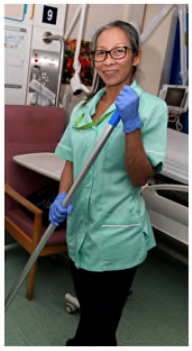
Respect
Integrity
Teamwork
Excellence

NHS
Dorset County Hospital
NHS Foundation Trust

Quality Account

2022 - 2023

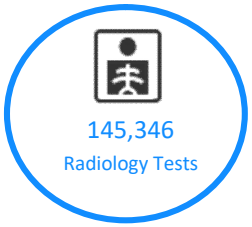


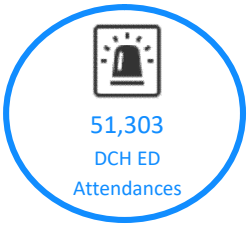



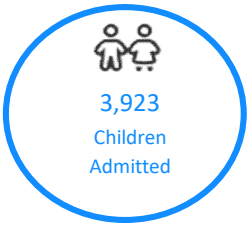
Outstanding care for people in ways which matter to them

Our Year 2022/23


67,793
Patients Admitted

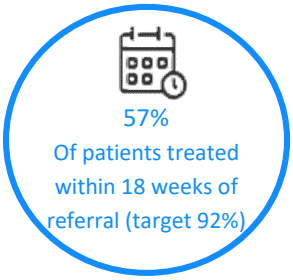

145,346
Radiology Tests


51,303
DCH ED Attendances

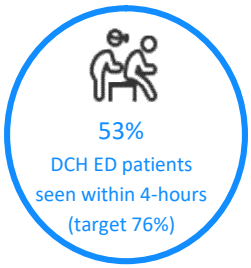

3,923
Children Admitted

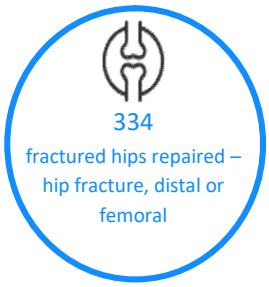

1,551
Babies born (registerable births)

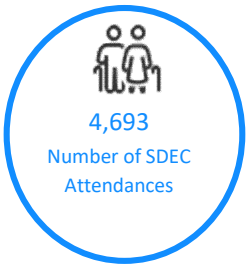

1,501
patients treated for cancer

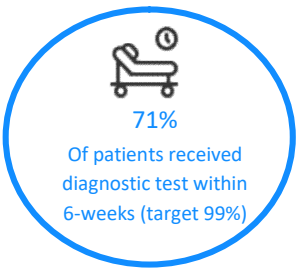

57%
Of patients treated within 18 weeks of referral (target 92%)

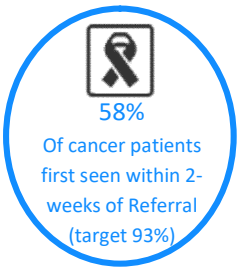

444
stroke patients treated

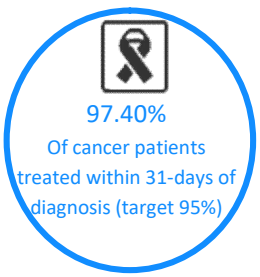

53%
DCH ED patients seen within 4-hours (target 76%)

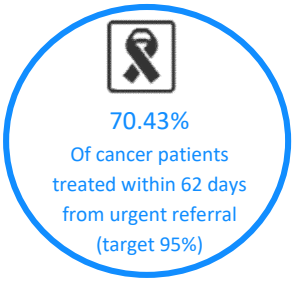

334
fractured hips repaired – hip fracture, distal or femoral


4,693
Number of SDEC Attendances


71%
Of patients received diagnostic test within 6-weeks (target 99%)


58%
Of cancer patients first seen within 2-weeks of Referral (target 93%)


97.40%
Of cancer patients treated within 31-days of diagnosis (target 95%)


70.43%
Of cancer patients treated within 62 days from urgent referral (target 95%)


165
New Doctors


111
New Nurses inc. Healthcare Support Workers & students

Quality Accounts 2022/23

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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 2022-2023

This year has continued to be a testing time for many, and I would like to acknowledge the tremendous hard work of all my colleagues in Team DCH. 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 this period of recovery post pandemic, the difficult winter and during the most recent Industrial Action. Despite the unprecedented pressures we have faced this year – limited workforce, limited funding, increasing demand for services and over a third of the hospital beds accommodating people waiting for non-acute care - I am proud that all of my colleagues have maintained our focus on quality improvement and safety, ensuring it is our number one priority.

