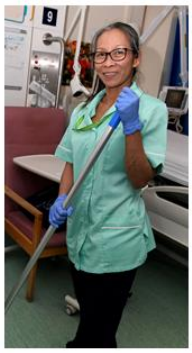
Respect
Integrity
Teamwork
Excellence

NHS
Dorset County Hospital
NHS Foundation Trust

Quality Account
2021 - 2022



Outstanding care for people in ways which matter to them

Quality Accounts 2021/22

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Part 1

FOREWORD – Nicholas Johnson, Interim Chief Executive

It gives me pleasure to introduce the Quality Account for Dorset County Hospital NHS Foundation Trust (DCH) for the year 2021-2022.

This year has continued to be a testing time for many and I would like to acknowledge the tremendous hard work of the staff. Each person has shown their commitment to the shared Values of Integrity, Respect, Teamwork and Excellence all of which is reflected in the achievements outlined in this report.

I would also like to thank our patients, their families and the local community for the patience and support shown to us during the restrictions which have been in place throughout this year.

Despite the ongoing Covid-19 pandemic the Trust has maintained its focus on quality improvement and safety for the local population.

Through new ways of working, including virtual clinics and the recovery work underway, The Trust have continued to put the patient at the heart of everything we do, and this will continue this into the new phase of hospital changes in the coming months and years as DCH develop the hospital and the services with the engagement of the people that count, the people who use DCH services.

The following Quality Account details the progress made against the priorities set for last year; it will also detail the priorities set for the forthcoming year 2022-2023.

I am pleased to confirm that the Board of Directors has reviewed the 2021-2022 Quality Account and are assured that it is an accurate and fair reflection of the Trust performance.

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

Nick Johnson
Interim Chief Executive

Part 2

Quality Improvement Priorities 2021/2022

In line with national guidance, DCH have developed priorities for the forthcoming year following engagement with DCH clinical staff, partners, the executive team, local community representatives and, of course, patients and their families. No new priorities were set for 2021/22 due to the changes to National Guidance during the Pandemic. Acute providers were asked to concentrate resources to the pandemic effort and as a result DCH priorities changed direction as DCH were unable to achieve them due to the operational needs of the services and the Pandemic response effort.

Dorset County Hospital NHS Foundation Trust (DCH) continued to work to deliver changes to improve both the effectiveness and the quality of its services throughout 2021/22. For complete quality and performance data the public can access Trust Board papers

Below are listed some of the quality improvement work and how these have been monitored and reported:

- Health and Wellbeing of Trust staff
  The trust continued to implement initiatives to support staff health and wellbeing. See Part 3 for a report

- Falls resulting in severe harm
  The trust has continued to reduce the falls which cause severe harm to patients. There have been no falls of this severity in the reporting year. Reporting continues through Trust Governance Processes.

- Improved Mortality Surveillance and Learning from Deaths – This work continues and is reported through the quarterly mortality reports.

- Improving early identification and treatment of Sepsis and the Deteriorating Patient – Quality Improvement work continues with the implementation of all cause deterioration pathway. Monitoring of this work is undertaken through the Trust Governance Processes.

- Patient Experience – A Dorset wide launch of the Carers Passport in June 2022 will be the culmination of the work undertaken collaboratively by the Trust and regional colleagues.

Quality Improvement Priorities 2022-2023

Priorities for 2022-2023 are developed together with clinical staff, Trust partners, the executive team, patients, and their families. These priorities were presented to the Quality Committee in May 2022 and were approved at the Trust Board in May 2022.

The Trust Strategy outlines how DCH will put people first and work together to deliver accessible, outstanding care and help make the west of Dorset a healthier place for all.

The Trust vision is that Dorset County Hospital, working with health and social care partners, will be at the heart of improving the wellbeing of the local communities. The Trust mission is to provide outstanding care for people in ways which matter to them. Underpinning everything DCH does, are the Trust values of:

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

To achieve the mission and realise the vision, DCH will focus on the Trusts three strategic themes: People, Place and Partnership.

Quality Priorities for 2022/23.

Priority 1: PEOPLE – The Trust will improve safety and quality of care by creating a culture of openness, innovation, and learning

- Clinical Plan
  - Population Health Inequalities, as part of the implementation of the Clinical Plan, DCH will work with system partners, to explore how to do things differently to understand and reduce health inequalities.

Priority 2: PLACE – The Trust will delivery safe, effective, and high-quality personalised care for every patient, focussing on what matters to every individual

- All cause deterioration
  - The Trust will continue with its progress following implementation of the All-Cause Deterioration pathway and the Clinical Deterioration Proforma. The Patient Safety Specialist will work to take forward the nine national priorities and to support with aspects of the Risk Management Strategy
- IPC working with Trust Partners
  - The Trust will engage and work with the Integrated Care System Infection Prevention and Control Team. Within this work networks will be available to support primary care and local patients, families, and carers. Public Health will be working within this 'System Team' to integrate their work alongside the ICS IPC Team.

Priority 3: PARTNERSHIP - Working together to ensure outstanding services, accessible to patients and population.

- Patient engagement and co-design.
  - The Trust will involve local people and community to improve and develop DCH services at the Trust.
  - Transition Service - The Patient Experience Team will work in partnership with patients, families, and carers to develop a transition service ensuring that young patients have an opportunity to influence the transition service at the trust.
  - To increase the awareness of carers and to include carers in the discharge process. In collaboration with local carers groups to co-design training materials for Trust staff to highlight carer awareness.
  - Your Future Hospitals Project. The Trust will engage with many different patient groups including local disability groups and young patients to ensure that their experiences are considered during the design of new services and Trust estate.

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

Statements of Assurance from the Board

Review of Services

During 2021-2022, the Dorset County Hospital NHS Foundation Trust (DCH) provided and/or subcontracted 35 relevant health services.

The Trust has reviewed the data available to them on the quality of care in all these relevant services in line with the national pandemic.

The income generated by the relevant health services reviewed in 2020-2021 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2021 – 2022.

The Trust income in 2021-22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework This was because of the changes in contracting arrangements due to COVID, as a result, defined CQUIN income was not received.

Clinical Audit

During 2021-22 52 national clinical audits covered relevant health services that the Trust provides.

During that period the Trust participated in 92% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2021-22 are as follows within the table.

The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2021-2022 are as follows within the table:

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2021-22, 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.

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, except for a few specific projects, to allow clinical teams to focus on the unfolding situation. Many of the national audits remained open, and clinical teams continued to submit data as they were keen to understand the impact of Covid-19 on their specific services. Publishing of National Audit, following the initial first waves of the pandemic were affected, and publication was suspended. This has recovered somewhat, and published reports are being received in the timeframes reminiscent of pre-covid timings. The number of National Clinical Audits has increased on the activity from 2020/21.

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. The number of local audits reviewed within the reporting year has increased on the previous 2020/21

Update on National Data Opt-Out

HQIP has been informed of the following by the DHSC Data Policy Team in the NHS Transformation Directorate:
'The mandatory implementation of the National Data Opt-Out (NDOO), deadline of 31 March 2022, has been extended until 31 July 2022. DCH does not intend to extend implementation of the deadline any further.

As set out in the Operational Policy Guidance, the opt-out applies to the disclosure of confidential patient information for purposes beyond an individual's direct care across the health and care system in England, unless an exemption has been granted.

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 the Trust are required to participate in those that relate to services provided by this Trust. The following table describes the audits DCH 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	218	100%
Cardiac Rhythm Management (CRM)	Y	Y	458	100%
National Heart Failure Audit	Y	Y	338	100%
Name of Audit	**Trust Eligible**	**Trust Participation**	**Cases Submitted**	**% Of Registered Cases**
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	471	100%
National Audit of Cardiac Rehabilitation	Y	Y	Data not available	Data not available
Diabetes (Paediatric)	Y	Y	Data not available	Data not available
National Diabetes Audit – Adults	Y	Y	833 submitted	100%
National Diabetes Foot Care Audit	Y	Y	100	100%
National Diabetes in Pregnancy Audit	Y	Y	14	100%
National Audit of Care at the End of Life	Y	Y	40	100%
National Audit of Dementia	Y	N (due to Covid an optional casenote audit was completed)	24 sets of casenotes reviewed for the Optional Casenote Audit.	24 sets of casenotes reviewed
National Asthma and COPD Audit Program	Asthma	Y	54	100%
	COPD	Y	226	100%
	Children and Young Peoples Asthma	Y	24	100%
National Lung Cancer Audit	Y	Y	39	100%
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	548	100%
Major Trauma Audit	Y	Y	244	96%

(TARN)				
PHE Surgical Site Surveillance Audits	Y	Y	Data not available	Data not available
National Audit of Breast Cancer in Older Patients	Y	Y	Data not available	Data not available
Inflammatory Bowel Disease (IBD) Registry Biologics Programme	Y	Y	Data not available	Data not available
National Gastro-Intestinal Cancer Programme	Oesophago-gastric Cancer (NAOGC)	Y	Data not available	Data not available
	Bowel Cancer (NBOCAP)	Y	Data not available	Data not available
National Emergency Laparotomy Audit	Y	Y	108	100%

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% Of Registered Cases
National Joint Registry	Knees primary/Revision	Y	Knees 131 primary +8 revisions	Nationally, elective joint replacement numbers halved from previous years due to the COVID pandemic, with cases being outsourced to other surgical centres
	Hips primary/revision	Y	Hips 124 primary +9 revisions Shoulder 21 primary +2 Revisions	
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service	Y	Data not available	Data not available
	Inpatient Falls	Y	5 in patient falls	100%
	Hip Fracture Database	Y	355 (308 NOF, 34 peri prosthetic, 13 Femoral)	100%
National Prostate Cancer Audit	Y	Y	Network submission via UHD-NHS	Network submission via UHD-NHS
National Audit of Rheumatoid and Early Inflammatory Arthritis	Y	Y (April to September)	80	(April to September) Since September all cases seen at UHD
Case Mix Programme ICNARC	Y	Y	640	100%
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE)	Y	Y	3	100%
National Maternity and Perinatal Audit	Y	Y	Data not available	Data not available

(NMPA)				
Child Health Clinical Outcome Review Programme	Y	Y	Data not available	Data not available
Neonatal Intensive and Special Care (NNAP)	Y	Y	Data not available	Data not available
National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	Data not available	Data not available
National Cardiac Arrest Audit (NCAA)	Y	Y	62	100%
National Ophthalmology Audit	Y	N	Medisoft software summer 2022 will then participate for 22/23 NOD	Nil
Name of Audit	**Trust Eligible**	**Trust Participation**	**Cases Submitted**	**% Of Registered Cases**
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	3	100%
Perioperative Quality Improvement Programme (PQIP)	Y	N	Ongoing local QI research project	Data not available
Serious Hazards of Transfusion: UK National haemovigilance scheme. Scheme (SHOT)	Y	Y	4	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) (49)	Y	Y	38	100%
Antenatal and new-born national audit protocol 2019 to 2022	Data not available	Data not available	Data not available	Data not available
Emergency Medicine QIPs [3]	Fractured Neck of Femur	Y	Data not available	Data not available
	Infection Control	Y	Data not available	Data not available
	Pain in Children	Y	Data not available	Data not available
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections.	Y	N	Local Audit	76.3% compliance
UK Renal Registry National Acute Kidney Injury	Y	Y	836	100%

programme				
Adult Smoking Cessation Audit July 2021- 31 August 2021	Y	Y	159	100%
Outpatient Management of Pulmonary Embolism	Y	Y	11	100%
Potential Donor Audit 2020 – 2021	Y	Y	3	100%
Pulmonary Rehabilitation- Organisational and Clinical Audit	y	y	273	100%

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.

