Respect
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NHS
Dorset County Hospital
NHS Foundation Trust

Quality Account

2019 - 2020





Outstanding care for people in ways which matter to them

Quality Report

Quality Accounts and Approach to Quality

What is a Quality Account?

Every NHS trust is required to produce an annual report and annual accounts. Within the annual report, there is a chapter which reports on our annual quality accounts, and these Quality Accounts are also published on NHS Choices.

NHS foundation trusts, such as Dorset County Hospital, have to submit these to Parliament and to our independent regulator, NHS Improvement. This happens in July each year and the reports are also published on our website.

This year the production of the Quality Account was deferred due to the international Coronavirus pandemic. NHS providers were requested to submit the account later than normal, with a recommended deadline of 15 December 2020. Therefore it is not submitted with the annual accounts and will be an abridged version.

The quality accounts are intended to allow people to compare the performance of different trusts as we are all required to report on predominantly the same things. They contain the quality priorities that we set for our hospital and services, and report back on our progress in achieving the priorities that we set ourselves last year.

Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered significant amounts of change to improve both the effectiveness and the quality of its services during 2019/2020. For complete quality and performance data the public can access Trust Board papers

The following report does not reflect all the additional improvement's that have been made, but does report on the nine Quality account priorities that were selected for inclusion in 2019/2020 Quality Account.

This report covers the period of April 2019 – March 2020.

- Robust methodology of Mortality data has led to an improvement in SHMI data and remains within the 'expected' range
- Timeliness of complaint responses has remained consistently above the standard set
- The nine Quality Account priorities selected for 2019-20 are being continued through 2020-21 and have been agreed by the Trust Board.
- Successful implementation of Young Volunteer Programme and Initiatives introduces through the Volunteer Expansion Programme

Our Approach to Quality

As part of the standards for patient services detailed within the NHS Constitution and the Care Quality Commissions' ('CQC's') fundamental standards of quality and safety, the Trust is committed to the provision of safe, high quality care and achieving a good or outstanding CQC rating. An overall rating of 'Good' was achieved in 2018 and the Trust continues to aim to improve to 'Outstanding'.

CQC Inspections are currently suspended due to the Covid-19 pandemic.

Part 1: Statement on Quality from the Chief Executive

It gives me pleasure to introduce our Quality Account for Dorset County Hospital NHS Foundation Trust (DCHFT). I am delighted to share the progress and achievements our staff have made during 2019-2020 in conjunction with our patients and stakeholders.

The account details the progress made against the priorities set for last year, it will also detail the decision to retain those priorities into the forthcoming year 2020-2021. This decision reflects the current and ongoing pandemic which has resulted in some areas of reporting being halted in order to free up essential resources within the Healthcare system (in line with the National Guidance).

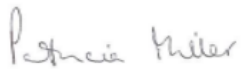
I am pleased to confirm that the Board of Directors has reviewed the 2019-2020 Quality Account and are assured that it is an accurate and fair reflection of our performance.

On behalf of the Board, I wish to thank our staff for their dedication and resilience to the ever changing situation at this time and our partner organisations for their support in helping to continue with the delivery of our services.

Finally, I would like to thank our patients, their families and the local community for their invaluable and ongoing support during this pandemic.

Patricia Miller, CEO

To the best of my knowledge, the information within this document is accurate



Chief Executive Officer

25 November 2020

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for Improvement 2020-2021

Every year we develop our priorities for the forthcoming year following engagement with our clinical staff, our partners, our executive team, local community representatives and, of course, our patients and their families.

Priorities for 2020/21:

Due to Covid-19 pandemic, The Trust was unable to complete 2019-20 priorities. The Trust board approved a recommendation to take these forward to the following year 2020-21

Patient Safety:

- Introducing three High Impact Interventions to Reduce Hospital Falls
- Improved Mortality Surveillance and Learning from Deaths
- Improving early identification and treatment of Sepsis and the Deteriorating Patient

Clinical Effectiveness:

- Improving timely access to Mental Health services when needed
- Improving the health and wellbeing of staff
- Reducing unwarranted variation (Implementing best practice linked to clinical audits)

Patient Experience:

- Improved learning from Complaints
- Improving the identification of Nutritional needs and support offered to patients
- Improving the support from Hospital Volunteers

Progress against these quality account priorities will be monitored and reported through the Trust sub-board Quality Committee. They will also be regularly reported to the Dorset Health Overview Scrutiny Committee and will be reported to the local commissioners.

Quality Achievements 2019/2020

Below are listed some of quality improvement projects of particular success in 2019/2020:

Robust methodology for mortality has led to a consistent improvement in our SHMI data	
Reduction in falls resulting in severe harm	
Implementation of a Young Volunteer Programme,	
Continuation of initiatives to support staff health and wellbeing	
Learning Opportunities included in all responses to complaints	
Improving the identification of Nutritional needs and support offered to patients through: - Quality Improvement Programme in Malnutrition Screening and care	

2.2 Statement of Assurance from the Board

1. During 2019-2020, the Dorset County Hospital NHS Foundation Trust (DCHFT) provided and/or subcontracted 35 relevant health services.

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

1.2. The income generated by the relevant health services reviewed in 2019-2020 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2019 – 2020.

2. During 2019-20 54 clinical audits and 4 national confidential enquiries covered relevant health services that the Trust provides.

2.1 During that period the Trust participated in 94% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.

2.2 The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2019-20 are as follows within the table:

2.3 The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2019- 2020 are as follows within the table:

2.4 The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2019-20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

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

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

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	197	100%
Cardiac Rhythm Management (CRM)	Y	Y	484	150%
National Heart Failure Audit	Y	Y	257	25% (against HES Data)
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	473	
National Audit of Cardiac Rehabilitation	Y	Y	541	100%
Diabetes (Paediatric) (NPDA)	Y	Y	111	100%
National Diabetes Audit – Adults	Y	Y	532	100%

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
National Diabetes Foot Care Audit**	Y	Y	153	100%
National Diabetes in Pregnancy Audit	Y	Y	15	100%
National Audit of Care at the End of Life	Y	Y	40	100%
National Audit of Dementia	Y	Y	Figures pending	
National Audit of Seizure Management (NASH3)	Y	Y	34	100%
National Asthma and COPD Audit Program	Asthma	Y	97	
	COPD	Y	229	
	Children and Young Peoples Asthma	Y	7	
Adult Community Acquired Pneumonia	Y	Y	88	100%
National Lung Cancer Audit	Y	Y	Figures pending	
National Smoking Cessation Audit	Y	Y	150/100	100%
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	420	
Major Trauma Audit (TARN)	Y	Y	357	100%
PHE Surgical Site Surveillance Audits	Y	Y	Total Hip replacement 37 Fractured neck of Femur 42 Breast 75	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Y	Y	MRSA bacteraemia 0 MSSA 52 (44 community acquired/ 8 DCH) Gram negative blood stream infections – all types 224, 29 attributed to DCH C.diff infections – 6 hospital acquired, 19 non-preventable.	
National Audit of Breast Cancer in Older Patients (NABCOP)	Y	Y	Figures pending	

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Inflammatory Bowel Disease (IBD) Registry Biologics Programme	Y	Y	Figures pending	
National Gastro-Intestinal Cancer Programme	Oesophago-gastric Cancer (NAOGC)	Y	Figures pending	
	Bowel Cancer (NBOCAP)	Y	Figures pending	
National Emergency Laparotomy Audit (NELA)	Y	Y	129	100%
National Joint Registry (NJR)	Knees primary/Revision	Y	216/15	100%
	Hips primary/revision	Y	277/24	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service	Y	Figures pending	
	Falls	Y	7	100%
	Hip Fracture Database	Y	311	100%
National Prostate Cancer Audit	Y	Y	Regional data collection submitted via PGH. Data reviewed via regional network meetings.	
BAUS: Nephrectomy; Percutaneous nephrolithotomy & Radical prostatectomy 2017-2021	Y	Y	Regional data collection submitted via PGH; data includes private practice and is reviewed regionally	
National Audit of Rheumatoid and Early Inflammatory Arthritis	Y	Y	Data entry started March 2019 – reporting period May 2018/19 – DCH recorded as non-participant.	
Endocrine and Thyroid National Audit	Y	Y	Figures pending	
Case Mix Programme (CMP) ICNARC	Y	Y	558	100%

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	5 stillbirths 1 neonatal death	
National Maternity and Perinatal Audit (NMPA)	Y	Y	Figures pending	
Child Health Clinical Outcome Review Programme	Y	Y	Figures pending-	
Neonatal Intensive and Special Care (NNAP)	Y	Y	Figures pending	
UK Cystic Fibrosis Registry	Y	Y	Figures pending	
National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	Figures pending	
National Cardiac Arrest Audit (NCAA)	Y	Y	58	100%
National Ophthalmology Audit	Y	Y	Figures pending	
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	3	100%
National Mortality Care Record Review Programme (NMCRRP)	Y	Y	SJRs completed via divisions. Outcomes reviewed through Trust Governance Structure	
Seven Day Hospital Services	Y	Y	Trust reached 90% threshold for compliance following Autumn 2019 survey	
Reducing the impact of serious infections (Antimicrobial Resistance & Sepsis)	Y	Y	Quarterly submissions made to NHS Digital. See Sepsis summary in Patient Safety Section	
Assessing Cognitive impairment in Older People/Care in the Emergency Department	Y	N	**Did not participate	
Care of Children in the Emergency Department	Y	Y	146/120	126%

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Mental Health – Care in the Emergency Department	Y	N	**Did not participate	
Perioperative Quality Improvement Programme (PQIP)	Y		Ongoing QI project	
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Y		Figures pending	
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Y	Y	37	100%

** ED felt greater benefit to the department would be achieved by focusing on local audits, specifically the Fast Assessment Bay, and a survey of ED activity. Agreed at divisional governance and escalated to Quality Committee November 2019

Covid-19 and Clinical Audit

With the advent of Covid-19, NHS England & Improvement took steps to reduce burden, and release capacity within the NHS care settings. The impact of this on clinical audit was an immediate cessation of all audit activity, with exception of a few specific projects, to allow clinical teams to focus on the unfolding situation. In reality, many of the national audits remained open, as they were keen to understand the impact of Covid-19 on their specific services, although publishing of reports was suspended.

NCEPOD also suspended all of their current studies at that time

Local audit was suspended in line with the above, although some areas found they had capacity to carry on, and several Covid-19 related audits were registered, still ongoing at this time.

As the pandemic took hold towards the end of the financial year, the figures for 2019-20 are largely unaffected; this will be more evident in the 2020-21 Quality Account. However, responses from clinicians in relation to published reports have been affected as clinical priority took precedence over summarising National reports.

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, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. *

Please note that in some cases the Trust may have been eligible, but 0 cases were submitted; this is because no eligible cases were identified during the period required.

(The results detailed in the report summary are based on the national responses to each study, and do not reflect the performance of Dorset County Hospital as an individual organisation.)

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Long Term Ventilation	Y	Y	1/3	100%
Acute Bowel Obstruction	Y	Y	1/2	50%
Out of Hospital Cardiac Arrest*	Y	Y	0	100%
Dysphagia*	Y	Y	2	100%

* Study still open, figures not yet finalised.

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

Report Title	Report Precis
NCEPOD Pulmonary Embolism - Know the Score – published October 2019	A retrospective case note and questionnaire review was undertaken in 526 patients aged 16 and over who had a PE (pulmonary embolism) either presenting to hospital or who developed a PE whilst as an inpatient for another condition. One or more delays in the process of care was identified in 161/420 (38.3%) patients, with recognition, investigations and treatment being the most common. The primary treatment for PE is anticoagulation. Where there might be a delay to the diagnosis of acute PE anticoagulation should be commenced. In this study there was an avoidable delay in commencing treatment in 90/481 (18.7%) patients. Once PE has been diagnosed an assessment of PE severity needs to be undertaken in order to treat patients effectively. In 144/179 (80.4%) hospitals their PE policy/guideline included the assessment of PE severity. This severity assessment was based on a validated scoring system in 128/142 (90.1%) hospitals. Case reviewers found no evidence of a PE severity assessment in the majority of patients (436/483; 90.3%). Severe (massive) PE requires additional or alternative treatment. A guideline/protocol for the diagnosis and care of patients with PE as provided at 151/180 (83.9%) hospitals. Ambulatory care has recently become a recognised pathway for PE management in those patients with low-risk of adverse outcomes. An ambulatory care pathway was used for all or part of the patient journey in 77/474 (16.2%) patients in this study. Wide variation in the selection of patients for ambulatory care was

	Report Precis
	observed, resulting in unnecessary hospital admissions. Patients should receive all the information they need to make an informed choice. Clinicians were unable to determine if the patient was given verbal or written information regarding PE in 336/600 (56.0%) instances and specific information/ education regarding PE was not routinely provided to patients at 55/167 (32.9%) hospitals
NCEPOD Long Term Ventilation – Balancing the Pressures – published February 2020	The aim of the study was to identify remediable factors in the care provided to people who were receiving, or had received, long-term ventilation (LTV) up to their 25th birthday. Data were collected to achieve an overall view of the care provided to this group. Data presented in the report highlights: the number of people identified on LTV during the study period; the clinical care provided to a subgroup of people on LTV; the organisation of LTV services; the views of service users, parent carers and health and social care professionals providing the care. The five key messages were agreed as the primary focus for action, being derived from 12 recommendations from the full report. Formalisation of the service planning and commissioning of LTV services through an integrated network of care providers is required. Improved access to an appropriate multidisciplinary care team is needed to ensure people on LTV and their parent carers can be supported in the community as well as during an admission to hospital. Templates for Emergency Healthcare Plans should be developed and standardised for people receiving LTV. Active discharge planning should start at the point of an admission and include all relevant members of the integrated care network to enable a prompt and safe discharge home or to other community services and reflect changes in care. Transition planning should minimise disruption and prepare for any necessary changes that will occur. There should be no gap in the provision of LTV care.
NCEPOD Acute Bowel Obstruction – Delay in Transit – published January 2020	This study has highlighted significant opportunities to improve the care of patients with acute bowel obstruction. The overarching finding: Significant delays in the pathway of care for this group of patients, from requesting imaging, diagnosis, decision-making and availability of an operating theatre. There were delays in imaging in 57/276 (20.7%) of the cases reviewed and the delays increased if an abdominal X-ray was performed as well as an abdominal CT. Delay in imaging led to a delay in diagnosis in 35/57 (61.4%) patients whereas only 14/219 (6.4%) patients had a delay in diagnosis with no delay in imaging. Delays in consultant assessment led to a delay in diagnosis in 13/32 (40.6%) patients. Whereas only 23/147 (15.6%) patients who were seen in a timely manner by a consultant experienced a delay in diagnosis. Following diagnosis 72/368 (19.6%) patients experienced a delay in access to surgery and in 38/72 (52.8%) patients the delay was due to non-availability of theatre and in 34/72 (47.2%) it was due non-availability of an anaesthetist. There was room for improvement in the clinical care of this group of patients. Risk and frailty assessments were variable. Risk assessment

