

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 2024 – 2025.

Data Security

On 30th December 2024, the Trust submitted the interim Data Security and Protection Toolkit (DSPT) baseline submission to NHS Digital to demonstrate that, to date, it had started to gather the evidence and had so far completed 11 of the 47 of the new National Cyber Security Centre, Cyber Assurance Framework requirements.

The internal audit on 12 of the contributing outcomes was conducted by BDO LLP, which opened on 13th March and closed on 25th April, we await the final report which will be submitted to the Risk and Audit Committee by BDO.

The Data Protection Officer continues to gather the evidence needed to complete the 2024/25 Data Security and Protection Toolkit, which is due for submission on 30 June 2025.

Learning from Deaths 2024/25

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 2024 – March 2025 1,361 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:

- 329 First Quarter
- 315 Second Quarter
- 364 Third Quarter
- 353 Fourth Quarter

By 01/04/2025 264 case record reviews and 0 investigations have been carried out in relation to the 1,361 deaths.
In 0 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:

- 79 First Quarter
- 46 Second Quarter
- 77 Third Quarter
- 62 Fourth Quarter (Completed SJR's)

3 representing 0.22% 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 329 representing 0.08% for the first Quarter
- 0 of 315 representing 0% for the second Quarter
- 0 of 364 representing 0% for the third Quarter
- 2 of 353 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. The national cardiac arrest audit reports on a 6 monthly basis, and there are no concerns over care at Dorset County Hospital.

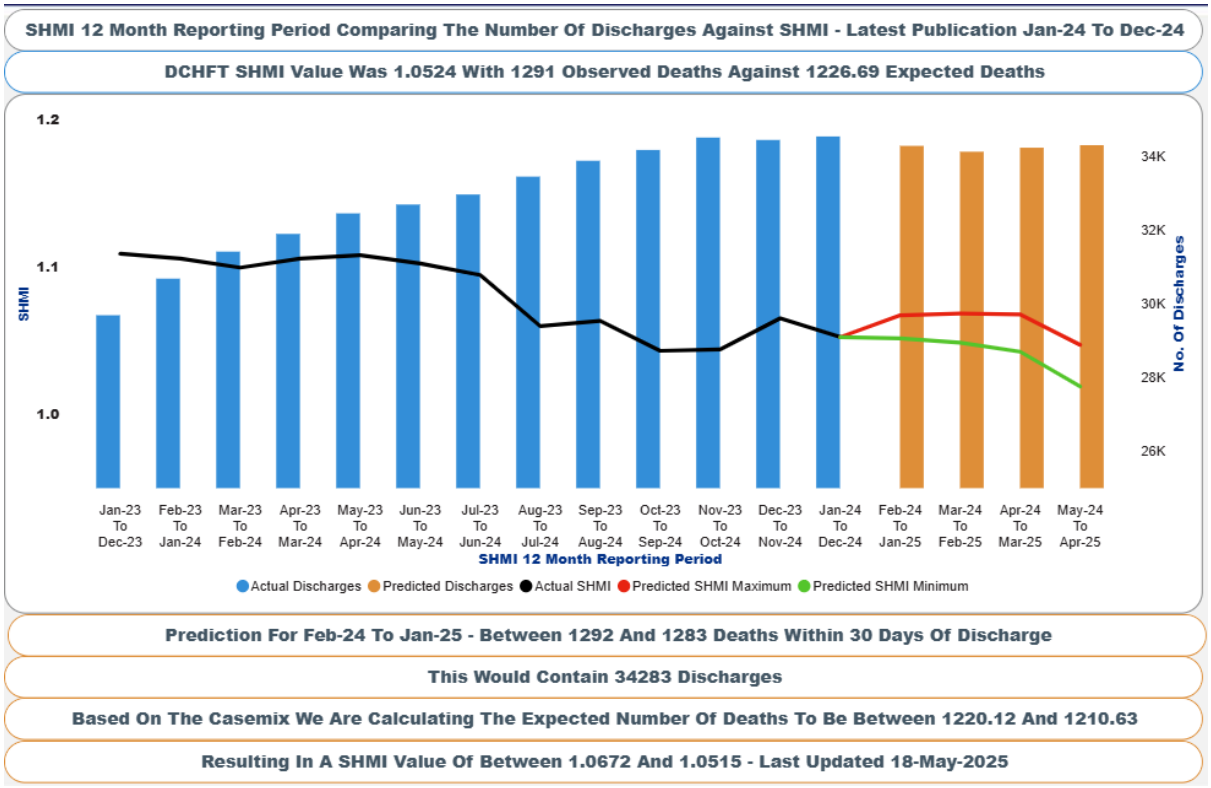
The quality of documentation is an ongoing theme in feedback from SJRs. Work is ongoing to procure a complete electronic health record (EHR) that will improve the quality of documentation. This will likely be only one facet of the solution to improve documentation, as despite the introduction of Agyle as an electronic record in the Emergency Department in 2022 – concerns persist about the quality of entries in the Emergency Department. There has been positive work within division B to look at improving the quality of surgical clerking's, and this work is ongoing.
Where issues are identified they are 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.