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

The following Quality Account details the progress made against the priorities set for last year; it will also detail the priorities set for the forthcoming year 2023-2024.
I am pleased to confirm that the Board of Directors has reviewed the 2022-2023 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 2022/2023

In line with national guidance, DCH developed priorities following engagement with DCH clinical staff, partners, the executive team, local community representatives and, of course, patients and their families.

Dorset County Hospital NHS Foundation Trust (DCH) continued to work to deliver changes to improve both the effectiveness and the quality of its services throughout 2022/23. For complete quality and performance data the public can access Trust Board papers

Below are listed the quality improvement priorities undertaken with an end of year update:

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 continues to 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 has continued its progress to implement the All-Cause Deterioration pathway. Following a Governance structure review a Deteriorating Patient Group and a Patient Safety Committee is now in place with multi-professional membership and a comprehensive workplan in place for the coming year. Work has recommenced to embed the All-Cause Deterioration flowchart and associated Clinical Deterioration Episode (CDE) form into practice. Further detail of this work can be found in Part 3 of this report.

- IPC working with Trust Partners

DCH Infection prevention and Control team (IPC) have worked closely with Integrated Care System Infection and Prevention and Control Team since the start of the pandemic in 2019. This close networking has continued and strengthened over time. Areas that the network supports includes.

- monthly post infection reviews,
- monthly covid working group which has increased in frequency depending on covid incidents and guidance changes,
- updates and teaching sessions on current relevant infections such as Avian flu and Monkey Pox.

DCH have also been collaborating with the prison service and covid working groups – particularly during increased incidence, DCH IPC Team have also worked closely with the Trusted Assessor team within Dorset to support discharges to care homes and correct covid testing as per government guidance. The Southwest IPC network continues to meet bimonthly to discuss and support IPC teams on all current IPC issues.

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

The Trust continues to engage patients in development of services and the Trust estate. Stakeholder engagement continues to be an important part of our communications and engagement strategy for the Trust's Your Future Hospital programme. Further detail of this can be found in Part 3 of this report.

Over the last year the Trust have run a series of engagement events for young patients (12- 18-year-olds) with long term health conditions to get their thoughts about their forthcoming Transition journey and what they would like the Transition service to feel like for them. The Trust has also held engagement events (both virtual and face to face) for parents and carers of young people to understand their views of Transition. Additionally, patient engagement staff have attended the Kingston Maurwood event for families of children and young people with Special Education Needs & Disabilities (SEND). The Trust is planning further events with patients who have already been through the Transition journey to find out the areas of good practice and improvement. The Transition Nurse will also join the upcoming Dorset Parent Carer Council (DPCC) and Dorset Council Roadshows for families of young people with SEND, ensuring families and young people remain at the centre of everything we do to develop high quality, effective transition services.

The Transition service has put forward a business plan for 3 youth workers to join the team which would enable the development of a more robust young people's forum in the Trust.

The Patient Experience Team and the Transition Nurse are also planning to roll out a '15 Step Challenge' around the Trust with a view to looking at services from a young person's perspective. This will help improve quality of services for young people whilst involving young people.

In order to increase awareness of carers, the Trust has collaborated with Dorset Carers Hub to produce a short film about the experience of Carers at DCH. This film forms part of a rolling programme of education for staff to promote the importance of included Carers in the discharge process. This training is currently ongoing and being well received by department we have visited. This training was paused for some time over the winter due to the operational pressures in the hospital. The Carers Passport has been co-designed with local carers and in collaboration with the Carers teams at both University Hospitals Dorset and Dorset Healthcare. The passport has been developed to distinguish and identify informal carers on the ward. Once a carer is identified and their role agreed, the ward manager will issue a Carers Passport and lanyard to ensure that all carers are clearly recognisable by the ward team.

Quality Improvement Priorities 2023-2024

Priorities for 2023-2024 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 2023 and were approved at the Trust Board in May 2023.