	Report Title
	is important as patients who had a risk assessment had better escalation of care, however this was inadequate in 98/219 (44.7%) patients. Similarly, only 34/124 (27.4%) patients over 65 years of age had their frailty score assessed on admission to the ward and if patients did have a Rockwood frailty score of 5 or higher this was more likely to result in discussions around mortality Only 163/686 (23.8%) patients had their hydration status recorded, 105/254 (41.3%) patients either had no nutritional status assessment or the assessment was inadequate and only 88/233 (37.8%) patients had a nutrition assessment on discharge. The areas for improvements in care highlighted in the report, and the recommendations made, have the potential to improve the care of a large proportion of surgical patients. This should lead to measurable improvements in outcomes and enhanced patient care.
NCEPOD Mental Health in Young People and Young Adults – published September 2019	These are the key messages from this highly complex report: 1. Mental healthcare was not given the same level of importance as physical healthcare in general hospitals. 2. General hospital staff were not receiving enough support from mental health professionals in the general hospital setting, particularly with regard to risk management. 3. Planning for the transition of care from child to adult mental health services, particularly in secondary care was not always done well. 4. Clinical information related to patients with known mental health conditions was not always communicated at the interface between healthcare providers or between the multidisciplinary clinical groups caring for the patient

2.5 The reports of 17 National Clinical Audits were reviewed by the provider in 2019-20

2.6 The table below summarises the audit outcomes and the actions taken as identified by the review undertaken:

Audit / Clinical Outcome Review Programme	What this Trust learnt
National Paediatric Diabestes Audit (NPDA) **Published September 2019**	The NPDA Spotlight reports on staffing and technology (including unit level reports to compare to regional and national levels). Findings include: • DCHFT staffing levels are low for consultants and psychologists, but average for nurses and dietitians • DCHFT is unusual in not having a dedicated transition clinic young people moving to the adult service • Administrative support averages not supplied as so many units had none. DCHFT is therefore better than many • DCHFT has fewer patients on pumps than other units regionally or nationally • Use of glucose monitoring devices above average

Audit / Clinical Outcome Review Programme	What this Trust learnt
	Good performance - good admin support, meet requirements for offering clinic appointments, have robust 'Did Not Attend' policies in place Actions: Identified shortage of consultant time impacting on nursing workload, currently vacant dietetic role also impacted on ability to deliver, shortage of psychology time. Staffing and skill mix review to be completed.
National Diabetes Foot Audit (NDFA)– published May 2019	The report covers a 3 year period (2015-8). Improved quality of data Inclusion of new referrals into the audit increased from 8% to 30%. Also with regards to outcome of patients entered into audit, DCHFT 'loss to follow-up' or 'unknown' is now 0%. This has fallen significantly from 22%. This has improved the quality of the data and allows a better comparison of outcomes from year-to-year and against national levels. Hospital admissions Foot admissions and Length of Stay are comparable to national average. Severity of ulcer At DCHFT 55% of ulcers were classified as severe at diagnosis compared with 44% nationally. Patients at DCHFT were more likely to have ischaemia and neuropathy compared to others in England. Outcomes at 12 weeks 50% of DCHFT ulcer patients were ulcer free if seen within 14 days. The same value was 33% if seen after 14 days Actions: As much of the data is historic, continue to submit data and review for national analysis
National Diabetes Inpatient Audit – Harms May 2018 – June 2019	National report was for 6 months (May 2018-Oct 2018) 750 harms from 77 hospitals (99 registered for NADIA-harms) Local register 7 harms submitted 1 May 2018 – Jun 2019 2 DKAs (Diabetic Keto-Acidosis) 2 foot ulcerations 3 severe hypos requiring iv/im rescue therapy Actions: The figures for DCHFT are too small to compare against National figures. Work is ongoing with the foot team and pre/peri operative teams to optimise offloading of feet when patients are in hospital.

Audit / Clinical Outcome Review Programme	What this Trust learnt
Learning Disabilities Mortality review – Annual Report 2018 – published May 2019	The CCG now produces quarterly reports on the LeDeR reviews carried out locally. These are shared with the Hospital Mortality Group and the Safeguarding Group. Areas of good practice at DCHFT: Link on public-facing website to LeDeR Programme Hospital Learning Disabilities Champions receive updates on LeDeR at their meetings LD Framework and Policy in place
Chronic Obstructive Pulmonary Disease (COPD) - Clinical Audit Report 2019:	Retrospective results for England and Wales examining the quality of care for patients with COPD admissions, examining process measures, length of stay, readmissions and mortality. There is no data in the report individualised for DCHFT. DCHFT are undertaking a Quality Improvement project to enhance completion of the COPD discharge bundle. Unfortunately Covid19 has put this on hold temporarily
Sentinel Stroke National Audit Programme – Annual Report 2019 – published June 2019	This complex report is reviewed on a quarterly basis through the Stroke Steering Group. Analysis and actions are reported and available in the published report.
National Diabetes Audit: Core Report 1 – Care Processes and Treatment Targets – published June 2019	This annual national diabetes audit looks at: • If all patients with diabetes diagnosed and recorded on a register • If they receive 9 care processes • The percentage achieving NICE targets for glucose, Blood Pressure and cholesterol control • Percentage offered and attended a structured education • The rates of acute and long term complications. There is no DCHFT specific data back from this audit at present
National Prostate Cancer Audit	The report for this audit is reviewed through the regional network, as data collection incorporates DCHFT, Poole and Bournemouth Hospitals.

Audit / Clinical Outcome Review Programme	What this Trust learnt
National Diabetes Insulin Pump Audit (18-19)	There were 2 key recommendations from the National Audit report: • More patients with Type 1 diabetes should be considered for pump treatment in line with NICE guidance. • Variations in pump use between specialist centres should be investigated. Actions: Increasing capacity for the insulin pump service is a high priority for business planning and strategic development in the next year.
National Audit of Dementia Round 4	Change in requirement nationally from dementia screening to screening and recognition of delirium. DCHFT delirium screen patients using a modified module on Vital Pac. "This is Me" document is used at DCHFT and this is being embedded for suitable patients. Good ongoing communication with families and carers of patients with dementia, including information and written resources on admission, a private space for discussions, a record of discussions in patient notes and provision of out-of-hours visiting. DCHFT provides a good level of user-friendly, relevant training for staff. Environmental reviews using PLACE are carried out, leading to redesign of some ward layouts to make them more appropriate for individuals with cognitive impairment. Where possible, movement of patients with dementia are kept to a minimum, and take place as early in the day as possible. The hospital is signed up to the Dementia Action Alliance 2018 Charter and will work to distribute and display an annual Trust statement on dementia Care.
National Heart Failure Audit 2018	The audit data has been entered for approximately half the number of patients eligible for participation. Drug therapy on discharge compares well to National figures.
British Thoracic Society Community Acquired Pneumonia	This audit looks at treatment of patients admitted with Community Acquired Pneumonia (CAP) measured against nationally agreed standards. All patients admitted over the audit period, with CAP confirmed by chest x-ray (CXR), were included. The key findings were improved mortality compared to previous audits (DCHFT 7%, National 10%); time between admission and CXR 145m (National 173m) ; time between admission and first antibiotic 219m (National 230m) ; good adherence to the local antibiotic guideline 98% (National 58%); prompt administration of antibiotics and timely senior review. Actions: Identification of how further improvements can be made is being discussed at the clinical speciality group meetings

Audit / Clinical Outcome Review Programme	What this Trust learnt
Cardiac Rehabilitation 2019	This National Audit of Cardiac Rehabilitation data shows that each year DCHFT cardiac rehabilitation service improves and the comprehensive annual audit shows that DCHFT's service provision is far in excess of that provided by the majority of the cardiac rehabilitation centres within the UK. DCHFT cardiac rehabilitation service is efficient and effective in engaging with all patients, through the use of the cardiac event follow-up clinic which ensure that DCHFT sees all cardiac patients who have had heart attacks, coronary angioplasty +/- stents, coronary bypass surgery, valve surgery and other structural heart surgery. DCHFT receive referrals to the heart failure cardiac rehabilitation program from both the hospital and community heart failure nurses when the patients are appropriately stable on their optimal medication.
Epilepsy 12	Local results of this audit are reviewed as and when the reports are published. At DCHFT, there are sufficient general paediatricians with expertise in epilepsies to correctly diagnose epilepsy and provide appropriate ongoing management for all children with epilepsy. Since the last report, DCHFT has appointed a 0.5 WTE specialist epilepsy nurse to ensure ongoing support for this group of children. DCHFT is compliant with provision of epilepsy follow-up clinic capacity and providing epilepsy services fulfilling best practice criteria.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) 2017 – summarised Nov 2019	Preterm birth Named consultant in place who reviews women throughout their pregnancy at risk of pre-term birth. There is a smoking cessation service in place with dedicated midwives working with a Pan Dorset approach. All women have CO (Carbon Monoxide) screening at every antenatal appointment. Continuity of care is being explored as a model of care and will be piloted in one area initially. Currently women who are under the age of 20 are case load managed by named midwives. At DCHFT, a small group of staff have had training to provide unbiased counselling. If this staff group are not available, staff from the bereavement office will assist with this process. <u>Actions:</u> No further actions required at present
National Ophthalmology Database Audit 2019	DCHFT has yet to submit to this continuous audit.
National Early Inflammatory Arthritis Report –First Annual Report	DCHFT started submitting data to this audit in March 2019, having previously lacked ability to participate. From June 2019 to May 2020: 157 patients recruited. Analysis of data currently being undertaken

Audit / Clinical Outcome Review Programme	What this Trust learnt
Hip Fracture Database 2019 Report (2018 data)	Key findings: 85.9% of patients had surgery within 36 hours of admission; 90.6% of patients had medical assessment from orthogeriatrician within 72 hours of admission. DCHFT performs well in length of stay, with an average of 14.7 days. Actions: Provision of orthogeratrician service/expertise is being reviewed by the division to enhance this service
Adult Asthma Report 2019 – published December 2019	These are the initial findings of the National Asthma Audit which looks at a variety of quality indicators, most notably the measurement of Peak Expiratory Flow Rate within 1 hour of admission, the asthma discharge bundle being completed and smoking status being addressed. DCHFT figures are low relative to other hospitals. These figures are regarded as the baseline figures, since no intervention has been undertaken to achieve these standards. Actions: DCHFT are undertaking a QI project to improve completion of the COPD discharge bundle. Unfortunately Covid19 has put this on hold, though DCHFT are continuing to review the first data from February.
National Smoking Cessation 2019	DCHFT has an older population than the National aggregate 74years (67years national). Documentation of smoking status has declined since previous audit, and is below the National figure – 70.3 %(76.8% National). The percentage of patients being asked about quitting and being offered nicotine replacement therapy has improved from 16.7% in 2016 to 41.2% in 2019(national figure 30.7%). Actions: DCHFT was participating in a pan-Dorset approach to smoking cessation in conjunction with Public Health England, unfortunately this was placed on hold due to Covid -19, but is imminently about to restart.

Local Clinical Audits

Local audits are carried out by the specialties in relation to areas of their work. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 176 local audits were registered during 2019-20 and work will continue to see these through to completion.

2.7 The reports of 161 local clinical audits were reviewed by the provider in 2019-20.

2.8 A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

Name of Audit	Finding	Outcome
4338 - Heparin use during diagnostic angiograms using the trans radial approach to reduce the incidence of radial artery occlusion (RAO). An audit of potential impact on bleeding complications post procedure at Dorset County Hospital.	This study aimed to look at whether there were increased bleeding complications in patients undergoing diagnostic angiogram, who were given heparin and those who were not and whether there was a significant increase in the time taken to remove the TR band (radial artery compression device). The study found that there was no significant difference in time to removal of TR band 73.5 minutes for those receiving heparin, compared to 69.5 minutes for those not receiving heparin	Giving heparin 5000 IU during a diagnostic angiogram using the trans-radial approach is known to reduce the incidence of RAO from previous studies and this study has demonstrated that, at a local level, there is no significant increase in bleeding compared with those who do not receive heparin. This approach will be adopted by the Cardiology Department as standard practice.
4774 - Atrial Fibrillation and DC Cardioversion Audit January 2017 to December 2018	The audit aims to assess the Nurse Led Arrhythmia Clinic and Cardioversion Service; The audit found a majority of referrals are from Primary Care and referral into clinic is a variety of ages but mainly older population, with a vast majority of patients on anticoagulation prior to being seen in clinic. 4 out of 10 patients are referred on for Cardioversion, which is the main premise of our service and there is a short waiting time for Cardioversion, which in turn is helping increase the chances of patients holding sinus rhythm. Low adverse outcomes which concludes that Cardioversions are safe	To review the audit data collection process, findings and excel spreadsheet: this will help with onward understanding of how to improve the service and data collection further. To ensure data collection is entered in a timely manner so as not to spend vast amount of time entering data retrospectively. To develop a more efficient Excel spreadsheet for data recording/collection and register a new audit.
4765 - Palpitations Clinic Audit	The aim of this audit was to assess the nurse led palpitations clinic service. To continue to make improvements in order	Steady referral rates. Actual waiting times from the GP referral much longer.

Name of Audit	Finding	Outcome
	to maintain the standards described in the Clinic Policy. (Nurse led palpitations clinic policy). Key findings were: Steady referral rates Average waiting times from referral into clinic to clinic appointment 6-8 weeks Most common diagnosis: Ectopy and Cardiac Awareness 10% pick up for pathology 48% patient in 2018 were not diagnosed at their first visit; further monitoring was needed	Direct referrals to palpitations clinic (via ICE) may improve the referral process/patient experience. Advice on referral offering 'monitoring only' option if symptoms suggestive of ectopy, to support GP managing the case without the need for a secondary care clinic. Refining the referral process to include key questions to individualise appropriate monitoring chosen is likely to improve the % of patients diagnosed at first visit
4744 - Audit of compliance with Dorset County Hospital Diabetic Foot Infection (DFI)antibiotic policy	Overall compliance with antibiotic choice being generally good and for those apparent non-compliances, there was justification or discussion with microbiology. There was significant non-compliance with respect to length of antibiotic courses for DFI soft tissue infection. It was found the average length of time until patients can be scanned is difficult to shorten, but this is a factor in lengthening antibiotics courses	The audit results have been disseminated and it has been recommended that the DCHFT DFI antibiotic policy is followed with respect to length of antibiotic courses for DFI soft tissue infection and microbiology sampling is performed before starting or changing antibiotics, sampling tissue scrapings, pus, ulcer fluid.
4736 - Dorset Cancer Partnership Patient's Views of Lung Cancer Services and Separate Carer's/Partner's View of Lung Cancer Services	2 yearly review of Patient Satisfaction of Lung Cancer Service provision in Dorset as agreed in the Dorset Cancer Partnership Operational Policy and individual Trusts' Lung MDT Operational Policy. When given diagnosis 100% felt they had enough time to discuss anything they needed to 100% of patients also informed that tests, treatment or plan of care was explained in a way they could easily understand 100% felt they were treated with dignity and respect 86% pf patients were told of diagnosis with LCNS (Lung Cancer Nurse Specialist) present Patient information –verbal/written- Your diagnosis-89% Your treatment-92% The lung cancer team-96% Helping you make decisions about	Patients being aware that they can ask for a copy of letter sent to GP Provision of LCNS contact details being given out Increase provision of Holistic Needs assessment forms, with help of Macmillan Support Worker Financial support information-ensure available in information pack Support organisations-ensure available in information pack 33% of patients would find it helpful to have a phone call 24-48 hours after being given diagnosis

Name of Audit	Finding	Outcome
	managing your illness-89% Where to get help if you need it-92% Coping after treatment-80% Follow up-96% Smoking cessation-80%	
4661 – An Evaluation of the effectiveness of triage calls to the Cancer helpline 2019	The Acute Oncology Service provides a 24 hour telephone triage service for patients receiving chemotherapy and other supportive treatments. This monthly audit This will look at time and day of call, cancer site of patient, reason for the call, what advice was given, if a follow up was needed/made, if the patient attended or was admitted to the hospital and who took the call and then followed up the call. The initial service evaluation audit will give an idea of who is managing the majority of the calls, if a hospital admission was necessary or could have been avoided, the most common cancer site that calls are taken from and the most common reason for the calls received. The findings showed that patients with breast, colorectal, haematology or lung malignancies are the most common sites that call for telephone advice and the most common reason for calling is not found on the drop down options.	In conclusion on average 50% of calls are taken by the Acute Oncology Service and 50% by Fortuneswell ward staff. The triage log indicates that the majority of calls are for other reasons and not those specified in the drop down list. Patients with breast, colorectal, haematology or lung malignancies are the most common sites that call for telephone advice and the most common reason for calling is another reason not one found on the drop down options. This audit recognised that patients are appropriately advised following the triage service. On average 120 calls are taken per month.
4559 - Efficacy of Physiotherapy treatment for Patients with urinary dysfunction and/or prolapse.	The results of this patient survey underpin the benefit of physiotherapy treatment for women with urinary dysfunction and or prolapse. 100% of patients found the advice and treatment offered helpful, and 94% found the EMS (Electrical Muscle Stimulation) beneficial.	Expansion of the service will be required to meet increasing demand for non-surgical treatment of these symptoms.
4536 - Implementation of MUST at DCHFT	This audit aims to identify the level of accurate completion of the Malnutrition Universal Screening Tool (MUST) tool and implementation of the action plan for the adult inpatient population over a 3 week period. Completion of MUST is a requirement for adult inpatients at DCHFT. The results indicate a shortfall in the screening of patients for malnutrition and the treatment of those patients identified at risk, falling to 64%(from 71% in 2017) of MUST scores completed/attempted within 24h of	Calculation of MUST should be carried out on Vital Pac. Cascading the use of MUST to be supported through the ANTs link nurse group, and the NHS-I Nutrition Collaborative project team. Further work with the catering department to adapt menus and improve snack provision to patients identified as requiring a high protein/high calorie menu.