At the beginning of the Covid-19 pandemic, NCEPOD also suspended all their current studies to allow clinical resource to be focused on the emerging situation.

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% Of Registered Cases
Epilepsy Study 01/01/21 to 31/12/21	Y	Y	5	100%
Transition from Child to Adult Health Services 01/10/19 31/03/21	Y	Y	9	100%
Crohn's Disease Study 1/10/21 to 31/3/22	Y	Y	6	100%

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

Report Title	Report Precis
NCEPOD Studies 2019/2022	NCEPOD Studies were suspended during the initial phase of the COVID 19 pandemic and were not due to resume until 2022. However, there have subsequently been 3 new studies published. • Dysphagia in people with Parkinson's Disease Submitted 31/12/2021 • Alcohol-Related Liver Disease Survey Submitted 12/10/2021 • Epilepsy Study Due 31/03/2022 29% complete • Transition from Child to Adult Health Services Submitted 9/2/22 • Crohn's Disease Study Oct 21 – To be released Spring 22

The reports of 5 National Clinical Audits were reviewed by the provider in 2021-22 and The Trust intends to take the following actions to improve the quality of healthcare provided, the number lower than expected as Covid-19 impacted on report publication.

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 Audit of Percutaneous Coronary Intervention (PCI) 2020 #5031	**Key Audit Results:** National Audit shows: • reduction in the number of heart attack admissions, fewer patients with STEMI self-presented (proportionately more received primary PCI). • Levels of care for patients admitted with heart attack maintained. • Fewer elderly, female and patients with comorbidities admitted with NSTEMI (this subset had a higher mortality than usual). • Fall-off in the number of patients presenting to hospital with heart failure more dramatic than for heart attacks. • Reduction in elective cardiac procedures. • Increase in patients presenting with out-of-hospital cardiac arrest. • Black, Asian and Minority Ethnicity patients with acute coronary syndromes more affected by the pandemic than white patients. • Excess mortality in England and Wales during the COVID Pandemic with 10% of 30-day deaths occurring after PCI during the pandemic due to COVID-19. **Actions agreed:** Integrated analysis of national data may inform COVID-19 risk profiles for those returning to work. High quality research is required to understand the longer-term impacts of COVID-19. Lessons from COVID-19 experience should shape the way for rapid nationwide data reporting. In quickly redesigning services to deal with COVID-19, local systems show how they need to be the future focus for QI. **What this means for DCH:** As the Trust move into the recovery phase from COVID-19 there will be pressures at local level to determine a way forward and put in place the capacity needed.
National Diabetes Audit NDA 2019	**Key Audit Results:** • Decline in 8 care processes mainly due to lower urine albumin checks. • Most care processes well completed but lower for type 1 patients (10-70% vs 20-80%). • 15% of Type 1 (T1) and 5% of Type 2 (T2) patients did not have a HbA1c (glycated haemoglobin) check during the audit period. • Achievement of treatment targets have improved in T1 pts driven by improved HbA1c</=58 but not in T2 pts. • Some services achieving HbA1c>40%, BP>80%, statins >80% T1s and HbA1c >70%, BP >80% and statins >90% for T2s. • Lower rates of statin prescription for primary prevention in T1 vs T2 (some services achieving >75%). • More than 25% T2s not prescribed statins for primary prevention (some services achieving >85%). • Some areas achieve >30% T1 and >45% T2 pts. • Structured Education offer and attendance remains stable, but attendance recording remains poor. **Actions:** Improve quality of NDA data to benchmark the trust against national results

National Diabetes Audit 2019/20 re-audit of #4449	**Key Audit Results** • Number of T1 people at adult specialist service was low (36%) • Much lower level of participation for core and insulin pump datasets. • National rate of A1c </= 58 is 27.6% (range 18.4-40.9%). • Individuals with T1 are more likely to have recommended A1c levels if on pump. • 10% of people with T1 use pumps (range 3.2-24.6%), more than 70,000 ppl meet NICE criteria for pumps as on basal bolus and A1c >/=69. • T1 people are more likely to have high A1c levels if young, female, of minority ethnicity, live in area of high deprivation. **Recommendations:** • All specialist services providing type 1 diabetes care must contribute to future National Diabetes Audits which will enable them to benchmark their results and highlight areas for service improvement. • All specialist services and primary care providers should ensure provision of insulin pump treatment is equitable and as per NICE guidelines (HbA1c 69mmol/mol (8.5%) or greater and using basal-bolus insulin). • All commissioners, specialist services and primary care providers should ensure that provision of, and access to, expert diet and lifestyle guidance and support for people with type 1 diabetes and associated obesity is on a par with the rest of the population.
National Diabetes Inpatient Audit (NaDIA) Harms, 2020 #4995	**Key Audit Results:** Patients at higher risk of experiencing an inpatient harm include: • emergency admissions, • white ethnicity, • T1 Diabetes Mellitus not had 8 care process in last 12months, • Not met combined targets of Blood pressure/A1cohol/Cholesterol, have Cardiovascular or diabetes specific complications on or during admission e.g., strokes and HHS. **Recommendations:** • DCH participates in the NaDIA harms audit. • Each 'harm' or case has a DATIX submitted, so cases and learning are discussed via the Safe Diabetes Care Group locally to ensure learning is disseminated and steps taken to prevent harms are implemented. • DCH Patients for elective surgery who have diabetes are highlighted to have a PAS alert. Elective surgical cases are referred to diabetes teams for review if HbA1c >69 for optimisation prior to admission. • At DCH all CBG readings are networked and DSNs can access abnormal readings and review cases. • DCH; Ongoing outreach to wards including surgical wards along with networked CBG readings provide a way to identify patients with abnormal readings to DSNs to provide problem solving prior to DKA. • Ongoing education of diabetes topics to junior doctors and nurses and HCAs on wards. **What does this mean for DCH?** • Submit cases to NADIA, harms & review internally • Outreach diabetes with remote CBG monitoring • Education to medical & nursing staff on prevention of harms
National Cardiac Audit Programme (NCAP) Cardiac rehabilitation (January-December 2019 data) Report	**Key Audit Results:** • DCH Cardiac Rehabilitation (CR) programme was assessed and classified as Amber. • DCH met 6 out of the 7 required Key Performance Indicators (KPIs): ▪ Multidisciplinary team: KPI Met. ▪ Priority Groups: KPI Met. Duration (days): KPI Met. ▪ Percentage with Assessment 1: KPI Met. ▪ Wait time Coronary Artery Bypass Graft (CABG): KPI Met.

published October 2020	▪ Wait time Myocardial Infarct/Percutaneous Coronary Intervention: KPI Met. • In 2019, 91.3% (above National average) of patients appropriately referred to cardiac rehabilitation completed their Core Cardiac Rehabilitation Program • At the end of 2019, nationally, 26% of cardiac rehabilitation teams offered technology/online cardiac rehabilitation options. • The Trust helped develop the My heart app. • In 2020 CR face to face clinics and groups were suspended March 2020 due to the COVID 19 this had a significant impact on service provision. • Face to face clinics for cardiac surgery patients re-commenced in July 2020 due to clinical need. Non-surgical patients continue to be offered their clinical assessment by telephone consultation only. • All written, DVD and online and telephone options of cardiac rehabilitation are continuing throughout 2020. • Assessment 2 targets were not fully met in 2019 and due to the COVID19 and the Assessment 2 target will not be met for 2020
National Neonatal Audit Programme (NNAP) 1/1/2019 to 31/12/19 Published 12/11/2020 # 4731	**Key Audit Results** • The Audit found that 1 in 7 babies have too low a birth weight or have a medical condition that requires specialist treatment. • This report, focuses on key measures of the care provided to babies in 2019 in the 181 neonatal services in England, Wales, Scotland, and the Isle of Man. **Recommendations:** • Antenatal Steroids; Optimise the timing and dosing of antenatal steroids for eligible babies, • Antenatal magnesium sulphate: all women who may deliver at less than 30 weeks' gestational age, adopt, and implement guidance for improvement: • Birth in a centre with a NICU; Prioritise structural changes and operational management ensuring that babies who require intensive care are cared for in the unit's best equipped to deliver it. Local Maternity Systems (LMS) should ensure appropriate clinical pathways exist to enable delivery of intensive care to all infants where this is required, with a minimum of postnatal transfers. • Parental consultation within 24 hours of admission; reflect on rates of parental consultation, use a quality improvement approach. including virtual presence. • Parental presence at consultant ward rounds; Neonatal units, in collaboration with parents, should build relationships and trust between parents, family members and neonatal unit staff by understanding, involving & empowering them in care planning and decision making. • By identifying the reasons for any gaps in parental presence on ward rounds, and working with parents to address any barriers to participation • On-time screening for retinopathy of prematurity (ROP) in Neonatal Intensive Care Units (NICUs). • Infection: Ensure that their use of evidence-based infection reduction strategies is optimised and focussed on identification and implementation better practices including "infection prevention bundles". • Bronchopulmonary dysplasia (BPD); Implement potentially better care practices, including any identified from NICE guidance about specialist respiratory care • Necrotising enterocolitis (NEC); All neonatal units should compare their rates of NEC to those of other comparable units with validated data and seek to identify and implement potentially better practices to reduce the associated higher risk of mortality and, for those babies who survive, the risk of longer term developmental, feeding and bowel problems.