Over the course of this year there has been a backlog for structured judgement reviews in Division A. An assurance exercise was undertaken based on completed SJRs which assured us that we were not missing significant learning from uncompleted SJRs. Due to very few concerns highlighted within prior SJRs a final decision on sampling the backlog will be made in quarter 1 2025/2026. In the meantime a new process has started for completion of SJRs to prevent a further backlog of SJRs.

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.
The chart below shows our SHMI since Dec 2023, including the trajectory over the next 5 months (the data is published in arrears). Our data predicts that our SHMI will remain in the expected range over the coming months.



Summary Hospital-level Mortality Indicator	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25*	Trend
Banding	2	1	2	1	1	2	1	1	1	2	2	
Value	1.10	1.16	1.12	1.17	1.19	1.13	1.14	1.13	1.13	1.11	1.05	
% of patient deaths with palliative care coded at either diagnosis or speciality	15.7%	24.9%	35.6%	32.3%	33.0%	39.0%	42.0%	45.0%	47.0%	51.0%	53.0%	
National Average	*25.7%*	*28.5%*	*30.7%*	*32.5%*	*35.0%*	*37.0%*	*38.0%*	*40.0%*	*40.0%*	*43.0%*	*44.0%*	
Lowest	*0.0%*	*0.6%*	*11.1%*	*12.6%*	*12.0%*	*9.0%*	*8.0%*	*11.0%*	*14.0%*	*17.0%*	*17.0%*	
Highest	*50.9%*	*54.6%*	*56.9%*	*59.0%*	*60.0%*	*58.0%*	*63.0%*	*66.0%*	*66.0%*	*67.0%*	*66.0%*	

Latest publication up to December 2024. Full year 2024/25 data published August 2025

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.

Emergency Readmissions

The table below shows the percentage of emergency readmissions to the Trust within 30 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.

Readmissions within 30 days	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24*	2024/25*	Trend
Aged 0 to 15 years													
Total Spells	2,715	2,725	3,040	3,165	3,005	3,065	3,010	1,775	2,780	3,185	3,145	N/A	
Of which, readmitted as an emergency within 30 days	310	325	375	400	390	420	435	255	395	465	515	N/A	
Dorset County Hospital	**11.2%**	**11.8%**	**12.1%**	**12.3%**	**12.8%**	**13.4%**	**13.9%**	**13.7%**	**13.5%**	**13.7%**	**15.7%**	**N/A**	
National average	*11.3%*	*11.4%*	*11.5%*	*11.6%*	*11.9%*	*12.5%*	*12.4%*	*11.9%*	*12.5%*	*12.8%*	*13.2%*	*N/A*	
Lowest	*3.3%*	*3.6%*	*1.3%*	*4.8%*	*1.7%*	*2.8%*	*2.4%*	*5.7%*	*3.4%*	*3.7%*	*1.6%*	*N/A*	
Highest	*19.0%*	*54.0%*	*87.6%*	*72.4%*	*54.8%*	*69.1%*	*97.0%*	*34.0%*	*49.1%*	*37.7%*	*69.1%*	*N/A*	
Aged 16 years and over													
Total Spells	16,060	17,595	18,465	18,805	17,790	17,585	17,415	13,900	16,650	15,135	20,255	N/A	
Of which, readmitted as an emergency within 30 days	1,765	2,135	2,345	2,485	2,290	2,455	2,515	2,115	2,370	1,875	3,360	N/A	
Dorset County Hospital	**10.9%**	**11.6%**	**12.0%**	**12.2%**	**12.0%**	**12.7%**	**12.8%**	**13.2%**	**12.5%**	**11.1%**	**14.4%**	**N/A**	
National average	*12.5%*	*12.9%*	*13.3%*	*13.5%*	*14.0%*	*14.5%*	*14.6%*	*15.9%*	*14.6%*	*14.4%*	*15.1%*	*N/A*	
Lowest	*1.7%*	*2.4%*	*1.9%*	*0.8%*	*2.2%*	*2.1%*	*1.9%*	*1.0%*	*1.5%*	*2.5%*	*1.7%*	*N/A*	
Highest	*29.1%*	*66.4%*	*86.4%*	*99.6%*	*63.2%*	*57.2%*	*34.0%*	*51.2%*	*44.8%*	*46.8%*	*99.6%*	*N/A*	