Name of Audit	Finding	Outcome
	admission. Implementation of action plans for patients with a MUST score ≥1 has reduced from 44% to 28%. Recording of actual weight has decreased significantly from 62% to 42%, despite all wards having access to weighing scales.	Progress against the action plan will be monitored through the Nutrition Steering Group.
5012 – Adult Nasogastric Tube (NGT) Audit 2020	This internal clinical audit sample is aimed to ensure that procedures are carried out as per policy guidelines, the rationale for NGT is documented and that 100% of NGT placement has been clearly documented in the patient's medical notes with written entries or a NGT sticker. It will monitor standards across the Trust to reduce harm from misplaced NGT and compliance with standards for ongoing checks of tube position; identifying cases where pH is not used first line to check position and ascertain why not. Findings showed that recording of important information, date and time of insertion, and measurement at nose once inserted and pH measurement is only being carried out 66% of the time; 67% of patients had a pH test as first line method and 16% were found to have X-rays to check the position of NGT that had already been confirmed by pH testing.	It is recommended that further training and evaluation of training methods used is necessary to achieve 100% compliance in all areas. I.e. work books, study days, junior doctors training, including training on pH testing. Introduction of Nutricare NGT will provide all equipment needed to safely position a NGT at the bedside and will be more cost effective long term and safer for patients if x-ray confirmation is needed. Compliance with NSPA guidance needs to be audited yearly to note any improvement since training and for future development of staff within clinical areas where NG feeding in necessary.
4327 - End of Life Care (EOLC) Quality Audit - 2018/2019	This annual audit monitors the quality of care provided at the end of life provided in DCHFT including identifying areas for improvement and tracking progress in meeting quality standards. The audit found that: • 90% of our patients receive either good or adequate end of life care • 34%good, • 56% adequate This could be significantly improved if the End of Life Care Plan was fully embedded into routine practice.	Increase the use end of life care plan. Asking patients about their concerns, wishes and preferences. Improve our holistic assessments, within the context of the EOLC. Discuss with both the patients and their families the need for clinically assisted hydration to minimise concerns and anxieties as the patient approaches end of life. This audit is monitored through the End of Life Group
4578 - Current smoker identification and smoking cessation provision in acute adult patients	This local audit was carried out following participation in the National Smoking Cessation audit to identify areas for improvement in delivering smoking cessation advice. Smoking history is poorly documented on admission, with a low incidence of referral to smoking	Accurate smoking history should be taken on admission, and discussion with regards cessation advice and pharmacotherapy documented within the notes. LiveWell Dorset, who provides support for smoking cessation, will

Name of Audit	Finding	Outcome
	cessation services and offer of nicotine replacement therapy.	be approached to provide training to Ward staff to improve referral rates.
4858 - 6 Week Chest X-RAY (CXR) following diagnosis Community Acquired Pneumonia	A retrospective audit to establish whether all patients with radiologically diagnosed community Acquired Pneumonia in hospital have a follow up X-Ray booked. The findings between December 2018 and January 2019 a total of 107 patients were admitted to DCHFT with radiological confirmed Community Acquired Pneumonias. Of the 107 patients; 10 died on admission, 51 had no mention of a follow up CXR on their discharge summary and 46 had a follow up CXR on their discharge summary as well as an ICE request. 53% had no CXR follow up; 47% had follow up.	It was evident from the results that the majority of patients in DCHFT did not receive adequate follow up following a diagnosis of pneumonia. Over half of the patients admitted with pneumonia had no CXR booked or documented on the discharge summary. It is recommended by January 2020 all inpatients with a radiological diagnosis of pneumonia on admission should have a 6 week CXR booked on discharge and their name and details added to the Careflow list. This list will be updated and monitored by the Respiratory team and abnormal follow up radiographs will be escalated as appropriate.
4434 - Direct Oral Anticoagulant (DOAC) Therapy for Stroke Prevention	The audit looks at accuracy of prescribing of DOAC's in term of dose, drug interactions and INR, if switching from warfarin, and adequacy of transfer of information in EDS. Overall 13% of prescriptions were inappropriate, made by a variety of junior grade staff. 82% of patients had the change in DOAC therapy mentioned in their EDS; however, due to a recent version upgrade on JAC, the pharmacy discharge wording was not being pulled through. We are not currently meeting our standards for either DOAC prescribing accuracy or transfer of information to GPs on Electronic Discharge Summary paperwork, and due to the nature of anticoagulants this is potentially hazardous.	Patient weight is essential for accurate prescribing and should be recorded electronically on Vital Pac/JAC. All patients commenced on DOAC should have their creatinine clearance calculated and dose should be checked with consideration of renal function, age and body weight. All EDS should have the relevant section completed regards medication changes where this applies in order to best highlight these to GPs. Highlighting the ongoing monitoring requirements/ interval would be even better. The actions from this audit will be monitored through the Pharmacy Medicines Committee.
4546 - Management of Hyperkalaemia in Adults	Hyperkalaemia is a potentially life threatening condition associated with cardiac arrhythmias. The audit aim was to compare the management of DCH inpatients with a potassium (K+) ≥ 6.0mmol/L with the audit comparison standard (100%)	The outcome of this audit have been discussed at Medicines Committee and recommendations made. These include implementation of a Trust algorithm to ensure standardised management and adherence to

Name of Audit	Finding	Outcome
	83% of patients with serum Potassium ≥ 6.0mmol/L had a 12 lead ECG performed prior to treatment; 100% of patients with a serum value ≥ 6.0 mmol/L and an ECG showing features of hyperkalaemia who had their 12-lead ECG repeated following treatment; The frequency of ECG changes in patients treated with intravenous calcium salts 9%; Severe hyperkalaemia (K+ ≥ 6.5 mmol/L) treated with insulin-glucose infusion 80%; Patients in whom serum K+ was measured at least once within 2 hours of treatment for severe hyperkalaemia 20%	ECG and potassium monitoring, a prescribing bundle on JAC to reduce discrepancies, and education for hospital staff on the new treatment algorithm.
4994 - Acute Management of Potential Neutropenic Sepsis on presentation to ED (re-audit no.8 #4861)	The sample of patients captured retrospectively for this audit attended DCHFT Emergency Department (ED) between January 1st 2019 and December 31st 2019 with potential neutropenic sepsis (NS). As per previous audits, NS is a medical emergency and can become rapidly life threatening and needs prompt treatment. Door to needle time should be 1 hour (60mins) or less and is defined as neutrophils of less than 0.5 x 109. The aim of the audit is to review results from this audit and establish any changes that can be implemented. Key findings showed that 24% of all cases attending ED with presumed NS received IV antibiotics (IVAB) within 1 hour compared to the 100% target; 44.5% received IVAB but after 1 hour and 31.5% did not receive any IVAB at all. Therefore, this has decreased from 27% in the previous audit and is still down from other audits of over 70% and 30% of confirmed NS patients received IVAB in under an hour (previously 45%).	Learning from this audit highlights obvious concern with regards to the low percentage of door to needle administration of IV antibiotics of less than an hour in those with suspected neutropenic sepsis. It also includes recognising, establishing IV access, giving IV antibiotics early and documenting accurately these times remains a challenge in patients with potential neutropenic sepsis in DCHFT ED. This chain of events falls foul on multiple levels and is work in progress in an increasing demanding, busy and crowded department. Therefore ongoing education and awareness of ED staff of target, low threshold for treatment, not waiting for blood results and collaboration with Sepsis/IT teams. Improve documentation, IT systems, ED workspace.
4718 - Breast Cancer Surgery re-excision and completion mastectomy rates at DCH 2017	For re-excision and completion mastectomy rates for screen detected (BSU) breast cancers 2017 in comparison with NHSBSP Guidelines for Surgeons in Breast Cancer Screening, DCHFT achieved: Re-excisions for BSU cases – 17% (national 10-25%)	Where the targets have been achieved, we aim to maintain the standard of service. Looking ahead, One Dorset Pathology and a new IT system should help to improve performance in currently failing areas.

Name of Audit	Finding	Outcome
	Re-excisions for symptomatic breast cancers – 9% (national 10-25%) Cancer resection reports contained structured data 100% (national 95%) Turnaround time (TAT) for lymph node biopsies, mastectomy (BSU), WLE (BSU) and re-excision (BSU) all failed to meet target adherence due to work force logistics.	
4554 - Re-Audit of Decompensated Cirrhosis Management After Introduction of a Care Bundle	This audit aims to assess whether introducing a decompensated cirrhosis care bundle, tailored to DCHFT has improved the performance of several actions in the initial of management of the disease. The audit demonstrates significant improvement in performance of diagnostic ascitic taps including within the first 6 hours of admission, and major improvement in the performance of blood cultures within the first 6 hours of admission. There is some ongoing uncertainty around use of LMWH in cirrhotic patients with raised INR. Minor improvements in other areas that were already identified as good on previous audit.	The introduction of a decompensated cirrhosis care bundle alongside education on its use has helped improve the performance of several key standards identified as poor in the initial audit.
4860 – Compliance of Pre-treatment checklist for Ultraviolet Violet B (UVB)/Psoralen Ultraviolet Light A (PUVA)	The aim of the quality audit is to review 10 sets of notes retrospectively to check compliance of the Pre-treatment checklist. This follows a significant patient incident a pre-treatment checklist was introduced to ensure the necessary safety checks were undertaken prior to phototherapy. This audit reviews the completeness of these checklists. The findings showed that a significant patient incident a pre-treatment checklist was introduced to ensure the necessary safety checks were undertake prior to phototherapy. This audit reviews the completeness of these checklists.	The audit of pre-treatment checklists will be repeated annually and annual findings presented in January 2021.
4656 - Evaluation of the quality of service provided in the glaucoma assessment clinic	This project looks at the potential problems of the glaucoma assessment clinic as it is a new virtual clinic, and identifies more efficient ways to run it, ensuring patients are not lost to follow up and that they are still having high quality care that is in line with NICE guidelines. All the standards were met at greater than	For the most part standards have been met but the biggest problem found from the audit was notes not being virtually reviewed which would have severely put patient's care at risk. Additional training required for Nursing staff for VA/OCT machines to ensure

Name of Audit	Finding	Outcome
	80% adherence; however, the virtual clinics are not booked through PAS, leading to potential problems with patient reviews and follow up, with many follow ups taking place more quickly than recommended by NICE, which carries a potential negative impact on waiting lists.	accurate testing. Patients now added to PAS to facilitate timely follow up, and additional time allocated to virtual clinics to allow completion of reviews.
4821 - WHO checklist and Consent Form electronic documentation on Radiology Information System for Interventional Radiological procedures in 2019	This annual audit demonstrated that the year on year improvement of scanning a fully completed consent form and WHO checklist onto the RIS (Radiology Information System) has continued, with 100% compliance in 2019. This provides evidence of safe working practice as DCH moves towards a paperless system, and reinforces the value of surgical checklists.	This action has become embedded in normal practice. Annual audit will be continued to ensure this high standard is maintained.
4433 - Paediatric Review Times and Designation of Clinician Clerking	This audit was undertaken as part of the Dorset Vanguard to review consistency of practice across different Trusts in relation to senior and consultant review. 77% of children were seen within 1 hour of admission; 93.7% of all children were seen by a senior clinician (ST3 or above) and 92% of all children had a consultant review within 14 hours. This demonstrates an improvement of the previous year.	Practice has improved since the previous year. There is still room for improvement, but obviously this is limited by clinical workloads and demands. Shared responsibility for escalating concerns regarding assessment of children and learning through the daily safety huddle.
4701 - Community management of hyperemesis gravidarum- re-audit	This audit forms the basis of a service improvement project with the aim to move management of hyperemesis gravidarum out of hospital and into community. 20 women with admissions met the RCOG criteria for ambulatory management of nausea and vomiting in early pregnancy and were therefore suitable for AHAH. Of these, 8 were successfully managed by AHAH, 10 could have been managed, but AHAH lacked capacity.	Ambulatory care management should be used for suitable patients when community/primary care measures for severe nausea and vomiting in early pregnancy have failed. An updated guideline for Hyperemesis will be produced and a prescribing bundle on JAC. Further analysis of potential cost saving of inpatient stay versus AHAH to be carried out.
4661 Fluid Balance Charts – a Snapshot Audit Over Medicine and Surgery	Accurate fluid balance allows appropriate fluid resuscitation and maintenance. This is significant especially in critically sick individuals such as septic patients, cardiac/renal failure and those with high output stomas or obstruction. Out of a sample group of 86 patients, 60% had total intake/output/balance recorded, although only 105 of these were accurate. 73% of patients had at least 1 hour where	Fluid balance charts are incredibly important for acutely unwell patients and are not being filled in accurately or acted on to a safe standard. A QI project to introduce a redesigned fluid chart will be carried out, with education for junior doctors, nursing and health care assistants around fluid

Name of Audit	Finding	Outcome
	urine output was recorded as <30mls, which should have triggered escalation, but only 6% of these had escalation documented in nursing notes, and 12% recorded by doctors. 68% of fluid charts did not accurately reflect IV fluids and boluses prescribed on EPMA; 76% of fluid charts included a reason for starting, just 1% had an estimated time of completion.	prescribing and fluid balance recording to support this. Outcome report shared with lead nurse for deteriorating patients.

3. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2019 -2020 that were recruited during that period to participate in research approved by a research ethics committee was 983.
This is our lowest level of involvement in the last few financial years and reflects a sustained drop due to continued cuts in NIHR funding and resource, and represents 104% of our target recruitment for this period.

However it is worth noting that this period has seen successes in opening up new areas of research (ophthalmology, maternity) and some large-scale studies such as EMPA, Orion-4, and HERITAGE, as well as some unforeseen challenges which are ongoing, but led to the opening and recruitment of Urgent Public Health Covid-19 studies in short time, (CCP and RECOVERY) and recruitment to these studies.