	• Minimising separation of mother and baby • Breastmilk feeding at discharge home; Focus on the early initiation and sustainment of breastmilk feeding by removing barriers, • Follow-up at two years of age; Produce plans to provide or organise follow up of care for preterm babies in accordance with NICE guidance • Mortality until discharge home in very preterm babies; Consider a quality improvement approach to the delivery of evidence-based strategies in the following areas to reduce mortality: timely antenatal steroids, deferred cord clamping, avoidance of hypothermia and management of respiratory disease. • Ensure that shared learning from locally delivered, externally supported, multi-disciplinary reviews of deaths • Nurse staffing in neonatal units; Ensure that sufficient resources are available for the education and employment of suitably trained professionals to meet and maintain nurse staffing ratios described in service specifications.
LeDeR Programme 2021-2022	For the year 2021-2022 DCH submitted **3** notifications to the LeDeR Programme. Learning was shared and progressed through the divisions.
National Emergency Laparotomy Audit (NELA) December 2018 – November 2019	National Report highlighted 5 Key Messages and made 11 Recommendations Key findings from DCH data • Ascertainment has slipped significantly, although this coincided with the first year of COVID-19 pandemic • Reporting of CT scans before surgery has fallen, which may relate to concerns about COVID-19 contamination and infection • New data collection on sepsis and antibiotic administration implies poor quality care, but this may be due to poor quality data • Pre-operative input from Consultant Anaesthetists and Intensivists has fallen, which again may relate to resource diversion to COVID-19 care • Input from Elderly Care remains below target and has fallen slightly • Outcome measures remain stable over time and are better than national averages **What does this mean for DCH?** DCH continues to deliver good care to patients with emergency abdominal pathologies requiring unplanned surgery. The year 2019-2020 included drastic changes to resource allocation but the outcomes remained stable and continue to be better than national average. There are several process measures that need to be inspected carefully in Year 8, which will hopefully show bounce-back after COVID-19.
National Child Mortality Database and Perinatal Mortality Review 2019/20 #4955	**Key findings:** A report of the analysis of a national dataset. • There is a correlation between the risk of death for children and the level of deprivation. 2.On average the risk of death increases by 10% for each decile of deprivation. • If the children in the most deprived areas had the same risk of death as those in the least deprived areas >1/5 of all deaths might be avoided. • The proportion of deaths with identified modifiable factors increases with the level of deprivation. • At least 1/12 deaths in the study had 1 or more factors linked with deprivation identified. The report included exemplars of good practice in areas where there is work being undertaken to try to reduce infant mortality. **Benchmarking** • The Pan-Dorset and Somerset Child death overview panel (CDOP) submits data to the national child mortality database. Local numbers of deaths make this sort of detailed analysis difficult and the strength of the NCMD is that it collates information about all deaths in England. • The largest group of children that die are infants. Many are neonatal deaths

	linked to prematurity, birth related problems or congenital problems. The other significant infant group is those presenting with sudden unexpected death. Multiple known risk factors are related to this, linked to social deprivation and this area has been actively trying to address this through antenatal and postnatal public health messages to both men and women. **What does this mean for DCH?** • DCH contributes to child death reviews for those infants and children that the hospital is involved with. • The report calls for all areas to work together to reduce social deprivation and inequalities and practitioners within DCH should comply and participate by engaging with evidence-based programmes • Continued engagement with public health campaigns around safe sleeping & safe sleeping when out of routine to be prominent in maternity and paediatric services. • A recent child death investigation (death in Dorset but child on holiday here) highlighted that although it was documented that safe sleeping advice had been discussed on several occasions, practitioners were not aware that the family had routinely co-slept with their baby from day 1. At a strategic level DCH should be advocating for improved services for families and young children in the community
Maternal, Infant and New-born Programme (MBRRACE-UK) * 2019 – 2022 # 4727	There were 8 Recommendations noted from this report. **What does this mean for DCH?** • All elements of 'Saving babies lives care bundle 2' is implemented. All perinatal pregnancy loss is reviewed using the PMRT with involvement of a neighbouring trust. Women who risk delivering before 32 weeks gestation are transferred out of DCH these cases are reviewed on an individual basis with learning shared if required. • Pathway designed with appropriate interventions in place to optimise fetal and maternal wellbeing. This is now being incorporated into the maternity digital system. • Data is reviewed and presented at Quality Committee. DCH currently sits at the expected perinatal level for an equivalent sized hospital. • Neonatal mortality rates are within the expected level for an equivalent hospital. • Updates on PM consent have taken place, there is very little ethnic diversity in perinatal pregnancy loss, and it has not been noted that any population group decline post-mortem examination. • Due to national shortage of perinatal pathologists undertaking PM examination there are long delays for families to receive results
National Pregnancy in Diabetes (NPID) 2020 # 5034	**What does this mean for DCH?** • The Trust are comparable to local neighbouring trusts in areas such as early pregnancy diabetes control in both type 1 and type 2 diabetes. Improvement could be made with type 1 and type 2 diabetes control in late pregnancy, DCH are close to national averages. • There has been improvement with preterm deliveries and SCBU admissions as well as with large for gestational ages for Type 1 diabetes. **Actions** • Highlighting importance of pregnancy planning to local primary and community colleagues, particularly for women with type 2 diabetes • Continuing with striving for good glycaemic control with all patients with known diabetes, actively offering CGM for all women with type 1 diabetes and are performing well as per feedback from CCG. • Ensuring the Trust highlights the fact that women with GDM are aware of the diabetes prevention programme
Inflammatory Bowel Disease (IBD) Registry Biologics Audit 2020/21	**Key Audit Results:** • The audit has identified the growing IBD population and the need for team expansion to meet ongoing demand and to safely care for patients. **Benchmarking**

# 5043	• The biologics audit has allowed us to monitor steroid and biologic use to benchmark us against other Trusts and national statistics along with recommendations to assess cost and reduction in hospital admissions. • The growing patient population and increased demand has supported the development of the team in line with IBD national standards. **What does this mean for DCH?** • Biologic audits have been conducted in a timely manner over the Covid period despite pressures, highlighting areas for improvement that may impact on service development and the standard of patient care **Actions completed** • Employed an IBD Specialist Pharmacist who is overseeing the input of data for biologic initiation and carrying out IBD biologic clinic reviews in which they can capture biologics data at 3M & 12M for auditing purposes. • Introduction of pre-populated panels on ICE for pre-biologic screening to ensure patient safety needs are met when starting biologics and for monitoring purposes. • Identified a need for local audit identified as due to the submission of historic data at each audit it is often difficult to get a true reflection of DCH current progress from the data added from the past year.
National Child Mortality Database March 2020 – February 2021 # 5060	**Key Audit Results:** Good performance: • All pregnancy loss that fit the criteria for review using the PMRT is undertaken. This has led to a robust process with review of care given and suggested recommendations. **Areas of concern.** • United Hospitals Dorset Meeting attendance from DCH panel members due to timing and meeting clashes; has been raised with UHD. DCH consultants have been very good at attending for part of the meeting if DCH have a case to discuss. • All families are asked if they would like to participate in the review, led by the bereavement midwives, with proforma supplied to help them recall areas of the pregnancy/loss that they may wish to have addressed. • Limited feedback from families; Communications from bereavement lead to team to encourage them to ask for feedback from families using the PMRT paperwork provided. • All incidents which flag up care issues are escalated as a Serious Incident, investigated, and presented both internally and externally. Action plans are followed up once again internally and externally at the LMS safety meetings held bi-monthly. Shared learning with UHD takes place at this forum as does learning from the wider region. **What does this mean for DCH?** • System level changes are identified and once again reviewed internally and externally.
Potential Donor Audit 2020 – 2021 # 5073	**What does this mean for DCH?** • Continuation of the Potential Donor Audit in both departments (ED and ICU). • Ensure that all appropriate families are approached with the option of organ donation Teaching both departments about the appropriate timings of referrals **Actions identified** • To ensure all approaches concerning organ donation to involve a Specialist Nurse Organ donation/ Specialist Requestor (gold standard) • To ensure early referrals to allow the timely mobilisation of a Specialist Nurse/ Specialist Requestor
SAMBA (Society for Acute Medicine Benchmarking Audit) 17/06/2021 #5303	**Key Audit Results:** • High discharge rate from Acute Medical Admissions ward (78%), is associated with an increase in low acuity patients being admitted. The cause of this is multifactorial, but most likely represents a shortfall in the system's

	ability to manage these cases in the community. **Areas of good performance** • All patients receiving senior review within the target time **Areas of concern:** • High readmission rate (31%) representing a significant increase in comparison to previous years **Actions agreed:** • A review of pathways for readmissions, consider better utilisation of SDEC for these patients to avoid further inpatient stay.
National Lung Cancer Audit 2019 1/1/19 – 31/12/20 4797	**Key Audit Results:** Uses of rapid cancer registration dataset (RCRD), makes data available more quickly, some data on poorer prognosis patients missing. **What does this mean for DCH?** • Trusts should review their data completeness in the Cancer Services and Outcomes Dataset the MDT should participate in the NLCA. Dorset County Hospital was flagged as a trust with high data completeness. DCH participated in the NLCA and view this as an important part of their work. • Cancer alliances and clinical commissioning groups (CCGs) should examine the route of referral and stage at presentation for their population and look at ways to increase the numbers of patients diagnosed who are presenting with early-stage disease. DCH actively discus's this as part of the Lung SSG meetings and has GP and patient representation. DCH has undertaken several media campaigns, including interviews for BBC South and webinars. • DCH Lung Cancer Lead (and Lung Cancer SSG Lead) has taken on the role of Clinical Director for Targeted Lung Health Checks for Dorset. This allows DCH to effectively enter the National programme earlier than planned. Brining people into the Lung Cancer Pathway at an earlier stage of the disease is key to improving their outcome. • Cancer alliances with lower-than-expected curative-intent treatment rates for stage I/II PS 0-2 NSCLC should review their processes for selection of patients for such treatment, in order that a rate of at least 85% is achieved. DCH has reviewed their figures, from April 2020 to date, and with the low numbers involved are satisfied with an 82.1% rate.
National Hip Fracture Database 2020 01/04/20 – 31/03/2021	**Key Audit Results:** • Recommendations 1-9 as published in Facing New Challenges: The National Hip Fracture Database (NHFD) report 2020. **Good performance**: • Mortality consistently below national average (DCH 6.1%, NHFD overall 8.2%). Above average categories for KPI1, KPI2, KPI5. Average categories for KPI3, KPI6 **Areas of concern:** • Below average category for KPI4 – prompt mobilisation. **Benchmarking** • Mortality run charts; DCH crude mortality 6.9%, case mix adjusted 6.1%. NHFD average 8.2% • DCH crude Vs case mix adjusted mortality variation 0.8% • KPI 1 prompt Orthogeriatric review DCH in above average category 94%, NHFD overall 87% • KPI 2 prompt surgery DCH in above average category 86%, NHFD overall 69% • KPI 3 NICE compliant surgery DCH in average category 71%, NHFD overall 71% • KPI 4 prompt mobilisation DCH in below average category 67%, NHFD overall 81% • KPI 5 prompt delirium assessment DCH in above average category 71%, NHFD overall 58% • KPI 6 return to original residence DCH in average category 74%, NHFD overall 70%

	• Signpost NHFD patient and carer resources **What does this mean for DCH?** • Clinical leads to examine mortality run charts quarterly, to monitor current position. • Clinical leads to monitor KPI to ensure above average achievement maintained • Action plan to address reasons for failure to mobilise and monitored through monthly governance meeting **Actions** • KPI 4; prompt mobilisation; action plan to address improvement • Trauma ward to advertise resources to ensure patients and their significant others routinely well informed.
National Fracture Liaisons Services Fracture Prevention Patient Satisfaction Survey 2021 (September 2021 to Nov 2021) #5442	**Recommendations** • Local lists of private strength and balance classes are being collated, being a rural community is it extremely hard to reach elderly patients who are struggling with mobility and transport issues. **Learning points:** • Clearer patient information required to provide an understanding of bone health. • Patients would like swifter to follow up Local exercise's classes are opening back up, FLS are compiling information for patients.
National Joint Registry 2021 – 18th Annual Report 01/04/20 - 31/03/21 #5016	**Key Audit Results:** • Nationally, elective joint replacement numbers halved from previous years due to the COVID pandemic. • THR – Hybrid fixation with metal head and poly liner is most common (as it is at DCH) • TKR – Nationally, most TKRs are cruciate-retaining (in line with DCH practice). • Shoulder – The proportion of reverse polarity TSRs continues to increase nationally, in line with local practice. **Benchmarking** • All implants used at DCH are evaluated by ODEP and show excellent reliability and survivorship in the registry. **What does this mean for DCH?** • DCH continues to follow the national standards in implant selection and surgical technique. • They will have to critically consider surgeon-operating volume over future years as the pandemic recovery begins.
National Audit of Dementia Care in General Hospitals 2021 21/06/221 – 30/09/21 #5314	**Key Audit Results:** **Areas of Good Performance:** • Improvement in: Mobility& Nutritional assessments, Recording of Body Mass Index (BMI). • Increase in the number of therapy assessments recorded & In use of the Assessment test for delirium & cognitive impairment (4AT) on admission. **Areas of Concern:** • Decline in: Delirium screening, pressure ulcer assessment, continence assessments and pain assessments. • Decrease use of 'This is Me' and documented conversations with the patient and carer/relative regarding discharge plans. • Repeat cognitive assessment not being completed on discharge **Actions:** • All patient overs the age of 75 to have a 4AT delirium screen completed within 24 hours of admission. • Increased completion of MDT assessments. • Ensure patients and relatives are included in the conversations around discharge and this is documented.