2024/25 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

Expected values are rounded to the nearest whole number. Numerators and denominators are rounded to the nearest 5 as per the HES suppression method.

Source

Compendium - Emergency readmissions to hospital within 30 days of discharge - NHS England Digital

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	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	2022/23*	2023/24*	2024/25*	Trend
Dorset County Hospital	**71.1**	**69.6**	**70.2**	**69.0**	**68.2**	**67.0**	**76.7**	**N/A**	**N/A**	**N/A**	**N/A**	
National average	*68.9*	*69.6*	*68.1*	*68.6*	*67.2*	*67.1*	*74.5*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*59.1*	*58.9*	*60.0*	*60.5*	*58.9*	*59.5*	*67.3*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*86.1*	*86.2*	*85.2*	*85.0*	*85.0*	*84.2*	*85.4*	*N/A*	*N/A*	*N/A*	*N/A*	

2021/22,2022/23,2023/24, 2024/25 data not published.
Following national consultation, the NHS Outcomes Framework publication now only includes 5 approved 'hospital based episode statistics' based indicators, which does not include the patient safety figures. 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.

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

Staff Friends and Family Test (SFFT)

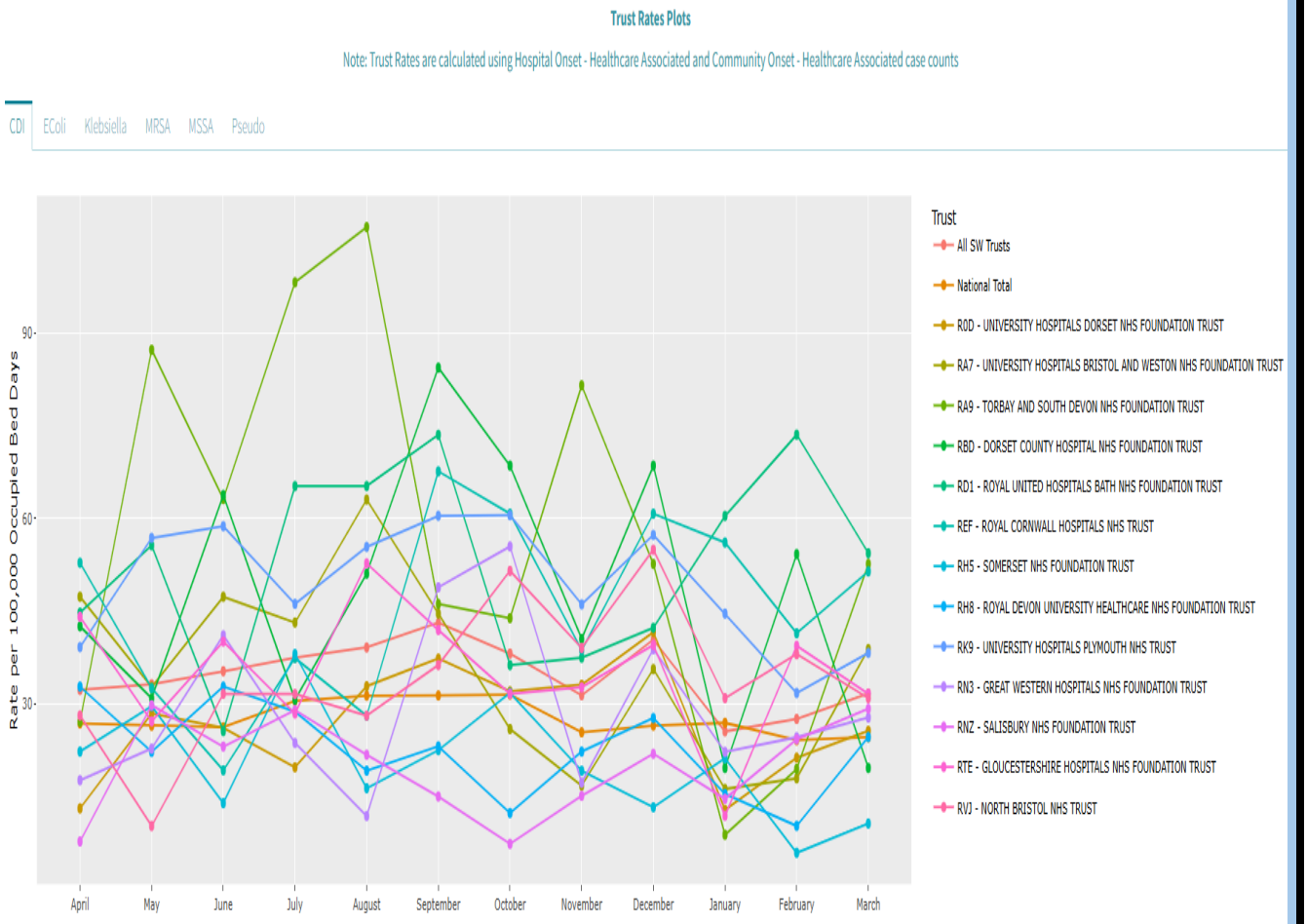
This test forms part of the national NHS Staff Survey undertaken in quarter 3 of each year. These figures are taken from the 2024 survey.