4. A proportion of the Trust's income in 2019- 2020 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment framework.

4.1 In 2018 – 2019 2.07% of our clinical income depended on achieving these goals. This equated to £3,300,618, of which we secured £3,300,850 (100%).

In 2019 – 2020 0.96% of our clinical income depended on achieving these goals. This equated to £1,754,627 of which we secured £1,756,787 (100%).

The change in percentage is due to national rules reducing the amount of Income being linked to the Commissioning for Quality and Innovation Payment framework.

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

5.1 The Trusts current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2019- 2020.

(Section 6 was removed from the legislation by the 2011 amendments)

7. The Trust has not participated in an inspection by the CQC during the reporting period.

7.1 The Trust was rated 'Good' overall by the CQC following inspection in July – September 2018. The areas identified as both 'Must – do's' and 'Should – do's' were collated into a Trust wide improvement plan, with many of the actions now completed. Evidence has been submitted to ensure that the CQC are satisfied that we have now addressed their recommendations, and this is shared at the local quarterly meetings with the CQC.

The ratings grid below, as published by the CQC on its website, shows the ratings given to the core services and five domains at the time of their inspection (please note some areas were not re-inspected in 2018 following the 2016 inspection, therefore the 2016 rating stands for those services until the CQC re-inspect and rate accordingly):

Ratings for Dorset County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑ Oct 2018	Good ↑ Oct 2018
Medical care (including older people's care)	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good ↑ Oct 2018	Requires improvement → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑↑ Oct 2018	Good ↑ Oct 2018
Outpatients	Good Oct 2018	N/A	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018
Diagnostic imaging	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Overall*	Requires improvement → ← Oct 2018	Good ↑ Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑ Oct 2018	Good → ← Oct 2018

8. The Trust submitted records during 2019 -2020 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:

	2015/16	2016/17	2017/18	2018/19	2019/20	National Average
Admitted Patient Care	99.9%	99.9%	99.9%	99.9%	99.9%	99.5%
Outpatient Care	100%	100%	100%	100%	100%	99.7%
Accident and Emergency Care	99.2%	99.2%	99.1%	99.0%	99.2%	97.8%

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

	2015/16	2016/17	2017/18	2018/19	2019/20	National Average
Admitted Patient Care	99.9%	99.9%	100%	100%	100%	99.8%
Outpatient Care	99.9%	100%	100%	100%	100%	99.8%
Accident and Emergency Care	99.5%	99.7%	100%	99.8%	100%	98.2%

9. Dorset County Hospital has continued to progress the actions identified within the 2018/19 Data Security and Protection Toolkit (DSPT) Action Plan agreed with NHS Digital. A key area of work was to ensure compliance with the National Data Opt Out policy allowing people to opt out of their data being utilised for secondary purposes (research / service developments etc.) by March 2020. Priorities arising from the COVID-19 pandemic meant that implementation of live systems to ensure compliance with this requirement was delayed until July 2020. The pandemic has also given rise to an extension to the submission date for the 2019/20 DSPT until 30th September 2020.

The Trust has appointed an Information Assurance Manager who will take forward respective elements of the DSPT requirements and the post of Information Governance Manager was also advertised in July2020.

As at the end of March 2020, the Trust was compliant with 31 of the 44 assertions within the DSPT and 5 of the 10 national standards. Work continued into 2020 to gain greater compliance with the standards and a number of key appointments have been made to ensure the achievement and maintenance of standard for the remainder of the year.

10. The Trust was not subject to the Payment by Results clinical coding audit during 2019 – 2020.

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

- New post of Information Assurance Manager has been created and appointed. Part of this role is to work with the Business Intelligence Team to identify data quality issues and work to resolve.
- Data quality metrics and reports are used to assess and improve data quality. The Data Quality Maturity Index (DQMI) and the Secondary Uses Service (SUS) Data Quality Dashboards are monitored and reports run on a daily/weekly/monthly basis via our PAS system and the Data Warehouse to highlight and address areas of concern.

27 Learning from Deaths

The Trust reviews all patients that have died and identifies from those patients that require further in depth reviews, using the Learning from Deaths national guidance. ('*National Guidance on Learning from Deaths*', National Quality Board, March 2017).

27.1 During April 2019 – March 2020 805 of DCHFT patients died. This compromised the following number of deaths which occurred in each Quarter of that reporting period:

- 171 First Quarter
- 178 Second Quarter
- 185 Third Quarter
- 271 Fourth Quarter

27.2 By 30/06/2020 157 case record reviews and 6 investigations have been carried out in relation to 805 of the deaths included in item 27.1.
In 6 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:

- 38 First Quarter
- 53 Second Quarter
- 35 Third Quarter
- 31 Fourth Quarter

27.3 4 representing 0.49% of the patient deaths during the reporting period are 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:

- 3 of 171 representing 1.75% for the first Quarter
- 1 of 178 representing 0.56% for the second Quarter
- 0 of 185 representing 0% for the third Quarter
- 0 of 271 representing 0% 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).

27.4 Summary of what the provider has learnt from case reviews and investigations conducted in relation to the deaths in 27.3:

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 all patients who suffer a cardiac arrest are automatically subject to an SJR.
A variety of positive good practice anecdotes and themes were noted in a high proportion of the record reviews, and these can be summarised:

- Rapid CT scan after admission
- Rapid consultant review noted in surgery, ICU, neurosurgical
- High quality of medical clerking
- 'Sepsis 6' completed within 30 minutes of admission, clear and timely family discussion
- High proportion of consultant delivered care

Anecdotes noted for improvement have been identified in a small number of case reviews, and these include:

- Failure to promptly recognise significance of elevated serum lactate in two cases
- Femoral fracture not reviewed by Elderly Care
- Patient not seen promptly by senior clinician
- Probable missed opportunity for instigation of palliative care pathway
- Nutritional status inadequately assessed

Themes identified in more than two SJRs and which have been identified for possible QI projects are itemised in 27.5 below.

27.5 A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the e provider has learnt during the reporting period.

Identified issues are communicated across the Trust via a newsletter, and cases of suboptimal care are forwarded to departmental Morbidity & Mortality meetings.
Themes identified from SJRs (i.e. similar aspects or incidents identified in more than two SJRs) and which are suitable for possible Trust-wide QI projects include:

- Timing & Signing of notes entries
- Legibility of written notes
- Identification of a deteriorating patient, especially where sepsis or cardiac arrest occurs
- Completeness of surgical admission clerking, both history and examination, and construction of a differential diagnosis
- Correct and timely implementation of End of Life Care pathway

27.6 An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

- Timing & Signing of notes entries – the blank note paper has been redesigned with prominent watermarks to highlight this issue. The new note paper is due to arrive in the Trust within Q3 2020/21
- Identification of a deteriorating patient is under constant review by the Trust's sepsis group
- Surgical admission clerking/differential diagnosis is now a taught session as part of FY1 education
- All case notes involving the End of Life Care pathway are reviewed by the EoLC group, chaired by a palliative care consultant, and reported back to HMG. The first report of this nature will be presented to the October HMG meeting.

27.7 36 case record reviews and 0 investigations completed after 31/03/2019 which related to deaths which took place before the start of the reporting period.

27.8 1 representing 672 (0.14%) of the patient deaths before the reporting period, are judged to have been due to problems in the care provided to the patient. This number has been estimated using the judgement score for whether death is determined more likely than not to have resulted from a problem in healthcare.

27.9 4 representing (0.59 %) of the patient deaths during 01/04/2018 to 31/03/2019 are judged to be more than not to have been due to problems in the care provided to the patient.

Reporting Against Core Indicators

Mandatory Statement 12: Mortality

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 reported of patients who were admitted to non-specialist acute trusts in England and either die while 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).

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

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

Source

https://beta.digital.nhs.uk/search/category/summary-hospital-level-mortality-indicator--shmi-

The Trust has engaged with NHS Improvement to undertake a supportive review and full analysis of mortality parameters

Mandatory Statement 18: PROMs

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

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

2019/20 to be published February 2021

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

Source

https://digital.nhs.uk/patient-reported-outcome-measures

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

Mandatory Statement 19: Readmissions

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

Readmissions within 28 days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Trend
Aged 0 to 15 years									
Total Spells	5,147	4,749	4,676	4,948	4,975	4,778	4,677	4,567	
Of which, readmitted as an emergency within 28 days	456	393	442	471	488	478	508	573	
Dorset County Hospital	**8.9%**	**8.3%**	**9.5%**	**9.5%**	**9.8%**	**10.0%**	**10.9%**	**12.5%**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Aged 16 years and over									
Total Spells	16,832	16,103	17,567	18,263	18,837	17,957	17,920	18,198	
Of which, readmitted as an emergency within 28 days	1,741	1,695	1,994	2,222	2,295	2,142	2,316	2,504	
Dorset County Hospital	**10.3%**	**10.5%**	**11.4%**	**12.2%**	**12.2%**	**11.9%**	**12.9%**	**13.8%**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	

Source Internal DCH report which follows the guidance as stated on p22 of:
https://improvement.nhs.uk/uploads/documents/Detailed_req_for_assurancefor__qual_repts_16-17_.pdf
NHS Digital has not published the recommended source reports since December 2013

Recommended Source (not available - see comment below)
https://indicators.hscic.gov.uk/webview/
Section Compendium of population health indicators > Hospital Care > Outcomes > Readmissions

To find the percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percentage, <16 years, annual trend, P" (Indicator P00913) from the NHS Digital Indicator Portal and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.

To find the percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percentage, 16+ years, annual trend, P" (Indicator P00904) and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.
Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

S:\Information\ICS Clone\28 Day Re-Admissions\QA_Methodology_Emergency_Re_Admissions.mdb
Amend dates in append query and run macro

Mandatory Statement 20: Responsive

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

Responsiveness to the personal needs of patients	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20*	Trend
Dorset County Hospital	**66.9**	**69.9**	**71.1**	**69.6**	**70.2**	**69.0**	**68.2**	**N/A**	
National average	*68.1*	*68.7*	*68.9*	*69.6*	*68.1*	*68.6*	*67.2*	*N/A*	
Lowest	*57.4*	*54.4*	*59.1*	*58.9*	*60.0*	*60.5*	*58.9*	*N/A*	
Highest	*84.4*	*84.2*	*86.1*	*86.2*	*85.2*	*85.0*	*85.0*	*N/A*	

2018/19 data publication TBC
Source
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/may-2020/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs
The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

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

Mandatory Statement 21: Staff Friends and Family Test (SFFT)

Since 2014, the Trust has asked staff on a quarterly basis if they would recommend the Trust to family or friends as a place to receive treatment. Usually, this information is gathered each Quarter 1, 2 and 4 via the staff friends and family test (SFFT). In quarter 3 this test forms part of the national NHS Staff Survey. The SFFT is currently suspended due to Covid-19. This means that 2019 Q4 data is not available.

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2016	2017	2018	2019
Dorset County Hospital	76%	76%	**80%**	**78%**
National Average (median)	70%	71%	**71%**	**69%**

Staff FFT feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	Quarter 1	Quarter 2	Quarter 4
Dorset County Hospital	86%	84%	N/A%
National Average (mean)	81%	81%	N/A%
Highest	98%	100%	N/A%
Lowest	51%	50%	N/A%

**Quarter 3 information is not included as the national staff survey takes place during quarter 3. Q4 not included as the SFFT has been suspended due to Covid.*

The Trust has taken a number of actions in 2019 to improve staff engagement and satisfaction and in turn the quality of its services. These include the delivery of the refreshed Trust-wide leadership development programme which delivers training to all staff including those within bands 4-6 alongside investment in coaching, training and development for staff. A Dorset-wide 'Leading through Covid-19' managers' toolkit focusing on psychological wellbeing is available and this has been publicised with all line managers. The Trust has continued to train our staff in Mental Health First Aid (MHFA), established a network to support our MHFAs and promote the role of our Freedom to Speak Up team.

Mandatory Statement 23: VTE

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

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

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

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

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

The Trust observed a slight decrease in this measure during this reporting year. Changes have been made to the processes for recording and improvements have already been observed.

Mandatory Statement 24: C-Difficile

Clostridium difficile, also known as **C**. **difficile** or **C**. **diff**, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others.

C-difficile rates per 100,000 bed-days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20*	Trend
Bed-days	101,156	102,674	98,654	105,719	99,883	98,908	99,751	N/A	
C-difficile cases	22	27	15	24	13	10	10	N/A	
C-difficile rate	**21.7**	**26.3**	**15.2**	**22.7**	**13.0**	**10.1**	**10.0**	N/A	
National Average	*17.4*	*14.7*	*15.0*	*14.9*	*13.2*	*13.6*	*12.2*	*N/A*	
Lowest	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*N/A*	
Highest	*31.2*	*37.1*	*62.6*	*67.2*	*82.7*	*91.0*	*79.7*	*N/A*	

2019/20 data currently not published

Source
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Mandatory Statement 25: 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.

Patient safety incidents reported	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20*	Trend
Number of patient safety incidents reported to NRLS	2,945	1,736	2,116	4,609	4,493	4,838	4,997	2,794	
Admissions	51,184	50,530	98,666	105,413	99,883	99,491	98,845	50798	
Incident rate per 100 admissions	**5.8**	**3.4**	**2.1**	**4.4**	**4.5**	**4.9**	**5.1**	**5.5**	
National Average	*7.1*	*7.7*	*3.6*	*3.9*	*4.1*	*4.3*	*4.5*	*4.9*	
Lowest	*2.5*	*3.0*	*1.7*	*1.6*	*1.9*	*1.6*	*2.1*	*2.3*	
Highest	*27.8*	*30.4*	*10.2*	*13.0*	*14.8*	*16.7*	*14.2*	*18.4*	
Incidents resulting in severe harm or death	25	3	19	25	24	22	25	19	
Percentage of incidents resulting in severe harm or death	**0.85%**	**0.17%**	**0.90%**	**0.54%**	**0.53%**	**0.45%**	**0.50%**	**0.68%**	
National Average	*0.65%*	*0.55%*	*0.49%*	*0.41%*	*0.37%*	*0.34%*	*0.32%*	*0.30%*	
Lowest	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	
Highest	*3.34%*	*3.90%*	*4.18%*	*1.74%*	*1.58%*	*1.76%*	*1.35%*	*1.60%*	

2019/20 April to September only, October to March data published November 2020

Source
https://digital.nhs.uk/data-and-information/indicators/indicator-portal-collection/quality-accounts/domain-5

The trust actively encourages staff to report incidents and 'near-miss' episodes to ensure that key learning points are shared throughout the organisation.

Part 3 – Other Information

This section of the report provides further detail on the quality of services provided or subcontracted by the Trust in the period 2019/20.

Patient Safety – Reducing avoidable harms from Hospital Falls

The Goal for 2019-2020 has not altered from previous year:

We continue to aim to reduce the number of hospital falls resulting in severe harm by 10% compared to 2018-19. (This is based on a nationally defined standard).