	• Repeat 4AT on discharge.
National Audit of Inpatient Falls (NAIF) Annual report 2021 (2020 clinical and 2021 facilities audit data)	**Key Audit Results:** • Despite the challenges posed by COVID-19 in 2020, there have been small improvements in all the key performance indicators. However, there is still work to do to improve prevention and management of inpatient falls and fractures. • The evidence from this audit is that falls risk factors are prevalent in people who go on to sustain an inpatient femoral fracture, emphasising the importance of risk factor detection and management. • NAIF has defined what should be included in a multi-factorial risk assessment (MFRA). To effectively assess quality, future reports and KPIs will focus on individual components of MFRA as a marker of MFRA quality. The longer-term goal will be to reduce variability between trusts in the rate of inpatient femoral fracture.
National Audit of Inpatient Falls (NAIF) (2020 clinical and 2021 facilities audit data) report of audit findings for DCH	**Key Audit Results** • The Trust participated in the March 2021 facilities audit • 67% of fractures occurred on older person/frailty wards, 33% occurred on Surgical Wards. • 100% of patients had a multi-factorial risk assessment (MFRA) performed in the hospital before they sustained the IFF. Compared with 76% Nationally. • In 33% cases, the patient had fallen in the hospital before the fall that caused the fracture. Of the patients who had already fallen, 100% had a subsequent review of their MFRA after the previous fall. **Recommendations** • MFRA Components that require improvement are Vision assessment 33% and lying/standing BP 33%. • Compliance with care plan & documentation regarding Mobility and Walking aids being used. • Only 50% of patients audited had analgesia prescription recorded and average time analgesia given from fracture time was 336 minutes, delays of over 30 minutes were reported in 18% of cases nationally and 33% cases in this Trust. • Use of a screening tool to identify those at high risk is against NICE guidelines. • No bed rail audit has been recorded as completed. • Audit found no written information about falls prevention. • Falls training is not Mandatory at this Trust. • There is no Executive, or non-executive director with specific responsibility for falls.

Local Clinical Audits

Local audits are carried out by the specialties in relation to areas of their work where they are wishing to explore quality improvement or risks in services for improving. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 460 local audits were registered during 2021-22 and work will continue to see these through to completion.

The reports of 286 local clinical audits were reviewed by the provider in 2021-22.

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	Learning points

Recording weights for inpatients in Orthopaedics #5055	The key conclusions show that recording of weights on the electronic systems is variable. There is no standardised equipment for recording weight, overall recording performance was 61.11%. More than 1/3 of patients are potentially exposed to mis-dosed medication. Only 1/5th (18.51%) of patients on weight dependent drugs had their weight recorded on JAC where the actual prescribing takes place	Improvement of available equipment to cater for orthopaedic patients. Limiting factors in establishing patient weight is the difficulties putting patients on scales. Improvement of the equipment available seems to be the only way to improve compliance with weight standards and patient safety with weight specific medications.
Inpatient Laparoscopic Cholecystectomy Referrals #5410	A total of 26 patients were identified over the 4-month audit period. key conclusions: Clinic appointments for this cohort of patients are avoidable using a simple proforma. The patients who required Telephone Appointment Clinic (TAC) only needed that because they had not been consented for surgery at the time the proforma had been filled out.	It is recommended to make the proforma virtual on DPR and to that the proforma should be incorporated as standard practice by the end of 2021.
Audit Compliance of the Local Safety Standards for Invasive Procedures (LocSSIP) Checklist for Laser Procedures within the Ophthalmology Department #5247	This retrospective audit aims to identify compliance and amendments with the LocSSIP Universal Safety Checklist for Interventional Procedures and to address any non-compliance through training and reflective practice for all staff involved. The findings showed 100% compliance with the checklist, except from; Sign in of expected eye and sign out of Registered Practitioner and Name of person undertaking procedure standards (95%). Overall, the checklist total was 99.3%	Mandatory use of the National Safety Standards for Invasive Procedures (NatSSIPs) and to continue educating staff in the completion of the checklist. Review of supporting documentation when new ways of working are introduced to ensure it still meets the requirements.
Project Title: Getting It Right First Time Audit: Procedure codes and patient outcomes in Orthodontics #5247	Key conclusions: Outcome forms are being completed for all patient appointments There is some variation in the orthodontic procedure codes (OPCS) codes marked on outcome forms	Monitoring of practices through Clinical Governance meetings importance of completion of the forms. An audit of the use of OPCS codes within departments to be undertaken to evaluate the useability of the OPCS codes and need for additional codes and/or modification of their definitions.
Do Not Attempt Resuscitation (DNAR) Audit – June 2021 #5319	To assess and evaluate DNAR documentation and completion within all relevant wards The findings showed 96.9% of forms were located at the front of the patients notes; 88.5% of DNAR decisions had been clearly documented in the patients notes either written or with a yellow sticker; 81.3% of decisions were made by the appropriate grade/trained clinician; 82.3% of decisions were discussed with the patient/family; and 83.55 of DNAR decisions were accompanied by a completed TEP form.	To continue DNAR training as part of Basic Life Support (BLS)/Mandatory training. To continue to reinforce the need for a Treatment Escalation Plan (TEP) to be completed with a DNAR decision. To request support from the medical director via Resuscitation Committee Chair as required.

Auscultation of fetal heart rate after the administration of spinal anaesthesia prior to elective caesarean section #5321	The aim of this retrospective audit was to assess whether midwives are listening to the fetal heart (FH) with a sonicaid for one full minute after spinal anaesthesia has been administered prior to elective caesarean section, and whether any abnormality has been appropriately escalated. 46 sets of notes reviewed for women who were booked to have an elective caesarean section between 01.03.21 and 31.05.21 The key findings showed 25/46 (54%) listened to with a sonicaid after spinal anaesthesia; of these all were within the normal range, therefore there was no need to escalate; 45/49 (91%) of babies had Apgar scores ≥7 at 1 minute and 48/49 (98%) had Apgar scores ≥7 at 5 minutes; and 3 babies were admitted to Special Care Baby Unit (SCBU); all 3 had had the FH listened to after spinal anaesthesia, all 3 FH rates were within the normal range, and all 3 had Apgar scores ≥ 7 at 1 and 5 minutes.	It is recommended to update guidelines to include listening to FH after spinal; to email a reminder to all appropriate staff and to paragraph in the next maternity newsletter.
Dietetics Mealtime Experience Audit #5264	The aim of this audit is to compare current mealtime practices at Dorset County Hospital to those recommended in the Food and Drink Policy (FDP; 2017), with the inclusion of patient reported outcomes measures. It sampled 2 bays on twelve wards, aiming for a sample size of 96-144 patients (i.e., 4-6 patients per bay). The resultant sample size was 102 patients in total.	The learning points from this audit were that there was significant variability in performance observed across wards. This could, perhaps, be attributed to staffing levels. There are some very basic standards that have not been met, and therefore intervention to improve upon this is required.
Electronic Prescribing and Medicines Administration (EPMA) Venous Thromboembolism (VTE) Assessment and VTE Prophylaxis Service Evaluation #5268	This audit aims to compare whether the EPMA VTE assessment is associated with an appropriate VTE prophylaxis prescription. The sample included a random collection of patients admitted to wards in May2021; a total of 100 patients. The key conclusions included 93 patients out of 100 had a completed VTE assessment. Out of 93 patients, 38 patients were not on VTE prophylaxis; among the 38 – 6 patients were not prescribed VTE prophylaxis, 22 were not on anticoagulation, 4 patients were suspected bleeding, 5 with low haemoglobin and 1 patient with low platelet. Overall VTE assessment is not 100% fully associated with VTE prescription	To encourage Doctors to prescribe the VTE prophylaxis. Reminder emails are being sent monthly.
Dorset County Hospital (DCH) Adult Physiotherapy Patient Survey for	The aim of this survey is to determine whether obstetric patients with pelvic girdle pain/back pain would prefer to have a 1:1 telephone appointment or a group, online class for their initial contact	This audit highlights some of the concerns that women may have regarding a virtual education group. It is therefore recommended that: All women

Obstetric Patients with Pelvic Girdle Pain - Lower Back Pain Preference for Virtual Online Class or One-To-One Telephone Assessment #5280	appointment with physiotherapy. The sample involved a question to be asked to obstetric patients that are currently undergoing treatment for pelvic girdle pain/lower back pain during their phone consultation. The key conclusions included acknowledging data collection was unable to continue after 01/07/2021 due to staff re deployment to ward services; and a total of 16 patients were asked these questions at the beginning of their virtual, initial 1:1 Physiotherapy appointment. Of these 12 reported that they would not like to attend a virtual group setting for information regarding there back or pelvic pain. 2 patients reported that they did not mind either way and 2 reported that they had no preference.	have the choice of 1:1 intervention or a group education class. During the class it will be made clear that Physiotherapist will be available after the session for questions that they do not feel they can ask in a group setting If the group session is not helpful the route to timely 1:1 treatment is easily accessible Any educational group that is offered to this patient group should have patient feedback specifically targeting the questions surrounding how comfortable patients felt asking questions
Assessing the improvement in the care provided to adult patients in the Emergency Department (ED) who have a confirmed diagnosis of fractured neck of femur (NOF) in ED setting after the introduction of the new FIB proforma (Re-audit #5152) - Phase 2 #5316	The aim of this retrospective data collection audit of 31 patients is to identify whether adult patients with fractured neck of femur (NOF) are receiving timely pain relief including Fascia Iliacus block (FIB)and whether post-procedural pain re-assessment, monitoring and documentation are appropriately done as per the Royal college of Emergency Medicine (RCEM) standards after the implementation of the new ED proforma, and the ED junior FIB teaching. The data was collected in ED at Dorset County Hospital Foundation Trust (DCH) from the period of June 1st, 2021, to June 30th, 2021. The findings showed significant improvement in FIB procedure documentation, post-procedural pain re-evaluation boosting the efficacy of delivering patient care; Evident improvement in post procedural observation, enhancing patient safety by allowing potentially life threatening and easily missed post FIB block complications to be promptly picked up; and Only mild improvement in initial pain assessment, pain management on arrival to ED and obtaining the essential diagnostic investigations, these, however, did not contribute to early admission or shorter stay in ED.	It is recommended for a longer time scale for data collection is required to demonstrate a clearer understanding of the emergency management of patients with confirmed NOF fracture and identify the reasons behind the delay in patients being seen by physicians, the delay in investigations and speciality admission; and to consider the introduction of validated pain assessment tool for patients with cognitive impairment such as Abbey Pain scale.
Dorset County Hospital (DCH) Home First: Inpatient Audit #5322	The aim of this Local Quality Improvement Audit is to understand how well patients are currently informed about their discharge plans and current treatment. The sample size aim was 110 (10 patients per ward); in total the responses of 78 patients were captured. The key conclusions were 56.4% of patients knew when they were going	It is recommended to ensure that discharge conversations are taking place, that there is an awareness of the treatment plan and estimated discharge date; Complex discharges will be made aware to the Discharge Team; and the findings of this audit will form the base of the communication

	home; 42 participants stated that help was required at home and 69% had someone who could help; 61.5% participants that stated that they needed help had not been asked during their stay; 46.2% of patients did not require help at home, so are expected to be simple discharges. At the time of the audit, 8 out of the 13 patients who answered, 'they required support at home but had no offer of help', had a Length of Stay ranging from 1 to 42 days, which suggests various opportunities for discharge related conversations to have occurred.	plan.
Gentamycin Use and Acute Kidney Injury #5214	This audit looked at a sample of 30 patients to determine the extent of Acute Kidney Infection (AKI) occurrence, and its severity with gentamycin dose, regardless of baseline serum creatinine and comorbidities in such patients. Gentamycin caused estimated glomerular filtration rate (eGFR) decline in 8 out of the 30 patients, although it could not be accountable solely, as the 8 patients had comorbidities and sepsis.	It is recommended to follow to eGFR three monthly after the last use of gentamycin in affected patients, to see if the baseline renal function has improved or not.