Patient Safety

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

Patient Experience

1. In collaboration with the Dorset 100 Conversations programme, increase staff capacity through a Train the Trainer Programme and capture the patient voice to inform service delivery and quality improvement.
    a. As measured by training numbers, captured feedback and direct application to targeted programmes and QI projects.
2. Deliver purposeful, therapeutic activity to patients through a planned programme of work developed by the Active Hospital Group and through the recruitment and delivery of a volunteer Activity Squad.
    a. As measured by progress against agreed action plan, training numbers, delivery of targeted activities and calendar of events, patient experience survey and overall incidence of violence and aggression against staff by patients who lack capacity (via Staff Survey)
3. Improve the experience of Children and Young People admitted to hospital with emotional, psychological, and mental health needs.
    a. As measured by local and national patient survey, progress against actions,

Clinical Effectiveness

1. Deliver continuous improvement in the Standardised Hospital Mortality Indicator (SHMI) to within expected limits.
2. Deliver the national target for Electronic Discharge Summaries of issue within 24hours of discharge.
3. Deliver full compliance with the Maternity Incentive Scheme (MIS), with emphasis on improving compliance with C02 monitoring at booking and audit of Transition.

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 2022-2023, Dorset County Hospital NHS Foundation Trust (DCH) provided and/or subcontracted 35 relevant health services.

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

The income generated by the relevant health services reviewed in 2022-2023 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2022-2023.

The Trust income in 2022-23 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 2022-23, 60 national clinical audits covered relevant health services that the Trust provides.

During that period the Trust participated in 83% 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 2022-23 are as follows within the table.

The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2022-23 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 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

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

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

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Breast and Cosmetic Implant Registry	Y	Y	15	100%
Case Mix Programme	Y	Y	643	100%
Child Health Clinical Outcome Review Programme 1	Y	Y	no data available	no data available

Elective Surgery: National PROMs Programme	Y	Y	no data available	no data available
Emergency Medicine QIPs: ***a. Pain in children***	Y	Y	20	incomplete
b. Assessing for cognitive impairment in older people	Y	N	no data available	no data available
c. Mental health self-harm	Y	N	no data available	no data available
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People 1	Y	Y		
Falls and Fragility Fracture Audit Programme 1: ***a. Fracture Liaison Service Database***	Y	Y	1397	100%
b. National Audit of Inpatient Falls	Y	Y	9	100%
c. National Hip Fracture Database	Y	Y	405	100%
Gastro-intestinal Cancer Audit Programme 1: ***a. National Bowel Cancer Audit***	Y	Y	221	not all patients diagnosed will meet the inclusion criteria
b. National Oesophago-gastric Cancer	Y	Y	40	not all patients diagnosed will meet the inclusion criteria
Inflammatory Bowel Disease Audit	Y	Y	851	45% (due to NDOO)
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Y	Y	5	100%
Maternal and Newborn Infant Clinical Outcome Review Programme 1	Y	Y	1481	100%
Medical and Surgical Clinical Outcome Review Programme 1 **National Confidential Enquiry**	Y	Y	Testicular Torsion = 4 Transition from Child to	Organisational Questionnaire for Crohn's not completed

into Patient Outcome and Death			Adult Health services = 4 Crohn's Disease = 6 Community Acquired Pneumonia =6 Epilepsy = 5	
Muscle Invasive Bladder Cancer Audit	Y	Y	41	not all patients diagnosed will meet the inclusion criteria
National Adult Diabetes Audit 1 ***a. National Diabetes Core Audit***	Y	Y	400	100%
b. National Diabetes Foot care Audit	Y	Y	100	100%
c. National Diabetes Inpatient Safety Audit	Y	Y	32	100%
d. National Pregnancy in Diabetes Audit	Y	Y	13	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme 1: ***a. Adult Asthma Secondary Care***	Y	Y	58/62	93.5%
b. Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	161/182	88.4%
c. Paediatric Asthma Secondary Care	Y	Y	17	no data available
d. Pulmonary Rehabilitation-Organisational and Clinical Audit	Y	Y	no data available	no data available
National Audit of Breast Cancer in Older Patients 1	Y	Y	58	not all patients diagnosed will meet the inclusion criteria
National Audit of Cardiac Rehabilitation	Y	Y	no data available	no data available
National Audit of Care at the	Y	Y	39 Case notes	78%