In addition we will be aiming to achieve 80% of older inpatients receiving key falls prevention actions

This Year the focus has very much been on the introduction of 3 high impact interventions to reduce hospital falls which include:

- Lying & standing blood pressure recoded at least once
- No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British national formulary defined hypnotics and anxiolytics and antipsychotics)
- Mobility assessment documented within 24 hrs of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit

The falls committee have reconfigured and are in the process of working through an action plan which includes specifically addressing the above interventions

A baseline audit was carried out in July 2019 and repeated in August 2019. This was then followed up by a comparable audit in Jan 2020:

Falls CQUIN 2019-20

	July 2019	August 2019	January 2020
Does the patient have a history of falls?	15/35		10/36
***Has the patient fallen during this admission?**	5/35		2/36
QQ1: Was patient bedfast or hoist dependant throughout their hospital stay?	5/35	12/57	6/36
Q1: Was the patient administered hypnotics or antipsychotics or anxiolytics during their stay?	5/35	4/45	3/36
Q1(a): Was a rationale for hypnotics or antipsychotics or anxiolytics clearly documented?	0/5	4/45	2/3
Q2: Was lying and standing blood pressure recorded at least once during their stay?	4/35	3/45	4/36
Did the patient die during their admission?	2/35		1/36
Q3: Did the patient have a mobility assessment within 24 hours of admission?	35/35	41/45	29/36
Q3(a): Was a walking aid required?	18/35	25/45	7/36
Q3(b): Was a walking aid provided within 24 hours of admission?	18/18	24/25	4/7

	July 2019	August 2019	January 2020
History of falls	43%		28%
Fall during admission	14%		6%
Hypnotic/antipsychotic/anxiolytic drugs prescribed	14%	9%	8%
Rationale for drugs documented	0%	100%	67%
Lying/standing BP completed	11%	7%	11%
Mobility assessment on admission	100%	91%	81%
Walking aid required? -yes	51%	56%	19%
Walking aid supplied to those in need	100%	96%	57%

Audit Analysis:

Lying & standing Blood pressure recording-

The numbers on vital Pac (observations) are indeed minimal however, there was evidence that this was sometimes documented in the medical notes but not on vital pac.

In mitigation Vital pac were intending on introducing their updated version on 09/03/20 to include ensuring lying & standing blood pressure is recorded within the observations for all patients over 65 (temporarily ceased due to Covid-19).

No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British national formulary defined hypnotics and anxiolytics and antipsychotics)

The numbers audited do show a very minor decline in use however, documentation regarding rationale has however improved. However this is only relative to the number pf patient having these drugs prescribed. This also links to the national dementia audit which suggest our use of antipsychotics in dementia patients has decreased. This in itself will contribute to a decrease in falls with these patients.

Mobility assessment documented within 24 hrs of admission to inpatient unit stating walking aid not required or walking aid provided within 24 hours of admission to inpatient unit

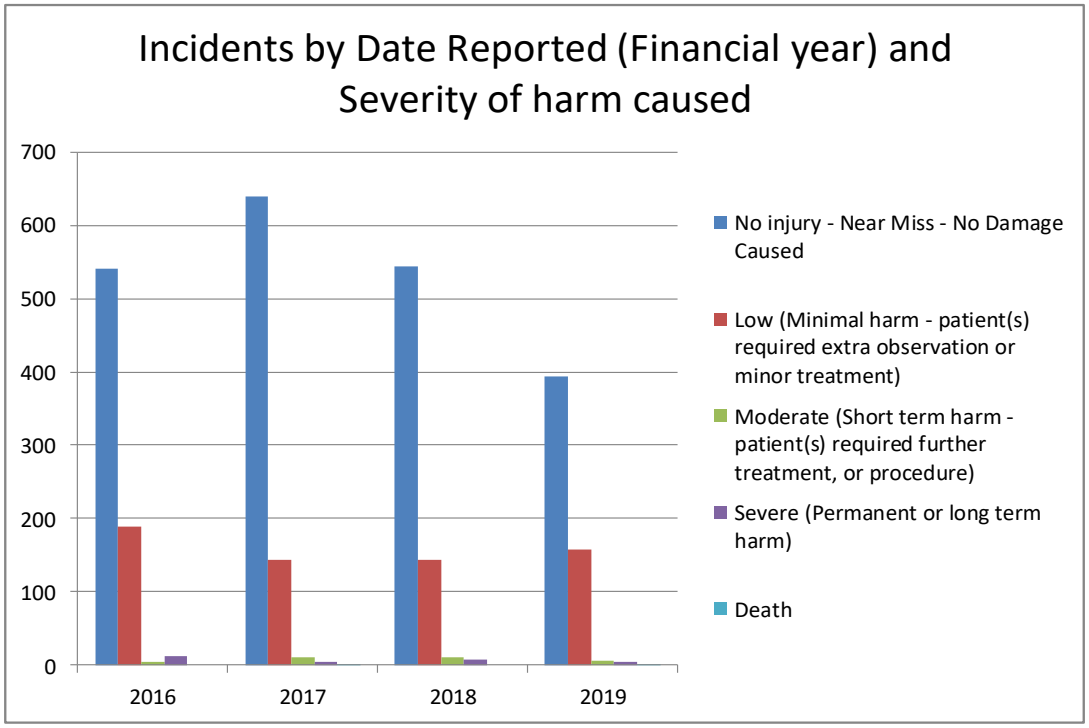
The audit for this element initially indicated excellent compliance with the interventions however there is evidence that this compliance has declined over the audit period.

It is however important to consider the contributing factors here, most notably the high vacancy factor within the therapies service for which there is a stringent recruitment drive currently in place. One could also question the availability of equipment.

Falls committee actions:

- The falls committee have a sub group that are currently reviewing the Slips Trips & Falls policy and all the related tools & checklist so as to review appropriateness and ensure it is in line with update policy, legislation & national guidance
- The committee are reviewing above bed signage and are to trial an agreed prototype on the Elderly Care wards. Signage will include falls, sight, feeding, & mobility
- Currently working with a company to gain ideas for environmental review for Elderly Care wards to maximise environmental space with the aim of reducing falls & being dementia/cognitive impairment friendly
- We are working with volunteer lead to introduce increased availability of floor walkers and involvement with activities to support our cognitively impaired client group and therefore minimise risk of falls and any subsequent harm

- Subgroup reviewing current 'PACT' (Falls risk assessment) tool and in line with national guidance are reviewing the fall safe document to produce a document to be utilised to assess falls on admission which also includes relevant care plans. It is proposed this will then be included in the planned adult inpatient Record, (AIRS) document.
- The committee will be inviting a rep to review current seat and bed alarms and make a decision on which to trial before agreeing a purchase request. Trial areas to include Barnes, Stroke, Day Lewis & Purbeck
- Dementia/Frailty Advanced Nurse Practitioner is monitoring numbers of patients > 75 years who are moved out of hours and group intend to do case review.



This chart is showing a definite improvement the numbers of falls over the past 4 years with 2016 having a total of 747 falls and 2019 having 563

Of these there is a reduction from 13 in 2016/17 to 5 in 2019/20 of falls resulting in moderate or severe harm.

Patient Safety – Improved Mortality Surveillance and Reducing Variation

What is mortality surveillance?

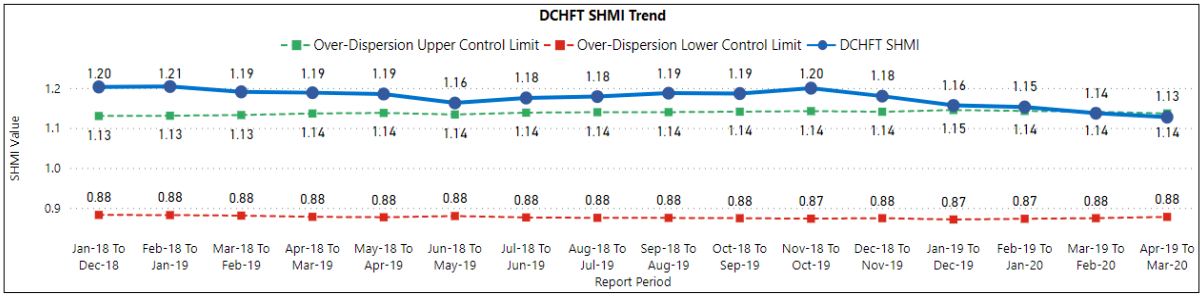
Mortality surveillance is the ongoing systematic monitoring and analysis of mortality data and the sharing of information that leads to actions being taken to address either data quality issues (the way information is documented, recorded and coded) or health concerns and delivery of care.

How did we perform?

The Trust has established robust mechanisms for the review of the mortalities, data and associated coding, through the monthly Mortality Surveillance Group and standardised Mortality and Morbidity meetings at speciality level.

The main mortality measure, published nationally by NHS Digital, is the Summary Hospital-level Mortality Indicator (SHMI) which reports at trust and site level across England using a standard and transparent methodology. SHMI is the ratio between the actual numbers of patients who died at the trust or within 30 days of discharge and the number that would be expected to die given the total risk of each inpatient spell, using nationally approved methodology.

Figure 1 - SHMI trend (rolling 12 months)



SHMI performance is constantly monitored against peers using nationally published reports. Although Dorset County Hospital Foundation Trust (DCHFT) has been consistently in the 'higher than expected' category since March 2017, the Trust has seen an improvement in the SHMI value over the last 6 months publications, recently moving into the 'as expected' category. The latest data from NHS Digital was published in August 2020 for patients discharged between April 2019 and March 2020. The Trust's 'expected' deaths during this period was 1,011, however 'observed' deaths were 1,142 resulting in a SHMI value of 1.13. This does **not** mean that there were 131 more deaths than there should have been.

Table 1 – Latest SHMI publications

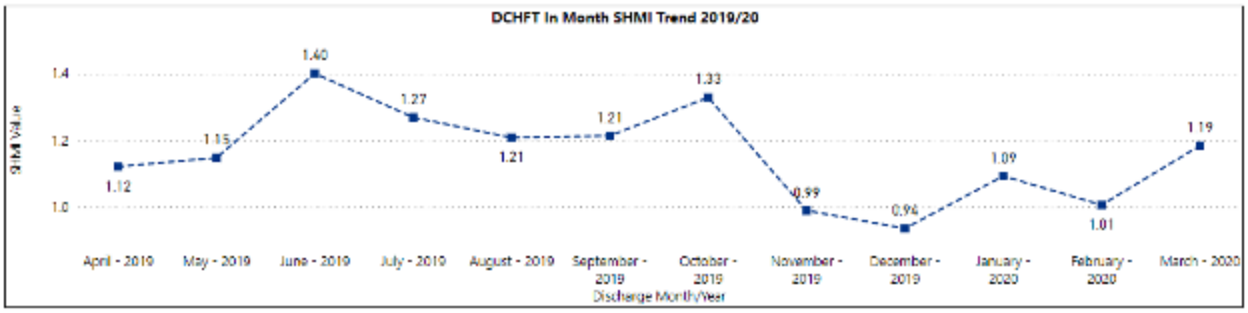
	DCHFT Last 6 published SHMI results					
	Nov18-Oct19	Dec18-Nov19	Jan19-Dec19	Feb19-Jan20	Mar19-Feb20	Apr19-Mar20
SHMI value	**1.20**	**1.18**	**1.16**	**1.15**	**1.14**	**1.13**
SHMI banding	Higher Than Expected*	Higher Than Expected*	Higher Than Expected*	Higher Than Expected*	As Expected	As Expected

**A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance. Instead, it should be viewed as a 'smoke alarm' which requires further investigation by the trust.*

Mortality indicators should be used as an alert requiring investigation with the first step being to examine whether what is recorded accurately reflects what the patient was treated for during their spell. There has been significant work in this area throughout the last 24 months and the Trust recognises that there are major issues around diagnosis recording which takes a considerable amount of time to resolve.

In-month trend of the latest SHMI publication (April 2019 to March 2020) shows an improvement since November 2019, especially in November and December 2019 when 'observed' number of deaths were below the 'expected' number of deaths, resulting in a SHMI value below 1.0. If this trend were to continue, the full impact of this would not be demonstrated until the reporting period ending October 2020 (which would be published in March 2021).

Figure 2 – SHMI trend (in month)



The Trust had previously identified that the depth of coding (the number of secondary diagnosis codes per finished provider spell) could have been having an adverse effect on the SHMI. In NHS Digital's latest report, although remaining below the national benchmarks, DCHFT has shown improvement in the mean depth of coding for both elective and non-elective spells, increasing from 2.8 to 3.3 and 3.1 to 4.0 respectively. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts.

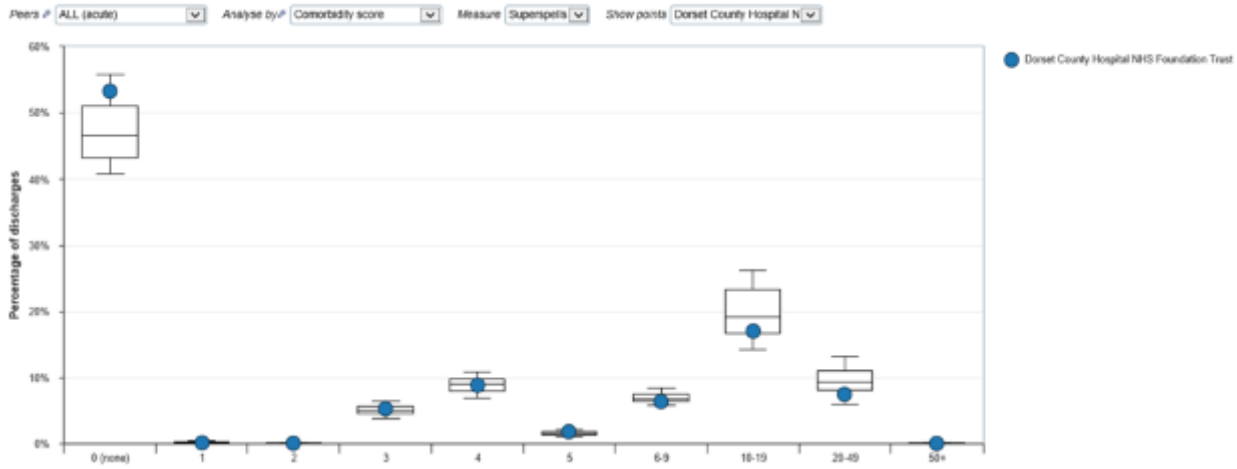
Table 2 – Mean Depth of Coding Scores (2018/19 and 2019/20)

	Mean coding depth for elective admissions	
	Apr18-Mar19	Apr19-Mar20
DCHFT	2.8	3.3
England	4.7	5.1

	Mean coding depth for non-elective admissions	
	Apr18-Mar19	Apr19-Mar20
DCHFT	3.1	4.0
England	4.8	5.2

SHMI methodology uses a number of statistical variables in order to calculate the number of expected deaths, one such variable is the Charlson comorbidity index. Each relevant Charlson Comorbidity diagnosis carries a weighted score (eg: Dementia = 14, Diabetes = 3) and these are then added together to give the Charlson Score per inpatient spell. These are then aggregated and grouped into three categories based on the combined Charlson Score with the highest group resulting in the greater patient risk score.

Figure 3 - Comorbidity Scores (for latest SHMI period April 2019 to March 2020)



DCHFT comorbidity scores for 2019/20 are represented by the blue circles in chart above, compared against all acute Trusts. This highlights that DCHFT has a higher proportion of spells with a Charlson score of zero and a lower percentage of spells with a Charlson score of ten or more. This could have resulted in the Trust being attributed a lower level of 'expected deaths', which consequently could lead to a higher SHMI. However, when compared to scores for last year, these variances are reducing. The proportion of spells with a Charlson score of zero has decreased from 57.0% in 2018/19 to 53.3% in 2019/20, while spells with a Charlson score of ten or more have increased from 19.9% to 24.4%, reducing the variance from 9.4% to 6.1% below the national average.