Clinical Research

The research department at Dorset County Hospital delivers clinical research and has been operational since 2001. The department currently has 22 whole-time equivalent staff based at Trust Headquarters and 17 volunteer Patient Research Ambassadors. It is part of Clinical Support Services and Research (Care Group 4) in the Urgent and Integrated Care Division, under the Executive Leadership of the Chief Medical Officer.

The pandemic has brought many challenges including pausing the majority of non-COVID-19 research. However, research became centre stage on the international agenda and led to the identification of life-saving treatments, diagnostic tests, and vaccines, being the way out of the pandemic. Dorset County Hospital research staff contributed to vaccine research (and continue to do so) as well as other COVID-19 research which has been recognised regionally and nationally. For example, the RECOVERY trial resulted in treatments that significantly reduced deaths – Dorset County Hospital recruited the highest percentage of possible patients (218 patients as of 31/03/22). The SIREN study revealed *"more information about the effectiveness of vaccines in preventing infection"* with 130 staff members recruited as of 31/03/22. The Clinical Characterisation Protocol informed the Scientific Advisory Group for Emergencies – Dorset County Hospital recruited every eligible participant rather than the one in ten target (902 patients as of 31/03/22). Whilst challenging, the pandemic brought new ways of working across disciplines as well as increased awareness of the benefits of research, a legacy to be built upon.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2021-22 that were recruited during that period to participate in research approved by a research ethics committee was 1583. The Trust actively recruited to 29 of approximately 50 projects which were open to recruitment during the financial year. Between three and six of these open projects were commercially funded and sponsored. Of the active studies, five were in family services, four were in critical care with another four in renal disorders, three were in gastroenterology and another three in anaesthesia, two were in cardiovascular with another two in infection, two in stroke, and two in cancer, one in trauma and emergency, and one in ophthalmology.

The most active recruitment areas were family services (recruiting 683 participants) and infection (recruiting 552). These were largely due to large-scale COVID-19 related studies in these areas. The

commercial areas were predominantly cardiovascular and renal, with a team of experienced clinical staff supporting strong portfolios in these areas. Critical care and ophthalmology had their first commercial studies, with the ophthalmology study performing the second highest globally. This is the department's highest level of research recruitment in the last few financial years and reflects both increased activity levels due to COVID-19 as well as increased financial investment. The research strategy has been refreshed for 2022-25 to build on this success by integrating research into services within the hospital.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2021- 2022.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC suspended scheduled onsite inspections during the Covid-19 pandemic. A Monitoring Approach was implemented, and risk-based inspections were to be undertaken where appropriate. No risks have been identified in the reporting period and no actions required against DCH.

The Trust engages with all developments of the regulatory approach and supports the CQC's future developments

The Trust is currently rated 'Good' overall by the CQC following inspection of certain services in July – September 2018. The Trust continues to engage in quarterly meetings with the local and regional CQC inspection team.

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

Data Quality

The Trust submitted records during 2021-22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

	2017/18	2018/19	2019/20	2020/21	2021/22	National Average
Admitted Patient Care	99.9%	99.9%	99.9%	100%	99.9%	99.7%
Outpatient Care	100%	100%	100%	100%	100%	99.8%
Accident and Emergency Care	99.1%	99.0%	99.2%	99.7%	99.7%	96.0%

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

	2017/18	2018/19	2019/20	2020/21	2021/22	National Average
Admitted Patient Care*	100%	100%	100%	100%	100%	99.7%
Outpatient Care	100%	100%	100%	100%	100%	99.6%
Accident and Emergency Care	100%	99.8%	100%	100%	99.7%	98.6%

*Please note that the latest figures for Admitted Patient Care cover the period April 21 to February 22 inclusive only. The Accident and Emergency Care figures cover April 21 to March 22 inclusive

The Trust was not subject to the Payment by Results clinical coding audit during 2021 – 2022.

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

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

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

Data Security

As at the end of February 2022, the Trust submitted the interim Data Security and Protection Toolkit (DSPT) baseline submission to NHS Digital to demonstrate that it was compliant with 23 of the 38 assertions and 3 of the 10 national standards. The internal audit performed by BDO LLP in February 2022 confirmed that the evidence provided for 41 of the 48 mandatory sub-assertion included in the sample were found to be satisfactory, and in line with the requirements of the Independent Assessment Framework.

Through the efforts of the DSPT Working Group, the Data Protection Officer continues to gather the evidence needed to complete the 2021/22 Data Security and Protection Toolkit, which is due for submission on 30 June 2022.

Learning from Deaths

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

During April 2021 – March 2022 819 of DCH patients died. This compromised the following number of deaths which occurred in each Quarter of that reporting period:

- 165 First Quarter
- 199 Second Quarter
- 245 Third Quarter
- 210 Fourth Quarter

By 01/04/2022 231 case record reviews and 20 investigations (mostly related to deaths involving covid-19) have been carried out in relation to the 819 deaths included in item 27.1.

In 14 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:

- 35 First Quarter
- 84 Second Quarter
- 74 Third Quarter
- 38 Fourth Quarter

7 representing 0.85% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 0 of 165 representing 0% for the first Quarter
- 3 of 199 representing 1.51% for the second Quarter
- 4 of 245 representing 1.63% for the third Quarter
  0 of 210 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).

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

Specific areas of learning:

- Poor handwriting and filing. Evidence on electronic systems of failure to capture relevant clinical information but hasn't caused poor care.
- Loose notes not filed. Incomplete or unclear documentation
- No times or dates attached to several of the entries making it very unclear when the patient was discharged and re-attended
- Scanned notes on DPR - difficult to review and therefore resource intensive

This reporting period was dominated by the covid-19 pandemic. Many comments within SJRs related to the quality of documentation which has been noted in previous years. DCH has now invested in a new fully electronic patient record which was introduced in ED and Acute Medicine on 26/04/2022, and which is expected to resolve most of these problems as it is rolled out to other parts of the Trust. However, it is unlikely to become a Trust-wide system within the coming financial year. Identified issues continue to be communicated across the Trust via a newsletter, and cases of suboptimal care are forwarded to departmental Morbidity & Mortality meetings and Divisional, Care Group and Specialty Governance meetings for further discussion and learning.

- AGYLE (Electronic Patient Record) software introduced 26/04/2022
- A repeat audit of Do Not Attempt Resuscitation (DNAR) forms was completed which identified that most forms are correctly completed, but that additional training would be beneficial on aspects of communication and documentation which have been problematic during the COVID 19 pandemic. A training plan is currently being discussed and an action plan will be put in place.
- The redesigned patient record note paper containing printed watermark reminders to date, time, sign and record their PIN number with each entry is now in use across the Trust.
- Identification of a deteriorating patient, especially where sepsis or cardiac arrest occurs remains a priority. An 'All Cause Deterioration' pathway is in use across the Trust and will be audited once embedded.
- VTE assessment recording was changed to a different IT system (EPMA) from mid-July 2020 and resulted in immediate achievement of the 95% recording target. A subsequent audit has shown that prescription of thromboprophylaxis is in line with this figure.

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

- Timing & signing of notes entries – Introduction of a partial Electronic Case Note Record commenced 26/04/22 and as it is rolled out, will solve any residual problems of signature and dating.
- Identification of a deteriorating patient is under constant review by the Trust's sepsis group, and the 'All Cause Deterioration' documentation is in use since 2020/21 Q4.
- All case notes involving the End-of-Life Care pathway are reviewed by the EoLC group, chaired by a palliative care consultant, and with a review of DNAR orders and appropriateness of escalation of care decisions. Results are to be reported back to HMG on a regular basis.
- Surgical admission clerking/differential diagnosis is now a taught session as part of FY1 education – usually delivered by the Trust Medical Director. Notes will be reaudited during 2021/22.
- VTE assessments have achieved the national standard of 95% within 24 hours of admission during the year overall. The Trust's Thromboembolism Group has been reconfigured with a dedicated consultant lead since May 2021.

51 case record reviews and 0 investigations completed after 31/03/2021 which related to deaths which took place before the start of the reporting period.

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

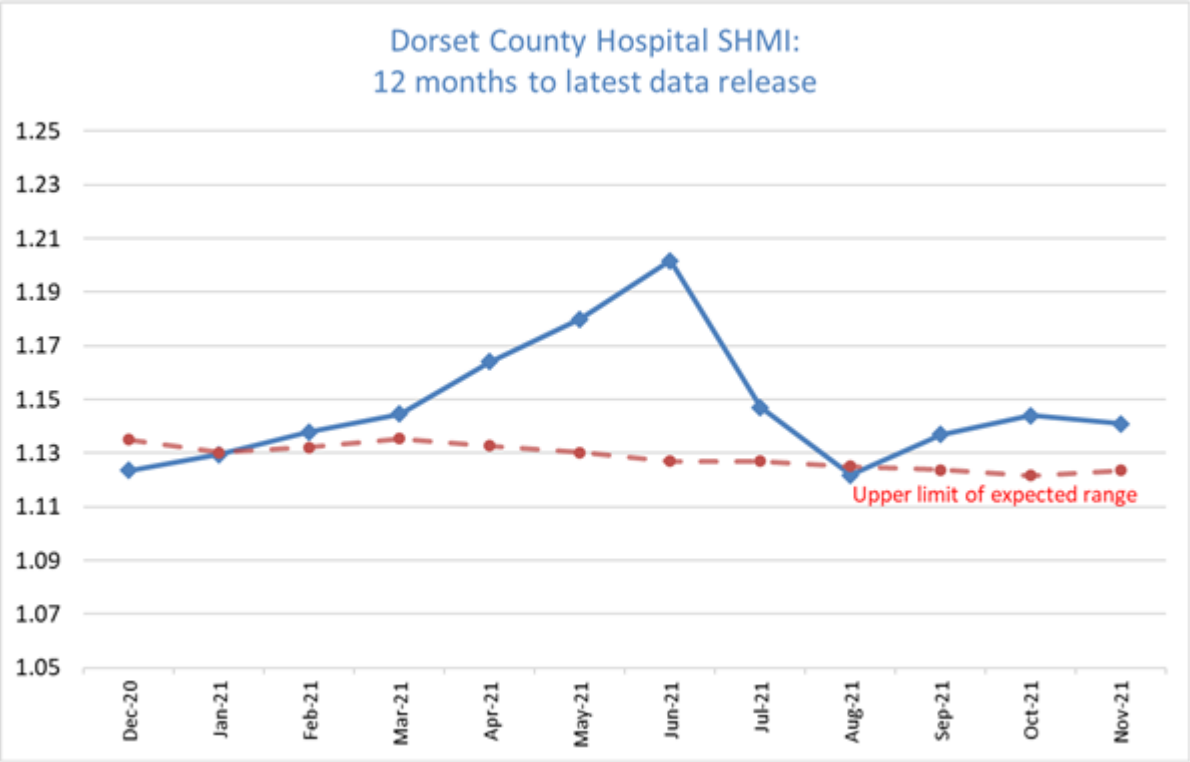
The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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

A lower score indicates better performance. In addition to individual scores, trusts are categorised into one of three bandings: 1 (SHMI higher than expected); 2 (SHMI as expected); 3 (SHMI lower than expected).