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2018	2019	2020	2021	2022	2023	2024
Dorset County Hospital	80%	78%	80%	66%	66%	72%	74%
National Average (median)	71%	69%	74%	58%	62%	63%	61%

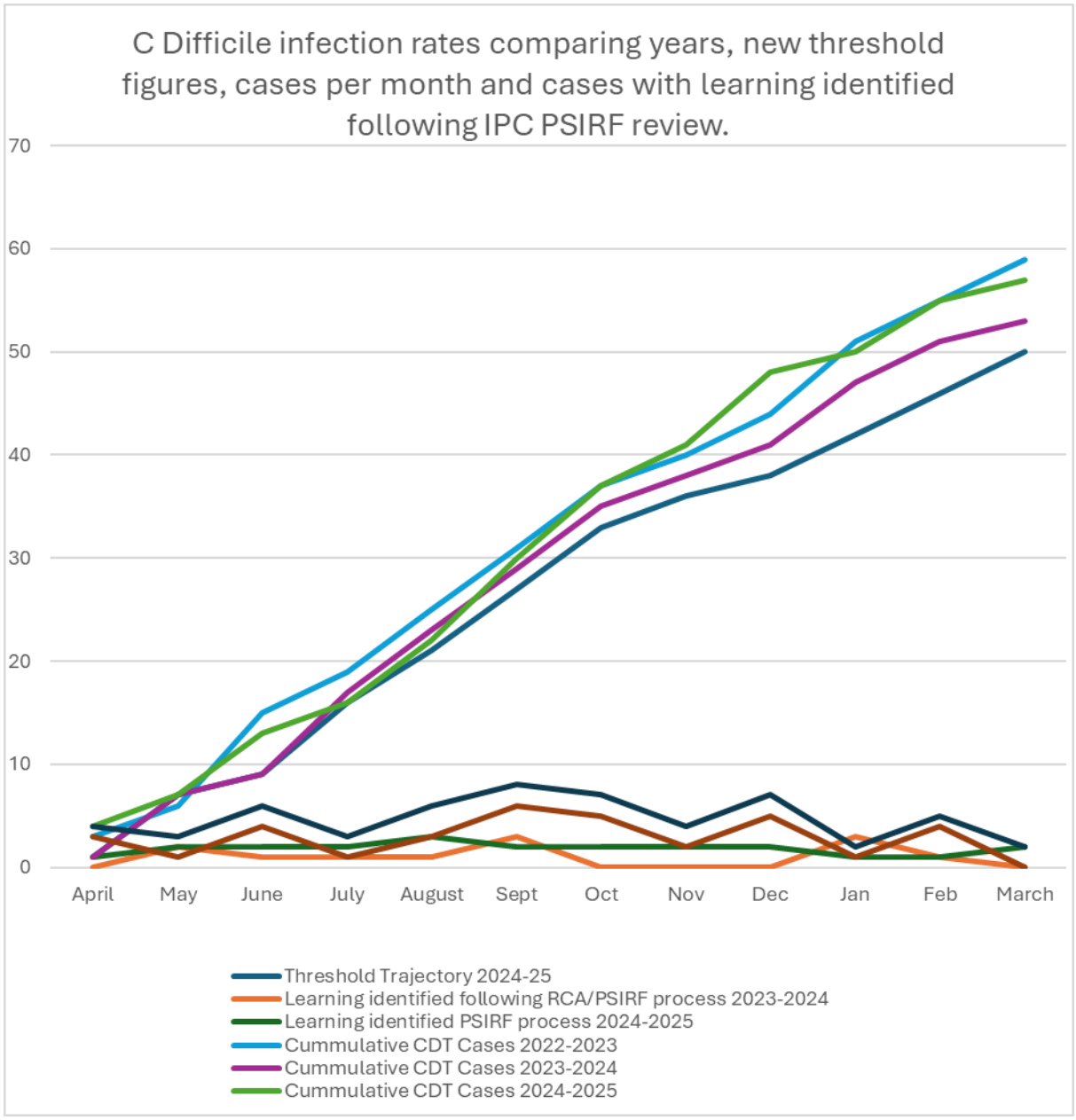
Infection Prevention Management

Clostridioides difficile

Clostridioides 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) are reviewed using the Infection Prevention Management PSIRF (Patient Safety Incident Response Framework) process. This process helps to identify recurring themes and trends, which then ensures focused quality improvement work. The case review process particularly focuses attention on sampling in a timely manner, isolating patients with new onset of diarrhoea and incorporates antimicrobial stewardship.



Official statistics can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis



Patient Safety 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	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	2022/23*	2023/24*	2024/25*	Trend
Number of patient safety incidents reported to NRLS/LFPSE^	2,116	4,609	4,493	4,838	4,997	5,542	5,552	7,582	8,763	9,181	5,528	
Incidents resulting in severe harm or death^	19	25	24	22	25	28	23	22	28	27	18	
Percentage of incidents resulting in severe harm or death	**0.90%**	**0.54%**	**0.53%**	**0.45%**	**0.50%**	**0.51%**	**0.41%**	**N/A**	**N/A**	**N/A**	**N/A**	
National Average	*0.49%*	*0.41%*	*0.37%*	*0.34%*	*0.32%*	*0.30%*	*0.44%*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*4.18%*	*1.74%*	*1.58%*	*1.76%*	*1.35%*	*1.31%*	*2.80%*	*N/A*	*N/A*	*N/A*	*N/A*	

^From 2nd April 2024 incidents reported via LFPSE (not aligned)
****Data no longer nationally published by provider***
Following national consultation, the NHS Outcomes Framework publication now only includes 5 approved 'hospital based episode statistics' based indicators, which does not include the patient safety figures.