Table 3 – Comorbidity Scores (2018/19 and 2019/20)

	Comorbidity score (% of spells)					
	Apr18-Mar19			Apr19-Mar20		
	0	1-9	10+	0	1-9	10+
DCHFT	57.0%	23.1%	19.9%	53.3%	22.3%	24.4%
All Acute	48.0%	22.7%	29.3%	46.7%	22.8%	30.6%
Variance	9.1%	0.4%	-9.4%	6.6%	-0.4%	-6.1%

The percentage of spells with a primary diagnosis of a sign or symptom (identified by ICD-10 codes beginning with the letter 'R') has also shown a small reduction, from 13.0% in 2018/19 to 12.8% in 2019/20. A high percentage of provider spells with a primary diagnosis which is a sign or symptom compared to other similar trusts may indicate problems with data quality or timely diagnosis of patients, but may also reflect the case-mix of patients or the service model of the trust (e.g. a high level of admissions to acute admissions wards for assessment and stabilisation).

Table 4 – SHMI Spells with Primary Diagnosis of Sign or Symptom (2018/19 and 2019/20)

	Apr18-Mar19			Apr19-Mar20		
	Spells	Primary diagnosis of sign or symptom	% Spells with primary diagnosis of sign or symptom	Spells	Primary diagnosis of sign or symptom	% Spells with primary diagnosis of sign or symptom
DCHFT	29,257	3,794	13.0%	28,939	3,715	12.8%
England	9,265,338	1,236,504	13.3%	9,308,083	1,210,205	13.0%

Improvements in the quality of clinical coding can be attributed to the implementation of a significant change programme for the Clinical Coding Service. This has included an increase in staffing of 3 WTEs, additional training and development opportunities and changes to the data capture process.

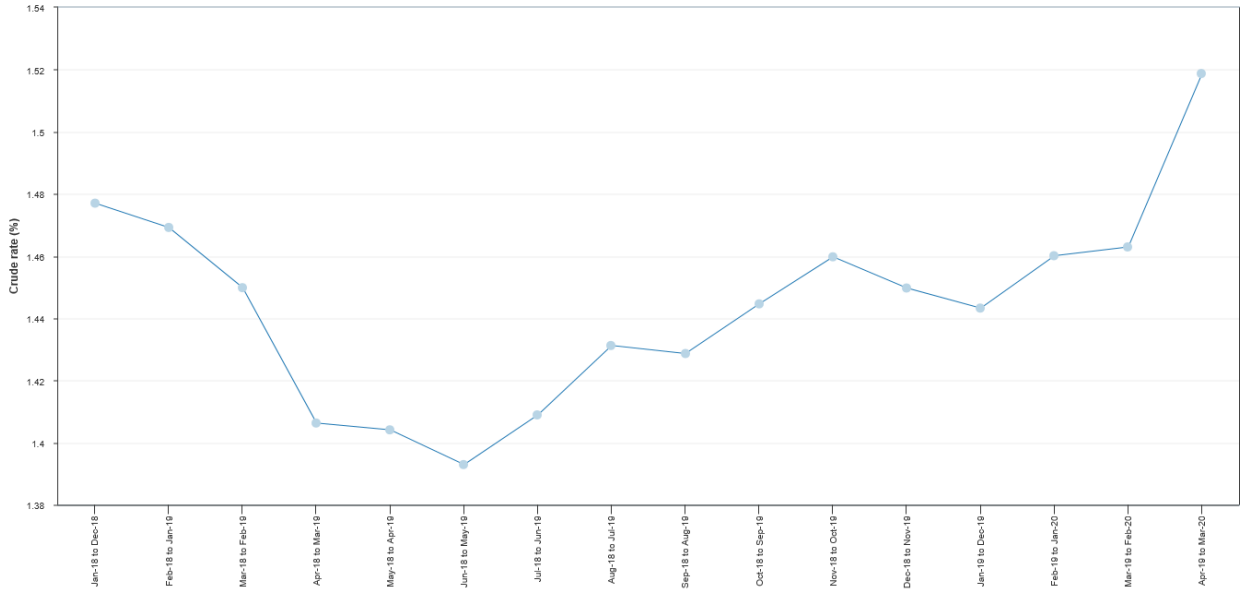
Prior to the changes, in order to meet financially driven deadlines a significant proportion of patient spells was coded using the discharge summary alone as the source of information. The advantage of using the discharge summary as the clinical coding source is that it is a far quicker process than reading and abstracting information from the full medical record and therefore uses less clinical coding resource. Using discharge summaries alone results in poor depth of clinical coding because these are not primarily designed as a clinical coding source document and will therefore often omit details, such as a full list of patient comorbidities, that are relevant to clinical coding. The increase in staffing has allowed the Trust to move to using the full medical record as the main source for clinical coding in the majority of cases which in turn has started to improve the depth of clinical coding.

Other factors which impact on the quality of clinical coding include the technical skills of the clinical coders and the quality of the source documentation. Provision of additional training for staff and engagement with clinicians to promote better understanding of the clinical coding process and to resolve queries about diagnosis and / or intervention will therefore also help to create further improvements in quality.

SHMI should not be looked at in isolation; therefore the Trust also monitors crude mortality in parallel. A hospital's crude mortality rate looks at the number of deaths that occur in a

hospital in any given year and compares against the amount of people admitted to hospital for the same time period. The crude mortality rate can then be represented as the number of deaths for every 100 patients admitted.

Figure 4 - Crude mortality percentage (rolling 12 months)



For DCHFT crude mortality has remained fairly stable (1.39% – 1.51%), indicating the quality of care has not changed. The slight increase in 2019/20 could be attributed to the 'COVID effect' during March 2020, which resulted in a reduction in spells and a small increase in number of deaths. COVID-19 activity has been excluded from the SHMI as it is not designed to account for such a pandemic and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

Whilst the Trust is confident that the historical higher than expected SHMI rate can be attributed to coding issues (for example comorbidity capture), more robust process for reviewing all deaths which occur in hospital have been introduced (please see Learning from Deaths report for more information). Deep dive investigations into grouped diagnoses alerting areas (e.g. pneumonia) help to understand the scale of the quality issues and seek to provide assurance around quality or care and identify areas for improvement.

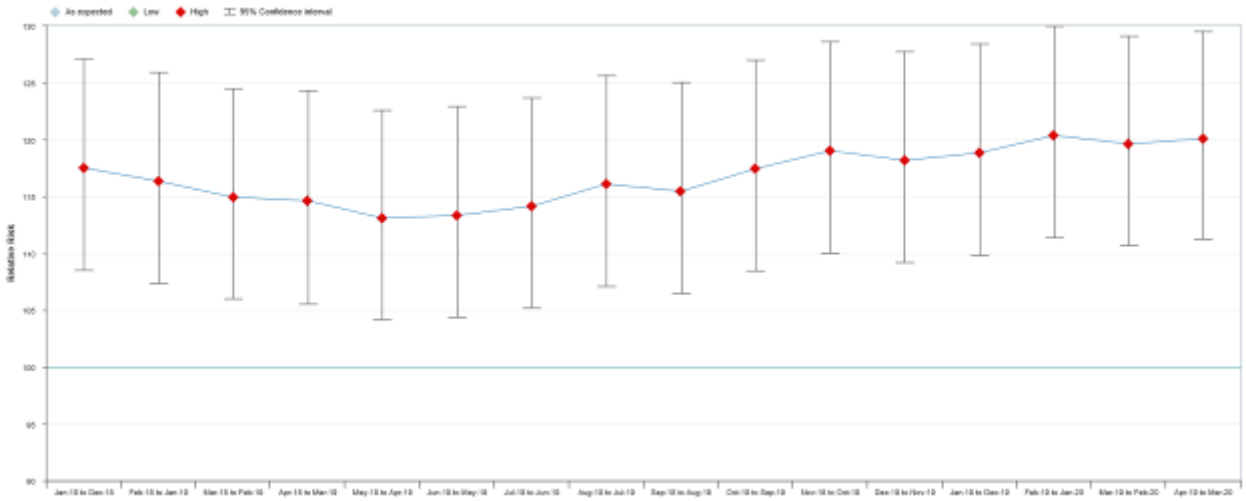
The Trust uses benchmarking software from Dr Foster to facilitate more in-depth analysis of mortality data and also enables the Trust to monitor another nationally recognised mortality index – the Hospital Standardised Mortality Ratio (HSMR). The key differences in methodology between the two indicators are:

- SHMI includes all spells, while HSMR includes a basket of 56 diagnoses (around 85% of deaths).
- SHMI includes post-discharge deaths within 30 days (which requires linkage to Office for National Statistics that incurs a time lag), while HSMR focuses on in-hospital deaths.
- HSMR is adjusted for more factors than the SHMI, most significantly palliative care but also including CCS sub groups, social deprivation, past history of admissions, month of admission and source of admission.

- SHMI attributes a death to the last spell within an acute non-specialist trust, whereas the HSMR attributes a death across a continuous in-patient spell.

HSMR complements the SHMI by focussing on deaths whilst in the care of the hospital, using more sophisticated risk models for individual diagnoses. As it only looks at in-hospital deaths, HSMR is produced more timely than the SHMI, therefore giving an earlier indication of any potential issues.

Figure 5 – HSMR trend (rolling 12 months)



In contrast to the improvement seen in the SHMI, HSMR for April 2019 to March 2020 remains in the higher than expected range at 120.1 and has increased compared to performance for the same period in 2018/19 (114.6). SHMI has seen an increase in the number and proportion of deaths in hospital, which may explain this variation.

Table 5 – SHMI Deaths In and Out of Hospital (2018/19 and 2019/20)

Period	Deaths In Hospital	Deaths Out of Hospital	Total Deaths	% Deaths in Hospital
Apr18-Mar19	671	404	1,075	62.4%
Apr19-Mar20	747	395	1,142	65.4%
Variance	76	-9	67	3.0%

Although HSMR remains 'higher than expected', SHMI has recently returned to the 'as expected' range, with evidence of a steady improvement over the past five months, to its lowest value since 2017. No other metrics of in-patient care suggest that excess mortality is occurring at DCHFT. Nevertheless the Mortality Surveillance Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. SHMI publications recently moved from quarterly to monthly, which has improved the ability to monitor performance in a timelier manner. At the same time internal processes around the completion of SJRs and Learning from Deaths are being improved.

Patient Safety – Improving early identification and treatment of Sepsis

Goal for 2019-2020:

We will continue to increase our sepsis screening rates up to 90% or above and administer antibiotics within 1 hour for those patients who require them.

What is Sepsis?

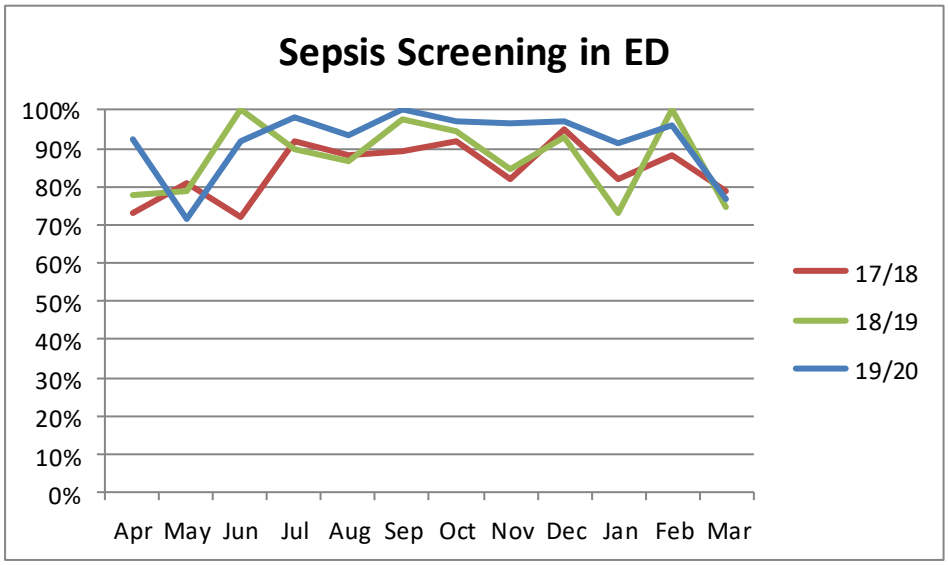
Sepsis is a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream and begins to injure its own tissues and organs. If a patient becomes "septic," they will likely have low blood pressure leading to poor circulation and lack of perfusion of vital tissues and organs.

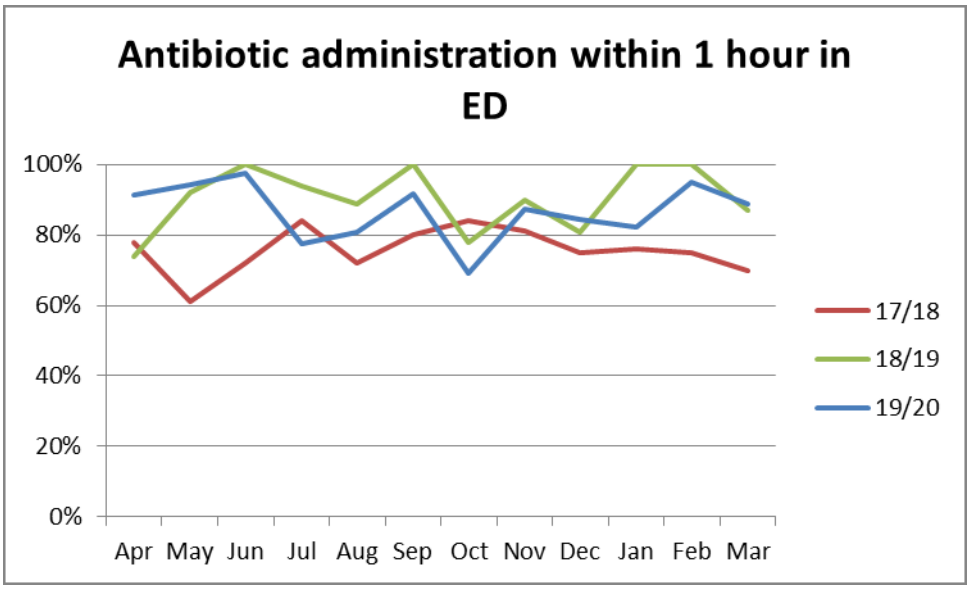
The early identification and treatment of sepsis has been demonstrated to reduce mortality from sepsis.

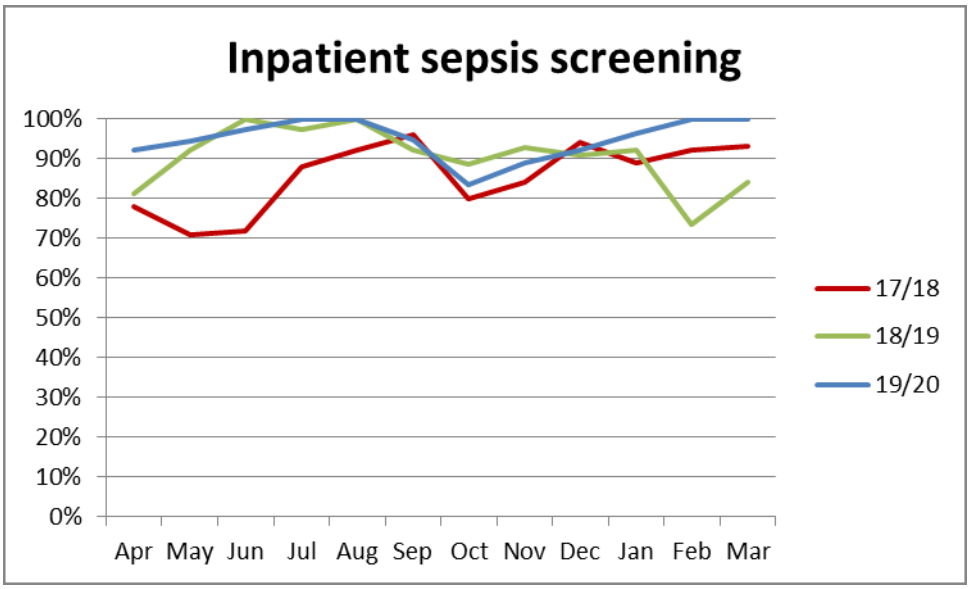
How did we perform?