	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021
DCH SHMI 2021	1.124	1.130	1.138	1.145	1.164	1.180	1.202	1.147	1.122	1.137	1.144	1.141
DCH SHMI Banding	2	2	1	1	1	1	1	1	2	1	1	1
% Deaths with palliative care coded	44	45	44	42	38	36	37	40	40	38	38	38

Latest published data prior to submission November 2021. For further information about the fluctuation in SHMI during 2021 please see the Q2 Learning from Deaths report published on the Trust internet site.



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

Latest publication up to November 2021. Full year 2021/22 data published August 2022

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

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

Patient Reported Outcome Measures (PROMs)

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

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

Provisional publication for 2020/21, 2021/22 data currently not published

In order to respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In addition it is possible that behaviours around activities relating to the completion, return and processing of pre and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place

^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.

Emergency Readmissions

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

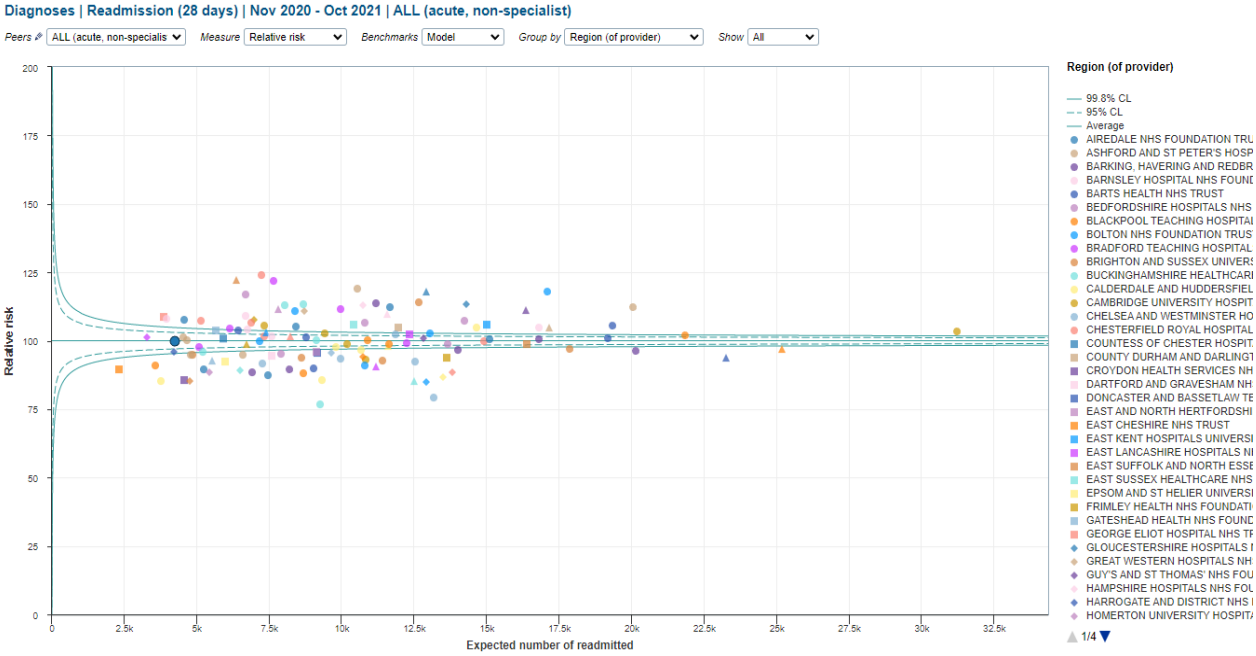
A readmission to hospital within 30 days may suggest either inadequate initial treatment or a poorly planned discharge process. The following funnel chart below shows number of readmissions within 28 days during 2021 for all acute, non-specialist Trusts. The large blue dot shows DCH's rate exactly on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

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



Responsiveness

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

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

2021/22 data to be published March 2023

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

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.
NHS OF will be published on an annual basis from March 2022 onwards. The August 2021 release was the final quarterly publication.
Source
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/may-2020/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

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

Staff Friends and Family Test (SFFT)

This test forms part of the national NHS Staff Survey undertaken in quarter 3 of each year. These figures are taken from the 2021 survey.

Results for 2021 survey shows a drop in completion locally and nationally. This is as a direct result of the Covid Pandemic

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2017	2018	2019	2020	2021

Dorset County Hospital	76%	**80%**	**78%**	**80%**	**66%**
National Average (median)	71%	**71%**	**69%**	**74%**	**58%**

Venous thromboembolism (VTE)

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

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

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

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

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

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

Clostridium difficile C-Diff

Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea. People who become infected with C. difficile are usually those who have taken antibiotics, particularly the elderly and people whose immune systems are compromised. For each HOHA – hospital onset healthcare acquired care (stool sample taken after day 2 of admission, day one being day of admission) and COHA -community onset hospital associated case (inpatient in previous 28 days prior to sample being taken) a full route cause analysis is performed to identify any learning or lapses in care with particular attention on sampling in a timely manner, isolating patients with new onset of diarrhoea and justification of prior antibiotic use.

Due to COVID-19 there has been a delay in formal review of these cases by the CCG and several PIR (post incident review) have been cancelled. As a result of this, not all the cases have yet been formally reviewed to agree if they can be removed from trajectory (learning identified). Of the cases reported for 2021/2022 to date there have been 55 HOHA and COHA cases 24 of these cases have been agreed as non-trajectory (no lapses in care or learning) 10 cases agreed as trajectory and 21 cases pending PIR via the CCG.

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

2021/22 data currently not published
Source
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Incidents

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

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

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

2021/22 data currently not published
NHS OF will be published on an annual basis from March 2022 onwards. The August 2021 release was the final quarterly publication
Source
NHS Outcomes Framework (NHS OF) - NHS Digital

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 2020/21.

Patient Safety – Reducing avoidable harms from Hospital Falls

The Trust is committed to preventing slips, trips, and falls wherever possible and minimising risk to patients in their care. Staff have specific duties in relation to assessing and managing the risk of falls in patients in order that preventative measures can be taken wherever possible.

The number of falls within the Trust has remained unchanged over time. As part of the Patient Safety Strategy, falls have been identified as one of the priority work streams to be taken forward within the Trust. The work will be led by a newly formed frailty group. This will involve multi-professional membership to include pharmacy, dietetics, and physiotherapy alongside clinical staff. It is recognized that falls are a multifactorial problem and cannot be addressed by one group of staff alone. It is envisaged that the frailty group will be overseen and report to the Clinical Safety Group.

Patient safety – All Cause Deterioration

The Trust have moved forward with a number of initiatives over the last year. The national emphasis has moved from the identification and management of sepsis to that of all cause deterioration, of which sepsis is a part. The Trust sepsis group has therefore been decommissioned, as it had achieved its objectives. This has been replaced by a Deteriorating Patients Group (DPG). This has a multi-professional membership and wider work plan.

The Commissioning for Quality and Innovation (CQUIN) scheme was paused during the pandemic but has been reintroduced this year, 2022 -2023. There are 15 indicator specifications, one of which is CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. This does not currently look at the quality of the patient management but the timing of any escalation. It is thought that this may be expanded next year. Monitoring of compliance with the CQUIN will be overseen by the DPG.

The All-Cause Deterioration Pathway and the Clinical Deterioration Episode (CDE) proforma have now been fully introduced and audit is underway to measure improvement in practice. Use of the CDE form will also allow collection of data to contribute to the CQUIN.

A Patient Safety Specialist has been appointed, as recommended in the National Patient Safety Strategy. They will oversee the workstreams set out above whilst taking forward the nine national priorities for the role. As there is much overlap between some of these priorities and the Trust risk management strategy, the two departments will join to form the Paient Safety and Risk department.

Patient Safety - Improving Mortality Surveillance and reducing Variation

To reduce duplication as per the guidance for writing a Quality Account, the Information regarding this metric is enclosed within Part 2

Clinical Effectiveness – Promoting the Health and Wellbeing of staff

Goal 2021-2022: 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 staff important to delivery of outstanding care?

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

How did DCH perform?

The Trust offers the current initiatives and support:

Wellbeing Guardian

The introduction of a Wellbeing Guardian within the Trust aligns with the current work to implement elements of the NHS Health and Wellbeing Framework. The Wellbeing Guardian role will support further development of a compassionate and inclusive wellbeing culture by independently challenging senior leaders and championing the messaging of the Trust's People Plan.

Staff Intranet

A Clinical Psychologist has been working directly with the Organisational Development (OD) Team to develop evidence-based approaches to health and wellbeing. These approaches have informed development of a 'wellbeing continuum' and assessment tools to help with self-assessment and triage approaches for more efficient signposting to appropriate support.
A new staff portal on the staff intranet has been developed where staff can access the assessment tools and be directed to relevant resources and a range of support options.

Internal courses and self-directed learning

The Trust's refreshed Health and Wellbeing (HWB) offer encourages both preventative and proactive elements, underpinned by a programme of internal courses and self-directed learning to help staff manage stress and anxiety. Self-directed learning comes in the form of workbooks, written by Clinical Psychologists. NICE guidelines clearly assert that self-help is very effective for people with mild to moderate anxiety levels.

Health and Wellbeing Coaches

A network of staff Health & Wellbeing Coaches (HWCs) has been launched to help signpost colleagues to appropriate support. The HWCs 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. This network is a rebranding and strengthening of Wellbeing Champions which had previously only been partially implemented across the Trust. The HWCs form an internal Community of Practice, with opportunities to join system-wide Networks and further development opportunities including Mental Health First Aid and Suicide Awareness.

Mental Health First Aiders

The Trust has 2 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 staff and partners. DCH currently has 75 MH First Aiders and continue to recruit from all teams, targeting particularly vulnerable groups such as junior doctors. Many MH First Aiders have opted to become Health & Wellbeing Coaches to develop wider awareness and skills to enhance the HWB support they can provide to colleagues.