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 2024/25. Information on Patient Safety, Patient Experience and Clinical Effectiveness can also be found within the Quality Priorities end of year update section.

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 DCHFT. This group enables the opportunity to influence and coordinate change for staff and provides an escalation route to the People & Culture Committee when needed. The meeting is held quarterly

Financial Wellbeing

DCHFT is partnered with Money and Pensions Service for staff advice and support. The Regional representative has given talks to HWB coaches and has set up the NHS SW Financial Wellbeing Network which holds bi-monthly webinars and issues a newsletter.

The Trust works in partnership with the Serve & Protect Credit Union who offer salary deduction based consolidation loans and savings.

Staff have access to confidential foodbank referrals and can receive a £25 shopping voucher support for those in need.

From June 2025, HWB coaches will be able to signpost staff who are in need to an internal foodbank managed by the catering manager.

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Health and Wellbeing Coaches

Our network of staff Health & Wellbeing Coaches (HWCs) continues to grow, with 80 coaches, and an additional intake planned for the summer. The March intake was diverse both in gender and job-role and we are working to increase diversity in other ways. 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. Surveys from coaches have shown that colleagues are talking to HWB coaches, and coaches are being proactive in increasing wellbeing practice in their areas. Surveys highlight themes that arise (e.g workplace stress, bereavement) so that coaches can be upskilled in these topics.