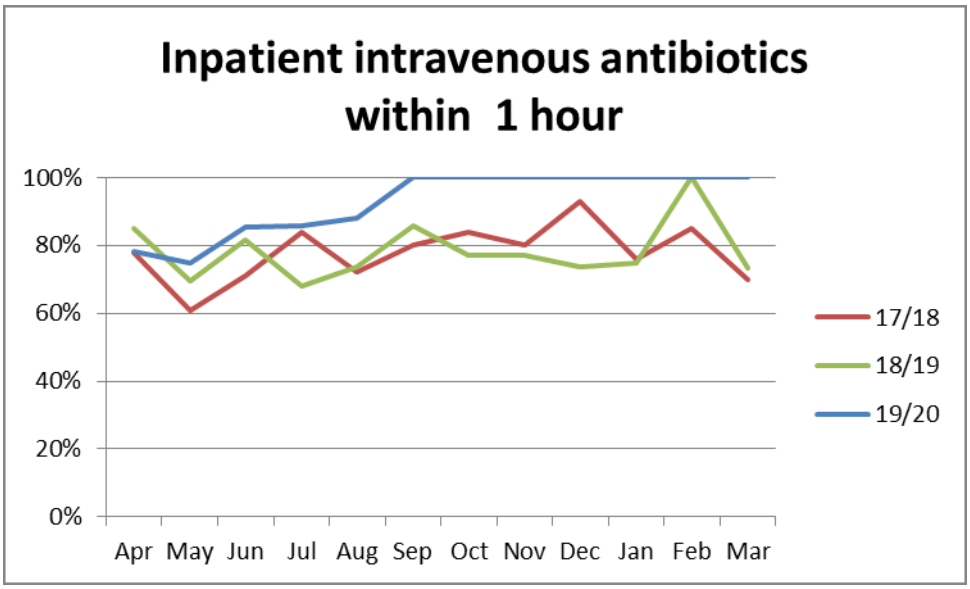
The Trust has been committed to awareness raising events to support staff in the identification and screening of Sepsis. As part of this work, the emphasis is changing to that of 'All Cause Deterioration', which includes identification of those patients who may be developing sepsis. We continue to work closely with the Wessex Academic Health Science Network deteriorating patient workstream and have commenced a trial of the Regional All Cause Deterioration flow chart and the associated documentation.

The sepsis screening tool is a national tool and is still evolving and has been updated to reflect feedback from those who use it regularly. It was felt that the location of the form, in the admission documentation, was not conducive to its use, particularly for those inpatients who may develop sepsis. We are now moving to a stand-alone form that can be used at any point in the patient journey.


Sepsis Screening in ED
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
17/18
18/19
19/20


Antibiotic administration within 1 hour in ED
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
17/18
18/19
19/20





Although the Trust recognises that there have been significant improvements made, there is further work required in this area. The sepsis group continues to meet and has good multi-professional attendance from across the Trust. An action plan for the group is in development to link this work to the management of the deteriorating patient and those with, or developing AKI (Acute Kidney Injury). This work stream will then also form part of our response to the National Patient Safety Strategy.

Clinical Effectiveness – Promoting the Health and Wellbeing of staff

Goal 2019-2020: Staff can access quality information to look after their health and wellbeing, and can get support when they need it.

Why is the Health and Wellbeing of our staff important to delivery of outstanding care?

The Trust recognises that its employees play a vital role in its aim to provide 'outstanding care for people in ways which matter to them'. The evidence shows that when our staff feel well and satisfied with their work, the experiences of our patients improve. It makes sound business sense to ensure all our staff can access timely, relevant and evidence-based information to maintain their wellbeing, and can get support when they need it.

How did we perform?

We offer the current initiatives:

Health and Wellbeing Champions

We have 20+ staff Health & Wellbeing Champions across the trust. They have volunteered to support and publicise events and initiatives which benefit the health and wellbeing of staff, and provide a way for staff to feedback their experiences. A monthly Champion Newsletter updates them on the latest wellbeing news and services. They will be offered training by Livewell Dorset in 2020 on the importance of physical activity and how to support colleagues and patients to make healthy lifestyle changes.

The Health and Wellbeing pages of our intranet and Staff App are regularly updated with all relevant information for staff to access 24/7.

Occupational Health & Wellbeing

The role of the Occupational Health (OH) and Wellbeing Service is to act in an advisory capacity to both staff and managers to promote and maintain the highest possible levels of health and wellbeing in the workplace. The OH and Wellbeing service is both confidential and impartial.

Employee Assistance Programme - Care First

Care First is a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues.

All staff can access Care First confidentially on the phone 24 hours a day. They provide additional support in both work and non-work related matters. From work-life balance to childcare information, relationships to workplace issues, health & wellbeing. Topics include

(but are not limited to) Debt, disability & illness, bereavement & loss, stress, elder care information, life events, anxiety & depression, family issues, education and consumer rights.

Our I&W lead works closely with Care First to ensure they can give our staff up to date information about local services and support.

Physiotherapy

All staff can access physiotherapy services via self-referral or through their line manager.

Emotional and Mental Wellbeing

The Trust values both the physical and mental health of our people. We believe that work should be a positive part of our lives, and strive to enable our staff to ensure they have the skills, knowledge and resilience to maintain their wellbeing, as well as knowing how to seek help when they need it by:

- **Raising Awareness and improving Mental Health Literacy:**

The Trust has 3 in-house Mental Health First Aid (MHFA) Instructors qualified to deliver Mental Health First Aider (MHFA) 2 day, 1 day Champion and half-day Awareness sessions to our staff and partners. Since March 2020, we have trained 50 Trust MHFAiders, and planned a programme Champion & Awareness training for 2021 which wills see over 100 more staff trained. We recruit from all teams, and target particularly vulnerable groups such as junior doctors.

- **Providing peer support and signposting to timely and appropriate help:**

We have a newly established MHFA network, which offers our MHFAiders a safe space to meet and provide peer support and informal supervision for each other, along with refreshing their learning and developing their skills.

- **Ensuring staff who are unwell receive the support they need:**

The Trust provides confidential access to both telephone and face to face counselling services for all employees, via our Employee Assistance Programme Care First.

MHFAiders and managers are also made aware of other local and national support available including Able Futures, providing up to nine months free coaching and support to enable people experience mental health difficulties to stay in work.

Financial Wellbeing

Neyber, a financial wellbeing service has been available to staff since February 2019, with a financial wellbeing portal offering free financial planning tools.

Initial planning meeting with Wyvern Savings and loans: A community based Credit Union, staffed by four paid staff and over 100 local volunteers providing members with a safe and ethical place to save (up to £15,000), as well as providing affordable loans. We are looking

to add bespoke financial wellbeing & planning sessions to staff e.g. benefits of NHS pension scheme for new/younger staff in 2021.

Pre-Retirement Planning

The Trust offers Pre-Retirement sessions for staff thinking about retiring in the next 3-5 years. These are delivered by Affinity Connect, and offer the opportunity to start looking at all the various options available and planning for the future. This session also includes information from Livewell Dorset on the importance of remaining active in the retirement years and the health benefits of doing so.

Chaplaincy Service

Chaplains are employed by the Trust to provide confidential support and pastoral care to patients, carers and staff. This support is completely confidential and available to people of all faiths and none.

The Prayer Room is also available at all times of the night and day as a place of quiet reflection and prayer.

Patient Experience – Improving the identification, assessment and referral for patients with Dementia

Quality account 2019-2020

Over the last year the Dementia screening rates have continued to fluctuate and the identification (screening) and subsequent onward referral to specialist services have not demonstrated the improvements that were hoped for despite action plans and reminders to staff.

The Frailty team has been an important vehicle in keeping Dementia and Delirium on the agenda for the trust. The team have developed a Comprehensive Geriatric Assessment pro forma which includes the use of the 4A tool for the screening of delirium and is currently waiting for this tool to be implemented onto the electronic patient record ready for use.

The use of the dementia screening module on VitalPAC will be changing to be more delirium focused and likely to include the 4A, this will be included in the next upgrade.

With the introduction of NEWS2 (Vital observation tool) a new parameter was added to the AVPU (Conscious level scoring), that of ‘new confusion’. This helps to identify those patients presenting with delirium as a symptom of sepsis. If the patient scores positively for new confusion, this increases their overall NEWS2 score and should increase awareness of their deteriorating condition allowing treatment to be instigated that much sooner. Awareness of the new score is included in the AIM course.

The Advanced Nurse Practitioner (ANP) for Dementia/Frailty continues to have a presence on Ilchester (admissions ward) and is able to assess and put plans in place for Dementia patients much earlier into their hospital admission, and with good links to the community services have been able to discharge patients safely who potentially would have had an extended length of stay due to the complexities of the discharge.

The ANP for Dementia/Frailty attends the Multi-Disciplinary Team (MDT) and Ward Round on Barnes ward (Elderly care) to contribute to specialist assessments for Dementia patients with a view to assessing and assisting with the complex discharges as well as supporting patients who are experiencing complex delirium. ANP for Dementia /Frailty continues to accept referrals across the trust from all areas requiring support with assessments, advice and prescribing.

The HCA (Health Care Assistant) for Dementia (secondment for 6 months) has ended but there are plans to recruit 2 WTE assistants to assist with the Dementia screening and also to take a proactive approach in supporting Dementia patients whilst they are inpatients (Awaiting funding to be agreed).

Throughout the year the ANP Dementia/Frailty has attended and spoken at a national event regarding mental health in frailty as well as attending conferences on Delirium and research in Dementia.

Staff from all disciplines including student nurses and Junior Doctors, in different areas of the hospital have received bespoke training on Dementia, Delirium and Managing “Challenging Behaviour”.

Preparation is currently underway for World Delirium Awareness day as well as Dementia Action Week in order to continue to raise awareness of both Delirium and in particular Delirium prevention, and Dementia and how staff can be supported when caring for a patient living with Dementia.

Patient Experience – Improved Learning from Complaints

Goal 2019-2020:

We will ensure that we learn when our patients tell us they have not had a good experience with us.

Why is learning from complaint important?

Complaints are an important way for the management of an organisation to be accountable to the public, as well as providing valuable prompts to review organisational performance and the conduct of people that work within and for it.

A complaint is an expression of dissatisfaction made to or about an organisation, related to its products, services or staff.

An effective complaint handling system provides three key benefits to an organisation:

- It resolves issues raised by a person who is dissatisfied in a timely and effective way;
- It provides vital information that can lead to improvements in service delivery
- Where complaints are handled properly, a good system can improve confidence in an organisation's administrative processes.

How did we perform?

We have continued to work hard to improve the management of complaints; we now include learning opportunities in all complaint responses so that complainants know that their complaint has been worthwhile in improving services/departments in the organisation.

Trust wide Performance

Much work has been undertaken in the last year to improve the management of complaints particularly the learning opportunities that occur when a complaint is made. Complaints have moved into a system called Datix to enable improved reporting; tracking of learning and actions; and thematic analysis

Learning and actions from complaint are monitored through the Divisions and Care Groups and where appropriate learning is shared across the organisation. Examples of learning from complaints are included in the quarterly Patient Experience report and reviewed by the Quality Committee.

Although we have made progress in learning from complaints, there is still more to be improved upon using the new system to fully embed and monitor learning from complaints in the Trust and this will be our ongoing focus for the next year. From April 2020 actions and learning will be allocated using the Datix system to support the Divisions and Care Groups in the monitoring and completion of actions/learning from complaints

Patient Experience – Improving the support from Hospital Volunteers to have positive effects on clinical outcomes

Goal for 2019/2020

The goals for the reporting period above were set as a continuation from those set in 2018/2019 continuing with development and then the implementation of the 3 key goals below for the Volunteer Service at DCHFT:

1. **Young Volunteer Programme**

We will implement a pilot Young Volunteer Programme (YVP) in line with the, Pears #iWill Fund, beacon area commitments and use results of this to then develop and implement a sustainable programme of young volunteer opportunities and events in Year 2 of the project (Nov 2019 – Nov 2020).

2. **Volunteer Development**

We will implement a Volunteer Expansion Programme (VEP) based on research on volunteer need, developing current roles with departments and recruiting into these roles.

3. **Volunteer Experience**

We will based on the research from the 2018/2019 year of volunteer experience develop and implement improved processes for volunteer recruitment, training and retention focusing on efficient recruitment and effective training given and ensuring we are doing more to recognise and thank our volunteers.

How did we perform?

Young Volunteer Programme

Achievements in line with the 3 key themes of the #iWill beacon area commitments

Supporting the Community

- Focus has been on creating a Young Volunteer Programme, at DCHFT offering young people aged 16 – 24 opportunities to volunteer on a short term basis (8 weeks) with an option to extend beyond this.
    - Using the model above we completed a Summer and Autumn YVP with 30 Young People involved over the course of the two programmes. Both programmes have been successful and lessons learnt form the Summer programme helped to improve the Autumn programme. Since the end of the Autumn programme we have had the time to reflect and we are currently in a period of developing this programme further to embed it beyond the two year project and to improve the volunteer experience and opportunity through a tiered commitment offer allowing Young Volunteers to develop skills and get

more experience whilst at the same time supporting the hospital in a number of volunteer roles.
    - Young Volunteers who have taken part in the programme have fed back that they have enjoyed volunteering with many staying on to continue volunteering beyond their 8 weeks.
    - As part of the programme we were able to offer tours in the Theatres and Biomedicine department and again with the programme developing into Year 2 we hope to be able to offer more opportunities to our Young Volunteers to learn more about careers in the NHS.

- We have also carried out projects within the Trust with Young Volunteers coming in from the Princes Trust and NCS. Projects have included work in our therapy garden working with Arts In Hospital and with the Occupational Therapists on the Stroke Unit to clean it up and enhance it so it can be used by patients to aid their recovery. NCS have carried out projects to also tidy up one of the courtyards and also implemented a TLC box scheme in the hospital raising money to provide items from tooth brushes to stress balls which were then put into plastic tubs and donated to each ward for visitors / patients to use when needed.
- We are consulting currently with NHS England over the potential to start an NHS Cadet unit within the Trust later in 2020.

Having Your Say

- Two of our Young Volunteers helped to present the Volunteer Update at the Trust Board and Trust AGM.
- We have developed a positive relationship with the Dorset Youth Council, Dorset Young Researchers and Dorset Children in Care Council and with them are looking at ways ensuring that Young People have their say in hospital services and experience.
- Our Young Volunteers have represented the Trust at the Dorset Youth Summit and we have produced a short film with them on volunteering at DCHFT which was shown at the summit.
- We have also as a Trust taken part in the Dorset Takeover Challenge which saw 3 Young People come and spend a day with Trust personnel learning about their role and having their say in decision making.

Keeping Healthy

The focus on this theme was largely on supporting out-reach into the community and how we could engage with young people to support a culture of good health and wellbeing. Planning for this part pf the project largely put objectives around this theme into year two and we are consulting with the Head of Social Values within the Trust now to further input around this theme. We did focus on this area at the Trust Summer Spectacular last July working with a number of youth partners, including the Dorset Scouts and Dorset Youth Council to run a ‘Keeping Healthy’ themed stand.