Wellbeing Conversations

Throughout the last year the appraisal process has primarily focused on wellbeing conversations. From May 2022, managers will be offered the NHS Safe & Effective Wellbeing Conversations course to develop skills and approaches to further support staff.

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 (EAP) – Vivup

Vivup are 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 Vivup 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.
Vivup offer all the benefits listed above with the addition of a full benefits package including Cycle to Work, Travel & Leisure and access to a huge range of discounts across UK's major retailers.

On-site counselling service

The on-site counselling service has received guaranteed funding for the next 12 months. To ensure the service is sustainable and appropriately used, sessions will be capped, and usage monitored.
The on-site counselling service is available over 7 days. Staff with urgent needs are usually offered an appointment within 48 hours of contacting the service.

Trauma Response

Staff are supported by trauma response network across the Trust. TRiM (Trauma Risk Management) is a peer delivered assessment tool, used to determine by what degree, if any, a colleague has been affected by a potentially traumatic incident, and to ascertain whether they would benefit from further support. The network of trained TRiM practitioners will increase during 22/23, to strengthen the trauma response capacity.
Staff also have access to a 60-minute session focusing on self-care and peer support, particularly how to look for signs of psychological distress and potential trauma in self and others. This been delivered by a Clinical Psychologist to several teams across the Trust and received excellent feedback.

Physiotherapy

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

Wellbeing Walkarounds

The Wellbeing Walkaround process has been refreshed following an escalation from the People Recovery Steering Group (PRSG) to the Incident Management Team. The Walkaround timetable will prioritise areas based on known 'hot spots', People Pulse feedback and discussion with leaders within divisions and departments. The Wellbeing Walkarounds are supported by members of Senior Leadership Group (SLG), the Executive Management Team (EMT) and senior members of the People Division. The refreshed Wellbeing Walkarounds will provide visibility and accessibility to leaders as a platform for the staff voice

and to show compassion and support, whilst providing targeted HWB interventions for individuals and teams.

Financial Wellbeing

Salary Finance, a financial wellbeing service (previously called Neyber) has been available to staff since February 2019, with a financial wellbeing portal offering free financial planning tools.

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. 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.

Here for Each Other (Dorset ICS Wellbeing Hub)

The Here for Each Other service complements and enhances the on-site counselling and staff wellbeing support that is in place at DCH. The service has a variety of advice and guidance from trusted sources to help staff manage their own wellbeing. There is a link to this service on the Staff Intranet Wellbeing pages.

Covid and Flu Vaccinations

The Trust has successfully undertaken Covid and Flu vaccination campaigns. The Trust's Vaccination Hub and pop-up centres continue to offer staff easy access to vaccinations and boosters as required. The 2021/22 Flu vaccination campaign highlighted the Trust as one of the best performing for the year.

Clinical Effectiveness - Improving the identification, assessment, and referral for patients with Dementia

Dementia screening has improved since the appointment of 1.4WTE Dementia/Delirium support workers (Started in October 2021). Previously dementia assessments, in their old format have been variable and therefore the Trust welcomes a re-newed focus on all cause delirium.
They have been undertaking delirium screening of patients and following patients through their inpatient stay which enables the team, to assess, diagnose where appropriate, treat and discharge with onward care and support.
The support workers also visit every patient on the inpatient wards with a known diagnosis of Dementia to ensure that a support bundle in placed in the notes which signposts staff for additional support.
The Trust has been working with the digital team to ensure that 4AT delirium screening starts from ED and so have been part of the Agyle project*.
ANP for Dementia/Frailty continues to deliver education on Dementia, Delirium and behaviours that challenge to preceptorship students, medical training and offers bespoke training to ward teams.
Continued work on a frailty strategy with the wider MDT to provide an equitable service across the trust for patients living with Dementia.
ANP for Dementia/Frailty is engaged with the research department and is currently undertaking some research related activity funded by NIHR ARC Wessex looking at the link between Covid-19 and cognitive impairment

** Argyle is a digital patient record solution which facilitates real time clinical documentation, clinical process management, and operational management functionality. It forms part of the Trust's Digital Patient Record, and when fully implemented will be used in the Emergency Department and Inpatient areas.*

Patient Experience – Improved Learning from Complaints

Goal 2021-22:

The Trust will ensure that they learn when patients tell us they have not had a good experience with us.

Following on from the national pause of NHS Complaints during 2020, DCH have continued with a 40 working day response timeframe which was agreed by both Divisions. As the hospital has continued to experience high demand, this enabled the Trust to respond to complaints in a realistic timeframe due to the demands on the clinical staff during the past year. This timescale will continue to be monitored via the Patient Experience Group quarterly reports.

Why is learning from complaint important?

A complaint is an expression of dissatisfaction made to or about an organisation, related to its products, services or staff. Complaints are an important way for the organisation to continual learn and improve and ensure an organisation remains accountable to the public. They also provide valuable feedback to identify areas to celebrate good practice and areas where practice or services need to improve. The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints for the organisation to learn from what has happened to them. The Trust considers this feedback invaluable.

Ideally DCH would like to address any dissatified service user experience at the time, however when this has not been possible a complaint is an invaluable way to resolve concerns, acknowledge and apologise for errors and be open to learning for improvement.
For the complainants to be assured that the Trust has taken their complaint seriously and DCH have taken the opportunity to learn from their complaint, the learning points are included in the complaint response. The actions from learning points are monitored at Divisional and Care Groups meetings.

How did DCH perform?

Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings and support is provided by the Patient Experience Team which enables them to understand the emotional experience from the complainant and staff perspective and reflect upon improvements in relation to aspects of care.
Patients have continued assisted in making videos narrating their experience of the care that they received, and their feelings about the complaints process. These videos are shown to the relevant divisional leads and are available for presentation at Board when required.

Trust wide Performance

Learning and actions from complaints 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 the Trust have made progress in learning from complaints, using the digital system to help capture this, there is still more that could be achieved to fully embed and monitor learning from complaints in the Trust and across the system. As the Integrated Care System develops the shared learning will be DCH focus for the next year.

Patient Experience – Volunteer Report 2021/22

Goals for 2021/22

Reimagining, remaining flexible and responding have been the key themes for the volunteer service over the last 12 months. These themes have shaped key goals for the service which are:

Young Volunteer Programme

To sustain and develop the Young Volunteer Programme (YVP) in line with the Pears #iWill Fund beacon area commitments, focusing on both volunteer opportunities within the Trust and community engagement projects.

Volunteer Service Development

To continue to develop the volunteer service with focus on development of the Response Volunteer Team.

Volunteer Experience

To continue to collaborate with volunteers to ensure the volunteer experience at DCH is positive and that the volunteer roles and opportunities DCH offer are meaningful, safe, and support the Trust.
This report focuses on what has been achieved over the last 12 months and how they have expanded the service to support changes within the Trust.

How did DCH perform?

Young Volunteer Programme

DCH have continued to recruit a steady stream of Young Volunteers over the last 12 months but have struggled to continue to develop the programme in the ways they had planned. This is partly due to ongoing COVID restrictions and partly due to unforeseen demands on the service which has limited capacity. Despite this, DCH were able to deliver a Summer Activity Programme in August 2021 which saw Young Volunteers take part in workshops looking at the future Emergency Department plans from a young person's perspective, a research workshop and dementia awareness training. One of the young volunteers was also given the opportunity to volunteer in the Maternity unit during the summer holidays.

DCH have been able to support Weymouth college Health and Social Care students offering them volunteer placements. They have been able to count their volunteer experience towards meeting the requirements of their college course. DCH have reengaged with both Blandford Sixth Form and Weymouth College attending their volunteer fairs which they have been able to hold face to face again. The Trust will continue to reengage with local schools and colleges into the 2022/23 year.

After agreement from the Trust Senior Leadership Group, DCH signed a MOU with St Johns Ambulance (SJA) in September 21 to open an NHS Cadet unit linked to the Trust. This is due to start running in May 2022 following recruitment of cadets and a project lead. The project is funded by NHSEI and run by SJA and gives opportunities for young people aged 14 to 18 to take part in a programme which will see them

complete training ranging from learning first aid skills to developing leadership skills. As part of this programme, DCH will offer those on the foundation programme (14 to 16 years) opportunities to visit the hospital and learn more about different services and careers. The young people on the Advanced programme (16-18) will be offered volunteer placements in the hospital.

The Trust has also re-established discussions with the Dorset Youth Association and hope to collaborate with them and other youth groups in the next 12 months to establish a Youth Voice across Dorset. This will link to the #iWill theme of 'Having your Say' promoting Youth Social Action.

Volunteer Service Development

The focus over the last year has very much been on building theTrust Response Volunteer Team and that is quantified in part by the increase in requests for volunteers to support on Wards. The role is divided into two key areas:

- Healthy Stay: Supporting Inpatients on Wards with key tasks, for example hydration rounds, meal-time support, and PPE replenishment.
- Healthy Visit: Supporting in Main entrances and Outpatient departments.

Whilst the demand for support on wards from the Trust's healthy stay team has been evident through the requests received, the role of the healthy visit team is of equal importance. Alongside ongoing support to the Dialysis Unit and Medical / Surgical Outpatients, the team support main entrances, meeting and greeting and directing. They have also increased support where numbers allow in ED Triage and most recently have started to provide regular support one morning per week in the Robert White centre. Along with the healthy stay team they also continue to ensure the daily distribution of surgical masks to departments across the hospital. They support areas which are not necessarily staffed (i.e., South 1 main entrance) so they do not receive requests for their help. However, when these areas are covered by volunteers supporting patients and visitors coming into the hospital, it makes an enormous difference to patient experience.

Six volunteers in the Response Volunteer Team completed Sitting Companion training in September 2021 with the Palliative Care team. They now 'check in' with the team as part of their shift and provide support for patients at End of Life.

Funding from NHS England in the 2019/20 financial year has also enabled us to plan a project to support patient activity. Planning continued throughout last year and equipment to deliver this service has now been purchased. The Trust will be conducting training with volunteers starting in June 2022 to enable them to support staff on wards with patient activity.

The Trust took on the volunteer service at South Walks House, (SWH) Outpatient Assessment Centre just before it opened in November 2021. 60 volunteers were inducted in the first two weeks of opening enabling

the volunteers to support the new centre. This was no easy task and supporting this with no additional resource has meant the reprioritisation of other projects. This is a new volunteer service operating in a new service for the Trust and has inevitably seen challenges. The Volunteer team are collaborating with the team at SWH to overcome these challenges and with the volunteer team to develop and shape the role. As part of the development plans at SWH, the Trust are also working with the Live Well / Active Dorset team to develop the Wellbeing Champion branch to the SWH volunteer role.

The last 12 months has also seen us working with a team from the CCG and the voluntary teams at UHD and DHC to deliver the new Better Impact - data base software. The system already used successfully in other NHS trusts will see us migrate volunteer recruitment, training, and management into one system which is designed for volunteers. It has also given us a chance across the three Trusts to align the volunteer processes and share best practice. DCH are on target now to go live with the recruitment element of the system from June 2022.