Wellbeing Conversations

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.

In the Meaningful Appraisal training, managers are advised to use the health and wellbeing section effectively, pausing the appraisal when a Wellbeing Conversation is more appropriate..

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

Charity Funding Support

Charity funding has continued to support the work of Health & Wellbeing at DCH and approval for a Health & Wellbeing Coordinator post for two years was supported by NHSCT (the period is being extended from the original 2 years due to a

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. Work is continuing around a cultural shift to embed the TRiM process at DCH, with plans to broaden this to a more holistic offering through various routes including clinical supervision	change of role-holder). Funds have also been used to support staff wellbeing through on-site yoga and Pilates sessions and staff training in bereavement support was well-received. We have had confirmation of funding for Suicide Awareness which will be primarily aimed at our Health & Wellbeing Coaches as part of their CPD offer
Menopause Support Following the formation of a Menopause forum in 2022 work has progressed to include the development of Menopause policy, information days and stands. Menopause Advocates, identifiable by their badges, are available to support colleagues and influence the organisation's stance on menopause. A dedicated MS Teams channel provides advocates with resources. The employee passport has been linked to the Menopause page on StaffNet to support reasonable adjustments as needed.	**Your Care** Originally launched in May 23, staff 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. This is going to be re-launched in 2025 to widen awareness of this useful tool so more staff can benefit from it.

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

The recently completed exercise for 2024/2025 consisted of organisational data collection and staff survey. We await the report to be published for this recent exercise

Key areas for work that have been completed since the last report include:

Accessible information - a new communicating with patients policy has been published as part of the work of the Accessible Information Standard Group

A Changing Places facility is now in place

Conversation Cafe – Bringing the Deaf Community together with DCH

A Conversation Cafe was held at Dorset County Hospital in January 2025 to bring together members of staff, representing departments across the hospital, with representatives from the deaf community. The cafe was supported by two British Sign Language (BSL) interpreters, who also shared their experiences of coming into the Trust to provide interpretation support to patients. The patient representatives all had experience of accessing services at Dorset County Hospital and we are incredibly grateful to them for giving up their time to come and share these experiences. Through the discussions which took place, we have been able to identify where we can do more to develop our services to improve the experience and access to healthcare for our deaf community.

Conversation Cafe is a methodology used to support facilitated but informal discussions around a specific topic carried out in a group session. There is usually no agenda but will focus on a key aim to learn more about the topic, bring people together to share experiences and understand where improvements to services can be made. Our Conversation Cafe was held in the library at Dorset County Hospital, providing an informal and friendly environment in which to bring participants together. This event had been arranged as the result of a complaint from a profoundly deaf patient about her experience in the hospital.

A meeting with the Director of Nursing to discuss the complaint had provided an opportunity for the patient to share her experience and the challenges people who are deaf or who have hearing loss face when accessing our services. It was clear that we had an opportunity to not just learn from this but to make some changes to our services to improve experience for our deaf community. This triggered the idea to hold a Conversation Cafe so that we could bring people together to talk and listen, understand challenges from all perspectives and work together to make change.

The key findings and recommendations from this event have been shared at Trust board and an action plan has been developed which will be monitored through our Accessible Information Standards group.

Maternity 15 STEP Challenge

In November 2024, Dorset County Hospital Patient Experience Team collaborated with the Maternity Unit and the Maternity and Neonatal Voices Partnership (MNVP) to host a 15-step event at Dorset County Hospital Maternity and Special Care Baby Units. Service Users were invited to take part in the event and to come and join us to visit different areas of the Units. As this was our first 15 step event for maternity, we decided to keep numbers small and alongside our MNVP partner we were joined by two patient / public participants who both had experience of using our maternity and neonatal services.

Using the 15 step challenge methodology participants assessed areas 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?
Discussions took place following the assessments where feedback was collated and recommendations made. These have been shared with the maternity unit and SCBU with plans to follow up with the participants during 2025 to share where change has been made.