We have since been working on a number of events working with the Dorchester Youth Club and other stakeholders to allow young people to have their say and to provide outreach to support the theme of Keeping Healthy. We are also working on the development of some workshops which we can take into primary schools to tie in with the International Year of the Nurse and Midwife.

Volunteer Development

Through our Volunteer Expansion Programme, we have continued to work with departments around the hospital to develop the current roles we offer and to implement new roles and services where needed. Main focus has very much been on Ward Assistant / Healthy Stay roles which we had established from the research phase of the VEP was much needed. Figure 1 shows the numbers of volunteers in roles in March 2019 and December 2019 showing where development focus has been a success. These figures do not include our Young Volunteers on the YVP who also volunteer in ward assistant / healthy stay roles.

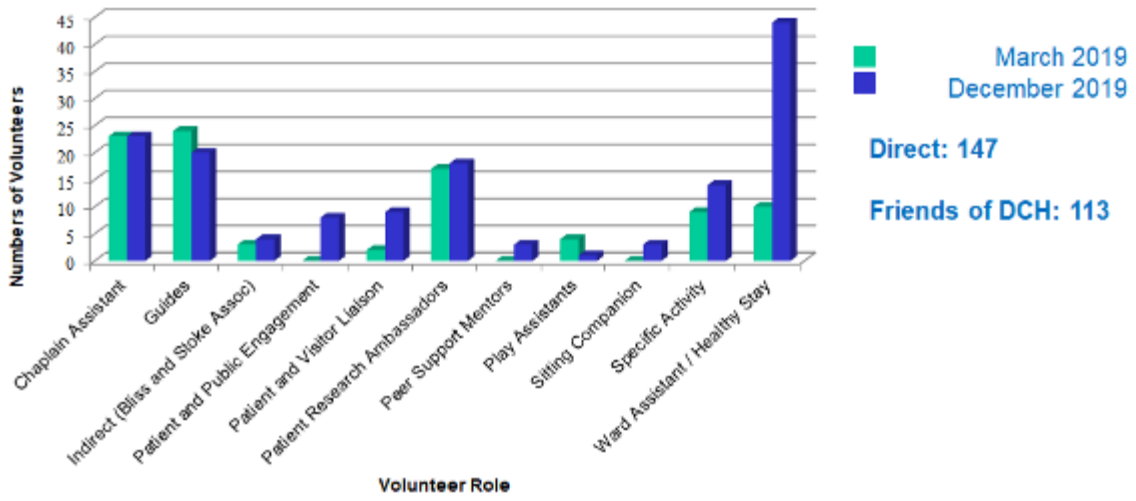


Figure 1 – Volunteer Roles

New Role Development through the VEP

- **Response Volunteer Service Funding:**

  We were successful in our application to receive funding from NHSE/I to start a Response Volunteer Programme (RVP). The invite to submit applications was anounced in October, therefore the turn around for this has been very quick! The £25,000 each funding has been given to 33 NHS Trusts and must be spent by the end of March 2020 and used to devleop and implement a RVP with the intention of supporting and allieviating 'Winter Pressures'. The funding is also to be used to provide the start up for a programme which can then continue post March. We are now working with departments and volunteers to implement the new RVP for DCH.

This will be concentrated in the first phase on Site Manager support, ED support and the set up of a Ward Referral system.

- **Paitent Liaison:**

  We have introduced volunteers in Patient Liaison roles in the Eye day surgery unit, CRCU (Critical Care Unit), Diagnostic Imaging and Medical Outpatients. The success in these roles has been mixed and we have established that whilst the role in the departments may seem busy, in reality they have not been, leaving volunteers with sometimes not much to do. We have relooked at this and are working with some volutneers who are trialling volutneering across departments and also enveloping elements of this role into our RVP.

- **Sitting Companion Service:**

  We have started our Sitting companion pilot working closely with the End Of Life (EOL) team to successfully train 3 volunteers. Use of these volunteers has been slow and we are working with them, pilot Wards and the EOL team to ensure we have a robust process in place so that volunteers can be called upon when needed and used.

- **Peer Support Mentors:**

  We have 3 new Peer Support Mentors now fully trained and working with the GUM (Genito-urinary Medicine) team at the Park Centre in Weymouth and with a plan for them to be used in Bournemouth as well.

- **Healthy Stay Volunteers:**

  We have worked with the Occupational Therapy (OT) Team on the Medicine For Older People Unit to develop a 'Healthy Stay' role supporting patients to meet three key objectives; ending PJ paralysis, hydration and nutrition and prevention of occupational deprivation. This has become an evolving and growing role which has seen some challenges but which are overcome through working closely with the OT team, the Ward Sisters and the volunteers and we are now seeing some great ideas come to fruition.

- **Gardening Volunteers:**

  To support the upkeep of the Therapy Garden post Princes Trust project to tidy it up we were lucky to have two people come forward to carry out tasks as volunteer gardeners. Thanks to them both the therapy garden and now the Organ donation garden, (at the request of the Organ Donation Committee) are regularly maintained. We are hopeful that once we have this role fully developed and supported through Estates that we can grow this team of volunteers and support more outside areas throughout the Trust.

- **Children's Community Nursing Team (CCNT) Volunteers**:

  We have been working with the CCNT team to develop a role for volunteers to be able to take medical equipment to patients. The main hold up on this at the moment is around travel expenses and time capacity / resource. However we will continue to pursue this to be able to support the CCNT team in the near future.

- **Patient and Public engagement (PPE) team volunteers:**

  We have developed a role supporting the PPE team with general administration and with Patient Voice. With these volunteers we have formed the 'Your Voice' Patient and Public Engagement Action Group who are already working on projects to gain patient feedback tasked by various departments around the Trust. We are planning an official group launch in April 2020

- **Specific Activity Volunteers:**

  This role has been developed to bring together volunteers who bring an activity to the hospital. This has included the recruitment of volunteers who bring Therapy dogs into the hospital, volunteers who bring Art and Music and most recently a volunteer story teller who is supporting the play specialists on Kingfisher ward.

- **Volunteer Partnerships:**

  We have developed partnerships with a number of other organisations who bring services into the hospital on a voluntary basis. This includes the Dorset Scouts who have brought the 'Scouting in Hospitals' initiative to Kingfisher Ward and Yeovil Free Wheelers where we are now working in partnership with Yeovil District Hospital to support recruitment of volunteer Blood Bike riders.

As we approach a new reporting year, focus will very much largely be on embedding the RVP so that it complements the Ward Assistant / Healthy Stay and Patient Liaison Roles and in ensuring the new roles developed over the last 12 months are operating successfully. We do have requests from departments enquiring about implementation of new roles and whilst we want to be able to support everyone we are at a stage now where we are having to be careful about what we can physically take on and deliver based on our own team resources.

Volunteer Experience

As part of the VEP we have looked very carefully at Volunteer Experience and have developed and started to implement a number of changes to processes around volunteer recruitment, training and retention which all aim to improve volunteer experience.

Volunteer Recruitment

We have not proactively recruited volunteers over the last 12 months. This is partly due the success of the Daily mail / Helpforce campaign which we signed up too and which saw over 50 Volunteers matched to DCHFT. It is also partly down to the overall VEP and focus on looking at our recruitment journey and putting in place processes and procedures to make this more efficient and 'volunteer friendly'. Figure 2 shows volunteer enquires for 2019 showing how many enquiries have resulted in new volunteers starting and reasons why some did not.

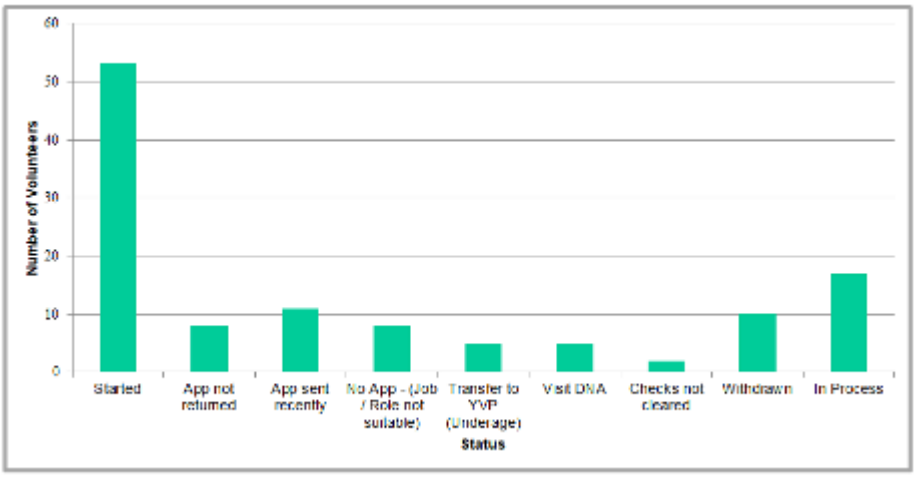


Figure 2 – Volunteer Enquiries 2019

The figures show that we had a large number of new starters which we are very happy with. If we were to proactively advertise roles then we currently do not have the resource to manage this. However we hope that over the next 12 months with new processes fully implemented to support and planned increased team capacity we will be able to increase recruitment further to support the Trust.

Volunteer Training

Over the last 12 months we have looked closely at volunteer training, putting in a successful proposal to Operational Education Group and Workforce Committee to change it to make it 'volunteer friendly' and better in line with NAVSM guidance and NHS Volunteer guidance to ensure training is 'relevant and proportionate to the role'. This has resulted in the following key changes now being implemented:

- The production of an Essential Skills training guide issued to all volunteers prior to induction training which covers all of the mandatory training. This has also been issued to all existing volunteers so that they can complete their 3 yearly renewal training.
- Volunteer Induction Training welcoming them to the Trust and covering the mandatory requirements delivered either on a one to one or group basis by the Volunteer Service team to ensure it is focused on volunteers and volunteering. The

group sessions are attended by the Fire Safety Advisor so that this can be completed at induction.

- The production of a volunteer handbook issued at induction to support volunteers with their volunteering in the hospital.
- A new volunteer agreement and training declaration which is signed once a volunteer is happy that they have read / understood their training role and responsibilities as a volunteer and they will abide by trust policy. This replaces the need for them to then have to complete Elearning modules, which they are still offered if they wish to still complete.
- Improved Local Induction ensuring initial welcomes to the department is covered and necessary safety briefs as well as ensuring they have had an opportunity to Shadow / Assist with volunteer role tasks.
- More opportunities to carry out role specific training to allow them to carry out other tasks within their role. At the moment this includes Listening Skills, Feeding and Dementia Awareness and we are working now to include Patient Moving training which will be instrumental in allowing the Response Volunteers to carry out their role fully.
- Access for Annual Fire safety training for volunteers is now through two annual scheduled update sessions plus more communication of Trust drop in fire update sessions.

Making and implementing the changes have been delayed mainly due to team resource and the priority of the Response Service application and development pre-Christmas but we have delivered two group sessions now with excellent feedback and we are now starting to see returns of Training declarations from existing volunteers who have read their guides which have been issued to them. We hope to be fully compliant with volunteer training updates by June 2020.

In addition to the new volunteer training programme we are also working closely with NAVSM and with Helpforce to further look at how NHS volunteer training can be made more consistent, whilst maintaining high standards of safety and compliance.

Volunteer Retention

Retaining volunteers is very much linked and focused for us on how we manage them, thank them and ensure they have meaningful and satisfying roles.

Key areas of achievement for this over the last 12 months have included:

- **Introduction of Volunteer Events:**
  In 2019 following a successful first Christmas event we held a volunteer tea party in June during national volunteer week. This was well attended and provided a great opportunity for our volunteers to meet up and talk about their different roles. We also organised a Mince Pie Mingle in December 2019 which again was well attended and enjoyed.

- **Introduction of a Volunteer Uniform:**

After a number of months getting approval for product procurement and logo design we were able to supply all of our Guide with a fleece which has made a huge difference both to their well- being when standing on cold main entrances to the hospital and also to their identity. Feedback from them all is very positive. We have also introduced our Yellow Volunteer polo shirts for Ward Assistants and our Young Volunteers which are very popular with them and staff alike and have again given them identity and reassurance for staff that the person on the Ward is a volunteer. This has led to better staff engagement with volunteers.

- **Volunteer Team Presence**

  We have made it a priority to be out talking to our volunteers, making sure they know who we are and checking in with them. This allows them to build a better relationship with us and feel more confident about coming to talk to us if there is a problem. It also supports work to ensure they feel valued and valuable within their volunteer role.

- **Volunteer Awards**

  We are nominating our volunteers for both internal and external volunteer awards to ensure they have recognition for the great support they give to the Trust. Our former head guide won a Volunteer of the Year award at the Dorset Echo volunteer awards and our Guides also won the volunteer group of the year award at the Dorset Volunteer awards in September 2019. Our Patient Research Ambassadors have also received awards for their research work and support to the research team and a number of our volunteers have also received Hospital Hero awards over the last 12 months. Over the next 12 months we plan to develop this area further to introduce a recognition programme for all of our volunteers.

Key Volunteer development areas

- We are continuing to work to introduce Volunteer Travel Expenses for volunteers. Having secured the funding in April 2019 one of our biggest challenges over the last 12 months has bene to find a way for volunteers to access this in a ‘volunteer appropriate’ way. We hope to resolve this soon so that we can ensure volunteers can claim travel for volunteering where they want and need too.
- Volunteer Management System – Through the Response service funding we are hoping to get approval to buy Better Impact which is a bespoke volunteer management system being used successfully in a number of other Trusts and championed by Helpforce. This system will allow us to further improve our current processes whilst at the same time giving our volunteers a platform for better communication and experience.

- Volunteer Hub – As we develop our Response service there is an increased need for volunteers to have a base – some where they can leave their belongings, check in with us and essentially have a sense of belonging. We are working now to identify a space so that this can become a reality.

In summary it has been a busy 12 months and the next 12 months look to be just as busy. A busy volunteer service though is not a bad thing! As well as continuing to work on all of the above over the next 12 months, projects will also focus on the volunteer policy review, staff engagement, staff volunteering and volunteer impact measurement. It is important that we can maintain balance and effectiveness, so to do this well we will have to be realistic in what we can take on. With continued Trust support we have for volunteers and with the potential to grow the volunteer team we are confident that we can continue to maintain a successful service.

Risk Assessment Framework and Single Oversight Framework Indicators

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

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

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

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

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

Target achieved
Target not met

**Data revisions for ED 4 hour standard during 2019/20 submitted in July 2020, yet to be published nationally*
^pre 2019/20 criteria based on hospital acquired cases (post 72 hours) due to lapses in care, from 2019/20 onwards hospital onset healthcare associated cases defined as tho

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

Annex 1 Statement from Commissioners, Local Healthwatch and Overview and Scrutiny Committees

HealthWatch

No requirement for a statement from Healthwatch Dorset is required as per National Guidance.

DCHFT Lead Governor Commentary on the Trust Quality Report 2019-2020

No commentary required as per national guidance

Statement from CCG

Draft statement has been sent to the CCG and we await a response

Statement from Health and overview Scrutiny Committee

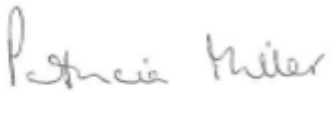
No statement required as per National Guidance

Annex 2 Statement of Directors' Responsibility for the Quality Report

Following National Guidance supporting Covid-19 pandemic response. This report has been written to the best of the Trusts abilities

By order of the board:

Mark Addison
Chairman



Patricia Miller
Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

No statement is required as per National Guidance