End of Life 1			18 Staff reported measures. 42 Quality surveys	- 22.2% response
National Audit of Dementia 1	Y	Y	87	100%
National Cardiac Arrest Audit	Y	Y	63 cases	no data available
National Cardiac Audit Programme 1: ***b. Myocardial Ischaemia National Audit Project***	Y	Y	247	100%
d. National Audit of Cardiac Rhythm Management	Y	Y	426	100%
e. National Audit of Percutaneous Coronary Interventions	Y	Y	473	100%
f. National Heart Failure Audit	Y	Y	226	100%
National Child Mortality Database 1	Y	Y	no data available	no data available
National Early Inflammatory Arthritis Audit 1	N	N	Cases seen at UHD	no data available
National Emergency Laparotomy Audit 1	Y	Y	109	100%
National Joint Registry **Knees primary/Revision**	Y	Y	Knee Primary =150/151 Knee Revision =11/14	99% 78%
Hips primary +revisions	Y	Y	Hip Primary = 219/211 Hip Revision = 23/20	96% 86%
Shoulder primary revisions	Y	Y	Shoulder Primary =24	100%
National Lung Cancer Audit 1	Y	Y	212	not all patients diagnosed will meet the inclusion criteria
National Maternity and Perinatal Audit 1	Y	Y	no data available	no data available
National Neonatal Audit Programme 1	Y	Y	no data available	no data available
National Ophthalmology Database Audit	Y	N	software not available	no data available

National Paediatric Diabetes Audit 1	Y	Y	no data available	no data available
National Perinatal Mortality Review Tool 1	Y	Y	no data available	no data available
National Prostate Cancer Audit 1	Y	Y	339	not all patients diagnosed will meet the inclusion criteria
National Vascular Registry 1	Y	N	no data available	no data available
Perioperative Quality Improvement Programme	Y	N	PQIP: Research project in this Trust	Governance through Research dept.
UK Renal Registry: ***a. Acute Kidney Injury programme***	Y	N	Local Audit	no data available
b. UK Renal Registry Chronic Kidney Disease Audit	Y	Y	Quarter 106 - Renal status 24/03/2022 - 820 patients Quarter 107 - Renal status 30/05/2022 - 836 patients Quarter 108 - Renal status 09/01/2023 - 841 patients Quarter 109 - Renal status 23/02/2023 - 836 patients	Data Collection Period 1st March 2022 to 28th February 2023. 100%
Respiratory Audits: ***a. Adult Respiratory Support Audit***	Y	N	no data available	no data available
b. Smoking Cessation Audit- Maternity and Mental Health Services	Y	Y	no data available	no data available
Sentinel Stroke National Audit Programme 1	Y	Y	479 Acute Stroke, 333 TIA 38 'Other' records (850 in total)	no data available

Serious Hazards of Transfusion UK National Haemovigilance Scheme	Y	Y	14	100
Pulmonary Rehabilitation- Organisational and Clinical Audit	Y	Y	150	100%
Society for Acute Medicine Benchmarking Audit	Y	Y	43	100%
Trauma Audit and Research Network	Y	Y	587	100%
UK Parkinson's Audit	Y	Y	20 cases from elderly care 20 cases from neurology	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.

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

Report Title	Report Precis
#4773 NCEPOD Dysphagia in people with Parkinson's Disease (PD) 2019 - Hard to Swallow 18/06/2019 – 31/12/2019	This Audit examines the pathway of care for patients with Parkinson's disease (PD) admitted to hospital, to explore multidisciplinary care and organisational factors in the process of identifying, screening, assessing, treating, and monitoring of their ability to swallow. Improvements made at DCH since this study: There is an alert system in place to notify the specialist PD service when a patient with PD is admitted to hospital and an In-patient PD report is available daily for PD nurses. PD patients with swallowing and communication difficulties are referred to Speech and Language Therapist (SLT) by the ward staff. Lead PD Nurse Specialist and SLT will ensure the hospital policy for "risk feeding", which includes the assessment of mental capacity, is implemented if appropriate. Hospital SLT liaise with community SLT to discuss best way forward. PD Nurse Specialist and SLT organise Multidisciplinary Team (MDT) meetings and have joint ward rounds

The reports of 20 National Clinical Audits were reviewed by the provider in 2022-23.
The Trust intends to take the following actions to improve the quality of healthcare provided.
The table below summarises the audit outcomes and the actions taken as identified by the review undertaken:

Audit / Clinical Outcome Review Programme	What this Trust learnt
#5716 **RCR National Re-audit Evaluating Radiological Reporting of Fragility Fractures** **01/04/2022 – 04/12/2022**	**Areas of good performance:** Bones/vertebrae were reviewed in 97% of the cases. Usage of correct terminology in 66.66 % of the cases. **Areas of concern**: The severity (grading) of the fractures is not mentioned. Audit result: 16.66% (Target- 90%). Appropriate onward referral to appropriate team not mentioned. Audit result: 0% (Target: 100%). Action plan in place to present report at Governance Meeting and re-audit within 6 months.
#5133 **NELA - National Emergency Laparotomy Audit 2020 – 2021 (01/12/2020 – 30/11/2021)**	**Areas of Good Performance:** DCH Mortality of 4.4% which is below the national average and best in Wessex. Excellent Consultant Surgeon engagement both with preoperative decision making and presence in theatre. Once decision to operate made, patients arrived in theatre in an appropriate timeframe. High rate (>90%) admission to ITU/HDU for high-risk patients. **Areas of Concern:** Case ascertainment was 65% of predicted. Action- to improve case ascertainment. Documented preoperative input from Anaesthetics and ITU consultant 'Amber and Red' risk. Consultant Anaesthetist presence in theatre 'Amber' risk resulting in Best Practice Tariff (BPT) rate of 71.4%. Action – Improve Anaesthetic engagement to achieve BPT. Post operative assessment of patients over 80 (or 65 years old+ and frail) by a geriatrician led multi-disciplinary team) is only 30% (Red risk)- Action- to discuss with Elderly Care Consultant re Geriatric Access.
#5290 **National Pleural Services Organisational Audit National Pleural Services Organisational Audit Report 2021** **1 April – 30 April 2021**	**What does this mean for DCH:** The overarching aim of this Organisational Audit - to implement Getting it Right First Time (GIRFT) recommendations by April 2024: - 1.An agreed out of hours protocol to access appropriately trained thoracic ultrasound and pleural procedural operators 2.Trusts/Health Boards should identify nominated Thoracic ultrasound mentors & pleural procedure training leads. 3.Nominated thoracic ultrasound mentors and training leads should have recognised time within job plans to deliver these leadership 4. Work towards achieving recommended nursing complement (1 band 6 Pleural nurse/300 pleural procedures. 5.Set in place admission avoidance pathways and appropriate infrastructure to reduce hospital length of stay and maximise generation of the Best Practice Tariff for Pleural Effusion. **DCH is not currently compliant with the above recommendations it** was decided at the Business Meeting 10/1/2023 that a separate group should meet to discuss the next steps, a business case will need to be submitted, an action plan is in place.
#4061 **National maternity and Perinatal Audit (NMPA)** **National Maternity and Perinatal Audit: Clinical report 2022** **1 April 2018 and 31 March 2019**	**What does this mean to DCH:** Recommendations of this National Audit to improve the availability and quality of information regarding possible interventions during labour and birth, by offering individualised evidence-based information in a language and format which is accessible and tailored to each woman or birthing person's circumstances. **At DCH:** Every effort is made to provide information in an accessible manner, including other languages. We do not have plans to introduce I DECIDE yet. All women consented for an instrumental birth are consented for episiotomy. Readmissions require an incident report to be submitted and these are