Armed Forces Community Support

Our work to support our Armed Forces Community within the Trust was recognized in October 24 following successful re-accreditation as a ‘Veteran Aware’ Organisation with the Veterans Covenant healthcare Alliance (VCHA). This accreditation demonstrates our commitment to supporting and improving experience for both serving military and those who have served when they access our services. During the 24/25 year this has included forming a partnership with the Dorset

Royal British Legion (RBL) who have funded and supplied items for the Patient Care Packs for RBL beneficiaries who are inpatients. These have been distributed by the Dementia team and have helped staff to both recognize veteran status and put in place support to help meet the needs of this community.

Volunteer Led – Patient Activity

Linked to the activity for patients' quality priority for this year has been the ongoing development of our volunteer activity team. This has included our team of five therapy dogs who never fail to bring a smile to patients, visitors and staff as they do their weekly rounds of the hospital and our music volunteer who in addition to the Bournemouth Symphony Orchestra provide weekly music therapy sessions to inpatients. We have also setup a book trolley this year, which was funded by the Dorchester Casterbridge rotary club. The book trolley is looked after by our volunteers who take donated books onto wards to gift to patients

Through closer working with our Dementia team and the Creative Arts ambassador, we have been able to recruit more volunteers into the team to support with one to one and group patient activity sessions. Activities offered are wide ranging and include everything from simply keeping a patient company to arts and crafts sessions and bingo. Volunteers are given training with our dementia team and the creative arts ambassador to support them and improve their confidence in delivering activity.

We ask our volunteers and staff to feedback on volunteer activity sessions with patients, and this is helping us to measure the impact and benefits of providing therapeutic activity to patients:

Activity Volunteer feedback:

We worked with six patients today all at various times, lots of laughter and socialising and interaction between patients which was good to see. One gentleman came into the room quite tearful and did not take part in the activity but wanted to talk and so sat and chatted with one of the volunteers for a good hour. Another lady who had broken one of her wrists found it hard to hold onto the pens but with support and handholding did make lots of marks on one of the Chinese dragons, so she was chuffed with her achievement. Another lady who was very reluctant to move from her bedside last week actually did take part this week albeit by us bringing the activity to her, but she sat very self-contained and coloured in a beautiful dragon for another hour.

Annie did a wonderful thing for a very distressed patient who was shouting out and very agitated and distressed. Doctors had tried to tempt her with a cup of tea, but she was too distressed. She kept saying she was cold despite having lots of layers on, but Annie sat holding her hand, snuggled her up with more blankets until she drifted off to sleep. Not only did that comfort that individual patient but it calmed the rest of the Bay who were getting distressed at that patient shouting out.
I had an amazing afternoon with six patients. We played bingo and did a couple of quizzes amid much hilarity, we laughed and chatted. J said she thought I was a cheetah, but I said I wanted to be a giraffe! We attracted quite a lot of attention, and I was ably helped by Emily, one of the OT team. It makes it all worthwhile.
Just spent a lovely morning with V, a wonderful 95-year-old, who, although she doesn't remember lots of things, was very with it and ' in the moment' for those three hours in the Day Room. She has been in hospital a week, and this was her first time out of the ward. We did lots of chatting, and some colouring. She asked if she should sign her picture, and when I said yes, she did, and then, with a huge smile said it would cost me three thousand dollars. She said several times that she was really enjoying herself in the Day Room and would like to come again. She said that she has always loved listening to different people's conversations, and that today was so special for her. Helped her cut up her lunch, but she was good at feeding herself.

Development and expansion of our Therapeutic activity offer for patients will continue to be one of our quality priorities for 25/26.

Green Spaces Strategy

The Trust is committed to improving the environment for staff and visitors and to enrich the experience they have from being at the hospital. There is a significant evidence base that indicates access to fresh air, green spaces and nature improves the wellbeing and recovery for patients and benefits staff wellbeing and retention.

The Green Spaces Group has overseen a number of developments to support this strategy:

A Livestream Bird Feeder from Devon Wildlife Trust is sited in the staff area in Damers restaurant. This is accompanied by a bird survey link sent out via the bulletin with positive responses to date.

Development of a Sensory Courtyard Garden – funding was secure via a successful bid to the Greener Communities Fund to develop a site next to the Special Care Dentistry department. The garden will be stocked with plants from Dobbies following a grant application and the retailer is also offering horticultural advice for a year. Kingston Maurward College Horticultural Students have helped with research and the design of the garden. The Garden will open in June 2025 and planting will take place from September 2025.

The garden is accessible to wheelchair users and is aimed at patients, staff and visitors who have mental health, anxiety or sensory needs.