Alongside the roles mentioned above the volunteer team have also continued to support other roles in the hospital including the Chaplaincy Assistants, Patient Research Ambassadors, the Friends of DCH and the YFW Blood Bikes. Figure 1 below shows the breakdown of volunteers per role at the end of March 2022.

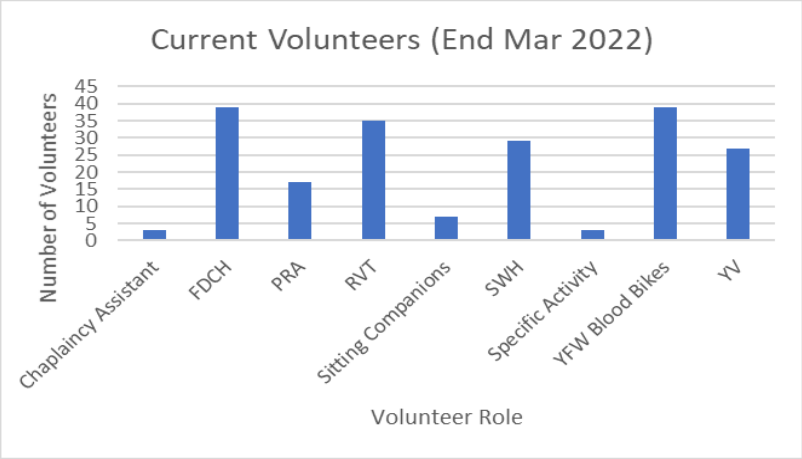


Figure 1 – Active Volunteer Role Numbers

COVID restrictions have continued to affect some roles returning to normal, this includes the Chaplaincy Assistants and also DCH PAT dog and Music volunteers, some of which have completed the returning to volunteering COVID risk assessment but who are now just waiting for the green light to resume their volutneer role in the hospital.

Volunteer Experience

DCH were delighted that as the end of September 2021 approached, the volunteers moved into the new and permanent volunteer hub. The new hub is located has been vital to supporting volunteers in the Response role giving them a base from which to operate and support effectively. This has in turn contributed to improving their experience.

Whilst COVID restrictions have prevented us from holding the Trusts annual 'thank you' events during the Summer and at Christmas, DCH has made sure it has acknowledged their contribution by providing thank you gestures in the hub and recognising their achievements through nominations at the Trust annual GEM awards, where DCH was delighted to see three of the team win the volunteer of the year award.

Volunteer health and wellbeing has been a priority for the service over the last year and continue to monitor closely the health and wellbeing of the volunteers. The support team make it a priority to be present so they can offload to us when they need too. They are also taking positive steps as a team to make sure the Trust is better equipped to support the health and wellbeing of volunteers. This has included a volunteer co-ordinator taking part in the first Health and Wellbeing Champion training course at the Trust. The support they provide for one another also continues to grow and the team ethos between themselves and the growing positive response they receive from staff and patients they help, is helping and providing a more positive atmosphere and volunteer experience.

Summary and the Year ahead

The focus over the last 12 months has largely been to continue to respond to changes and work with a small team of volunteers to shape the service provided. The next 12 months will see DCH build that team so that it can provide more effectiveness and opportunity both on the main hospital site and at South Walks House. To enable additional capacity to achieve this and to expand the voluntary services team, DCH are thankful for the funding from NHS England Voluntary Partnerships Winter funding programme. The funding supports anew post that will assist the team in their aspirations and the impact of this will be monitored as part of the overall delivering of volunteer support.

As part of the partnership approach of DCH the Trust will continue to work with the NHS England voluntary partnerships team, other NHS Voluntary teams and the wider voluntary sector is a key part of ongoing development of the service and will continue to contribute to the network and work with them on various projects. This is helping DCH to look ahead and understand better how volunteering will look in the future. This will be vital in looking at how DCH develop and recruit into volunteer roles which support the Trust, and which are safe, but which also offer flexibility, meaningfulness opportunities to use and develop individual skills and experience, as part of the social value pledge to the local communities.

As DCH head into another 12 months it will certainly continue to be busy, will see the projects come to fruition and hopefully offer opportunity to do more. Whilst DCH will need to remain flexible to changes, it will continue to build on what it has already achieved and continue the work to ensure it can provide a consistent volunteer service and positive volunteer experience.

Speaking Up Disclosure

It is a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian (FTSUG). The Guardian's key role is to support the creation of a positive, open learning culture where people feel listened to, and feedback is welcomed, and acted on. The Trust have designated FTSU roles including the FTSU Guardian, Senior Independent Officer who holds a Non-Executive Director position on the Trust Board, and FTSU Champions across the Trust. The holders of these roles ensure all methods of raising concerns are promoted, including Line Managers/Supervisors and colleagues, the Human Resources (HR) Team, Patient Safety & Risk Team, Trade Unions, Occupational Health and Chaplaincy Services, Professional Regulars, and the National Guardian Office. Staff are encouraged to Speak Up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

At DCH the FTSUG role is as a facilitator and enabler rather than 'fixer' of issues, following up with line managers on progress in resolution and identification of trends to support organisation learning. There are several enabling factors that support 'speaking up' throughout the Trust, including a visible leadership culture that supports and encourages the raising concerns at all levels in all parts of the organisation. DCH ensures that those raising concerns are listened to, feel valued and that their concerns receive the appropriate level of review and response. The FTSUG feeds back directly to those who raise concerns or ensures feedback is provided by others involved in cases such as HR Managers and Line Managers. Where staff are concerned, they will suffer detriment for speaking up, their confidentiality is protected (unless required to disclose it by law) and there are options to raise concerns anonymously.

The FTSUG provides six-monthly updates to the Trust Board, as recommended by the National Guardian's office, and meets bi-monthly with the Non-Executive Director responsible for FTSU and the Chief People Officer.

Rota Gaps

The Trust has processes in place to monitor and act on Rota Gaps.

Trainees are encouraged to exception report, and these are used to drive changes including recruitment to fill such gaps. The hospital departments, education team and Guardian work cooperatively to review exception reporting, liaising with doctors in training via the Junior Doctor Forum and aim to tackle problems proactively.

The current GMC survey is active, and the previous results (covering 2020-21 – Covid period) is available from DME presentations contained within the Trust Board papers which are available through the Trust Website.

Risk Assessment Framework and Single Oversight Framework Indicators

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

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

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

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

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

Target achieved
Target not met

^pre 2019/20 criteria based on hospital acquired cases (post 72 hours) due to lapses in care, from 2019/20 onwards hospital onset healthcare associated cases defined as those detected in hospital three or more days after admission
~2019/20 nationally published VTE data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic

Annex 1 Statement from Trust Partners

Letter to Mark Addison Chairman of Dorset County Hospital NHS Foundation Trust, re the Quality Account 2021-2022

Thank you for asking me to comment on the Quality Account 2021-2022 on behalf of Dorset County Hospital NHS Foundation Trust (DCH) Governors. This is a remarkable report, demonstrating the breadth, depth, and high quality of clinical audit (in the broadest sense) in this Trust. The level of involvement is impressive, and the detail of data and the presentation reflect the dedication and pride of those involved in its compilation. We have come a long way since the Commission for Health Improvement was formed in 1999 and charged "to provide national leadership to develop and disseminate clinical governance issues" under a framework of 7 pillars namely patient involvement, clinical audit, risk management, risk reporting, clinical effectiveness, staff focus and use of information. These remain relevant today.

However, whilst we are proud of the services we provide at DCH, we need to be careful to avoid complacency. The recent Okenden Report concerning maternity failings at Telford and Shrewsbury Hospital makes for very difficult reading. The four-page Executive Summary is an indictment of failure of clinical quality practice, audit, leadership, and personal integrity and serves as a reminder to all services. Of additional concern is that previous assessments covering the same period by external quality agencies (Care Quality Commission, Clinical Commissioning Group and the Royal College of Obstetricians and Gynaecologists) overlooked the failings and praised the exceptional low Caesarean Section rates, which may themselves have contributed to foetal intrauterine damage. Fear of retribution also resulted in staff withdrawing previous critical statements.

I believe DCH encourages openness and supports the reporting – including self-reporting - of errors and near misses, as this is the road to prevention and excellence. Recent General Medical Council guidance under consideration states "You must treat the patient with kindness, courtesy and respect". Profound advice which I am pleased to say I have consistently experienced during my 41 year association with DCH.

Yours sincerely

Dr David Cove

Lead Clinical Governor DCH

NHS
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Clinical Commissioning Group

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31 May 2022

Nicola Lucey
Chief Nurse
Dorset County Hospital NHS Foundation Trust
Williams Avenue
Dorchester
Dorset DT1 2JY

Dear Nicky

Re: Quality Account 2021/2022

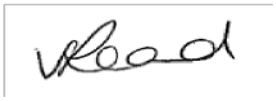
Thank you for asking NHS Dorset Clinical Commissioning Group (CCG) to review and comment on your Quality Account for 2021/2022. Please find below the CCG's statement for inclusion in the final document:

Dorset Clinical Commissioning Group welcomes the opportunity to provide this statement on Dorset County Hospital's Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of the information we have received during the year as part of limited monitoring discussions due to the COVID-19 pandemic during 2021/2022.

In 2021/2022 Dorset County Hospital NHS Foundation Trust did not set new priorities due to the ongoing Covid-19 pandemic. The Covid-19 pandemic prevented the trust from achieving the continued priorities due to operational pressures. However, quality improvement work continued which saw a reduction in severe harm falls to patients. Quality improvement work continued with the early identification of deteriorating patients and patient experience. The CCG acknowledges the challenges that responding to the Covid-19 pandemic has presented to quality improvement

The CCG supports the three key strategic priorities for 2022/23. The priorities include reducing health inequalities, recognition of deterioration and working in partnership with the population. We look forward to receiving regular further updates on the progress in these areas, whilst recognising that the NHS faces a challenging backdrop from increased demand alongside recovery of services from the impacts of the Covid-19 pandemic. The CCG remains committed to work with Dorset County Hospital NHS Foundation Trust, over the coming year to ensure all quality standards are monitored.

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



Yours sincerely

Vanessa Read
Director of Nursing and Quality

Healthwatch Dorset welcomes the opportunity to comment on the Dorset County Hospital NHS Foundation Trust Quality Account report for 2021-2022. Healthwatch exists to promote the voice of patients and the wider public with respect to health and social care services. We work with the health and care system to ensure that patients and the wider community are involved in providing feedback and that this feedback is taken seriously.

This year we've worked with Dorset County Hospital to gather feedback on A&E services. Our volunteers carried out 256 phone interviews with people who used Dorset County Hospital A&E in 2021. Most people we spoke to gave us positive feedback, areas for improvement included access, environment, information, and waiting times. Our report will help to make improvements to the current service and guide plans for a new modern hospital Emergency Department: https://healthwatchdorset.co.uk/wp-content/uploads/HWD-AE-Dorset-Hospital-report-final-April22.pdf

We look forward to working with the Trust over the coming year to share people's views and ensure the voice of the patient, their families and carers are sought, heard and acted on to improve quality.

www.healthwatchdorset.co.uk

Annex 2 Statement of Directors' Responsibility for the Quality Report

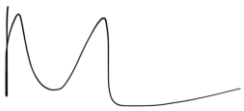
In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

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

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

By order of the board:

Mark Addison
Chairman



Nicholas Johnson
Interim Chief Executive