	reviewed by the maternity safety team. We work closely with our Maternity Voices Representative to ensure the voices of our service users are represented and heard. Skin-to-skin is recorded in our digital maternity system. We are currently focusing on skin-to-skin in theatre
#4847 **National Diabetes (Paediatric) NPDA Parent and Patient Reported Experience Measures 2021** **August 2021 – January 2022**	**Benchmarking:** -Scores received were in line on average with the average of other units. - Emotional Wellbeing scores given were below average, it was agreed this was expected as no Psychologist currently in post. - Scores for 24-hour access to the service were satisfactory, despite not currently offering a dedicated 24-hour diabetes response service. - Responses confirmed that school awareness of diabetes was high which is a positive. **What does this mean for DCH** -Transition Service – currently being set up. Processes to be finalised. -Clinic capacity/ format to adhere to local and National guidance. -Emotion Wellbeing – Psychologist recruited and in post 30/11/2022. -To increase the number of responses in future PREMS surveys – use of 2 laptops to be addressed. Report presented: 15/9/2022.
#4841 (2021) **National Audit of Breast Cancer in Older Patients (NABCOP) 2021 Annual Report** **Jan 2014 – Dec 2020** **2022 Annual Report**	**What does this mean to DCH:** DCH achieved very good documentation of treatments used in secondary care. **Actions:** To ensure Oncology reviews their chemotherapy associated morbidity and surgical teams review their reoperation rates in a timely fashion. Have adopted the NABCOP fitness assessment for Older Patients into routine use in clinics
#4714 **2019 UK Parkinson's Audit** **Patient Management: Neurology**	This audit enabled assessment of our current practice using the NICE guideline and NICE Quality Standards for Parkinson's disease and to benchmark our service to services nationwide. An action plan was agreed by the team to improve the compliance & quality of care of our Parkinson's patients.
#4995 **National Diabetes Audit (NDA) 2020/21** **Type 1 Diabetes** **January 2020 to 31 March 2021**	**What does this mean for DCH:** DCH is continuing to improve targets achieved for HbA1c, BP and Cholesterol – ensuring access to structured education, flash glucose monitoring, pumps, CGMS and other technologies along with statin use for primary prevention and tight BP control.
#3905 **12MBRRACE Maternal, Infant, and Newborn programme 2017/19** **Ref. 299 Maternal, Newborn, and Infant (MNI) Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care Core report: lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017/19** **Published November 2021**	**DCH Response to National recommendations:** 1 Risk factors associated with women over 40, are incorporated into relevant guidelines, for example prevention of pre-eclampsia. 2 Embryo transfers are only performed in In Vitro Fertilisation (IVF) units, transferring multiple embryos results in more twins in this higher risk age group, they may require admission to DCH for high-risk antenatal care. 3 Standard Operating Procedure developed that reflects guidance from Royal Colleges of Obstetricians and Gynaecologists, Onward referral when appropriate. 4 Clear pathways for referral to perinatal mental health care with a Multi-Disciplinary Team (MDT) approach. 5 There is no exclusion based on diagnosis (though responsibility for this lies with DHC rather than DCH). 6 All investigations use MDT approach with all groups of staff engaging when asked to contribute. There are a group of incidents that fulfil the criteria for external review (HSIB) and DCH supports this programme of investigation. In house investigations are reviewed at Learning from Incident Panel with any actions identified and allocated. 7 Antenatal VTE and Postnatal VTE guidance is available when staff input patient details onto the Badgernet digital system. Identifying women at high risk during the antenatal period. If applicable they are referred to the Haematology department for on-going care.

	8 Aspirin in pregnancy guidance aligns to national recommendations and will be available at pregnancy booking to identify those women who require aspirin. It will then be reviewed following the combined screening/Papp-a results. 9 There is a well-established post birth clinic staffed by an Obstetric Consultant. There is the capacity to refer to a midwife with counselling skills if required. 10 Continuity of care team caseload some women with mental health concerns. This point is not flagged as a specific reason for doing early postnatal review. Women could be reviewed by their primary care provider. Inpatient psychiatric care would be provided by DHC not DCH. 11 Working with the family is part of the holistic care provided by midwives. 12 If women have engaged with services during the pregnancy this will continue during the Postnatal period. Information is shared with Health visiting service. Should we become aware of issues post birth then these women are referred at that time. All women are assessed immediately following birth to ensure those that require it are provided with medication and training
#4955 **National Child Mortality Database (NCMD) and Perinatal Mortality Review 1st Annual Report 2019**	The report describes the links between neonatal illness and increased risk of death in the first 10 years of life and identifies regional variation in death rates. The Southwest of England is in the group with the lowest link between neonatal illness and death. The study looked at child deaths over a 2-year period. It linked information from the National Child Mortality Database (NMCD) to data available from Badgernet, the electronic recording system for neonatal care. Many of the recommendations are for national developments, commissioning of services and research programmes
#0000 **National Child Mortality Database (NCMD)- The contribution of Newborn health to child mortality across England** **April 2019 March 2021**	**DCH Response to National recommendations:** 1.Engage with social initiatives to reduce & mitigate risk factors, working with commissioners for health services and other agencies to improve social circumstances of families. 2.Audit the implementation of the overseas visitor charging and ensure exemptions are correctly applied to minimise the deterrent effect of charging for maternity services. 3.May have opportunity to participate in suitable Research trials. 4.NICE QS116 re domestic abuse, Maternity services have a social screening questionnaire used with all women Where domestic abuse is identified there is a protocol in place for how to respond to this and seek appropriate support for the family. 5.Works closely with the local network ensuring good communication between units regarding women with at high-risk pregnancies. 6.Uses evidence-based care bundles ensuring medical care prior to delivery is optimised. Compliance with the care bundles is audited and used to support benchmarking. 7.Uses evidence-based care bundles and liaises closely with the neonatal network about the care of individual babies. Neonatal care and outcomes are monitored via the network. Regular audits, case discussions and dissemination of learning is shared. 8.May be able to participate in suitable Research trials looking at initial resuscitation and stabilisation applicable to our patient cohort. 9.Ensures training and competencies of all staff involved in the care of neonates meets national training requirements in this area. 10.Staff give safe sleep advice to all families. It is particularly important for families of infants born preterm or of low birth weight and needs to be repeated at each opportunity. 11.Parents of children with learning disability need to be aware of the risk factors for death in their children. These messages are regularly reinforced and are particularly relevant to paediatric staff working with these families as the difficulties become apparent but also needs to be considered on a