Nature Recovery Ranger - The Trust was successful in securing funding for a Nature Recovery Ranger who will start in post in 2025. This post will be hosted by DCH for 4 days a week, managed and patrolled by the Centre for Sustainable Healthcare, and as 1 of 9 Trusts in the 'HealthybyNature' project funded by the National Lottery Communities Fund. The role will oversee all outside green spaces including Mark's Meadow, delivery of the Trust Tree Strategy, development of our sustainable nature agenda and leadership of the staff gardening group.

Memorial and Babyloss Garden – a site has been identified for development and establishment of a permanent memorial garden following the displacement of the previous garden due to capital building developments. The garden is being developed with the Bereavement Midwives and with funding support from the ForgetMeNot charitable fund.

Freedom to Speak Up

It is a contractual requirement for all NHS 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 50 FTSU Champions across the Trust. All have received either in-house training with the FTSUG or completed mandated 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 to ensure regular triangulation where necessary. The FTSUG meets quarterly with the CEO and NED and reports monthly to the People & Culture in Common Committee and bi-annually in person, 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 Management Team and sits on the Patient Safety Weekly Huddle.

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 of 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 2024 and 31st March 2025, a total of 499 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 new Joint Freedom to Speak Policy (2025) 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 collaborate on workstreams where appropriate.

Annex 1 Statement from Trust Partners

I am pleased to have had the opportunity to review the Quality Account 2024/25 and these comments are made in conjunction with the Governors who have observed at the Quality Committees. One thing that stands out is the commitment of staff in pursuit of achieving improvements to the care and experience of patients and as Governors we are assured that there are processes in place to address challenging issues.

We are confident that the Non Executive Directors who sit on the committee focus on priorities and those areas that need extra scrutiny. Governors are able to get a real feel of the patient and staff experience as we take part in quality walk abouts around the Trust and believe we can be proud of the staff and leadership for their achievements this year.

I would also like to pay tribute to the wonderful volunteers for the work they do. There are, of course, more challenges ahead and we shall monitor closely how the joint committee with DHC develops to ensure that it does not dilute the good work that has been achieved. It has been a pleasure to work with the Trust and it hasn't gone unnoticed that despite the pressures and challenges there is always a friendly face and warm welcome at DCH.

Kathryn Harrison
Lead Governor
Dorset County Hospital NHS Foundation Trust

NHS
Dorset

NHS Dorset

19 June 2025

PRIVATE AND CONFIDENTIAL

Dawn Dawson
Chief Nursing Officer
Dorset County Hospital NHS Foundation Trust
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Quality Directorate
County Hall
Colliton Park
Dorchester
Dorset
DT1 1XJ

Dear Dawn

Re: Quality Account 2024/25

Thank you for asking NHS Dorset ICB to review and comment on your Quality Accounts for 2024/25. Please find below the ICB's statement.

NHS Dorset welcomes the opportunity to provide this statement on Dorset County Hospital NHS Foundation Trust's Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of the information we have received during the year 2024/25.

Progress has been made across all identified priorities in 2024/25. It is encouraging to note the positive improvements in your No Criteria to Reside with the implementation of the Transfer of Care Hubs. The introduction of patient safety improvement plans and adoption of Martha's Rule further demonstrate a strong commitment to enhancing care quality. Efforts to amplify the patient voice have also been successful. Notable improvements have been observed in the experiences of children and young people in hospital and the quality and timeliness of electronic discharge summaries. Furthermore, the improvements in the Standardised Hospital Mortality Indicator and full compliance with the Maternity Incentive Scheme, underscore the ongoing progress and a continued commitment to quality care.

The ICB is supportive of the focus on the quality priorities for 2025/26. Ten trust priorities have been identified, some of which are a continuation from previous years to ensure they are fully implemented. It is positive to see that one of your priorities relates to the Health Inequalities action planning, to include Equality Delivery System 2 and CORE20Plus5. In addition, it is encouraging to see one of the priorities is centred on sustaining momentum towards the full implementation of Martha's Rule. The ICB will continue to work with the Trust over the coming year to ensure all quality priorities are supported as well as the reporting requirements of the NHS Contract. The ICB also remains committed to supporting the Trust in building upon collaborative working with all health and social care partners within the Dorset Integrated Care System.

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

Yours sincerely,

Pam O'Shea
Interim 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