	multiagency basis. 12.Has access to interpreting services, staff are encouraged to be proactive in highlighting these to professionals and to service users. Staff are also aware of other areas where people may have additional needs for communication e.g., the deaf, the visually impaired as information we provide is in written format. 13.Provided excellent palliative care to a number of babies that have subsequently died. This has been noted at the Child Death Overview Panel. The Baby Loss midwives offer bereavement support to those families that have lost a young baby. For the older infants and children, the paediatric community nursing team offer support and access to ongoing support through Gully's place (local charity supporting bereaved parents). 14.Parents are routinely asked if they would like to contribute to the child death review process. The Perinatal Mortality Review Tool for infants <28 days has facilitated seeking parental views and at the child death overview panel parents are always consulted for their views.
#5022 **Round 3 of Epilepsy12, Cohort 2, Coordinating Epilepsy Care: a UK-wide review of healthcare in cases of Care: a UK-wide review of healthcare in cases of mortality and prolonged seizures in children and young people with epilepsies.**	**Areas of good performance:** West Dorset Children see a paediatrician with expertise in Epilepsy and have access to an Epilepsy nurse. We have better than national average waits for access to Electroencephalography (EEG) 75% v 53%. 75% of school children have an individual health care plan. **Areas of Concern**: Mental health support and screening: Although we do not use a specific screening tool our Clinicians identify autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and mental health problems during clinic appointments and refer/signpost patients to support services. Transition: DCH does not have a separate Epilepsy clinic to support transition to adult services we use the ready /steady /go model which we start at age 13 years old. Formal referrals are made to adult clinic at age 17. Currently the adult service has no capacity for face-to-face transition clinic appointments. **Actions/Recommendations:** 1. There is a need for investment in mental health services and resources to screen for ADHD and ASD 2. There is a need to commission increased integrated psychosocial and mental health support for children and young people receiving care for long-term conditions. It is proposed that this should be co-located within the epilepsy clinic, and inclusive of co-morbidities. 3.Transition: The Trust is reviewing Paediatric Epilepsy service improvements to support transition to adult services.
#5177 **National Surgical Site Surveillance: Repair of Neck of Femur 2020** **01/07/2020 – 30/09/2020**	**Areas Of Good Performance**: There were 53 operations carried out during this period with one reported post - discharge surgical site infection giving an infection rate of 1.9%. There were no inpatients/ re-admissions with infection post-surgery. Consistently low rates of infection post-surgery with zero inpatient infections and zero re-admission with a post operative infection. Good response rate of 66% of questionnaires returned with 47 individual questionnaires sent out. **Areas Of Concern**: Infection rate post discharge is higher in percentage terms when compared to previous audit (1.9% vs 0.0%) although this relates to a single patient of the 53-patient sample group. 1 Continue to monitor surgical site infections as per mandatory guidance from UKHSA. 2. Divisions to be aware of audit results to incorporate into Divisional IPC Workplans and Divisional Governance Plans 3. Audit results to be shared at IPC group meeting
#5032 **National Diabetes Footcare Audit**	**Areas of good performance:** Patients are seen 5 days from receipt of referral to assessment in clinic. This is well within the recommended 13 days.

(NDFA) 2020 (2014 – 2020)	The team have not been able to benchmark their data using the published report, however, the National team are launching a dashboard later this summer which will enable data to be reviewed regularly by local teams & to ensure our service meets the identified quality standards.
#5033 National Diabetes Inpatient Audit (NaDIA) 2020/21, including NaDIA Harms. 2018 - 2021	1.DCH has an inpatient diabetes team including diabetes specialist nurses and an inpatient podiatrist. -There is a need for succession planning with possibility for secondments. -No inpatient diabetes dietician, specialist pharmacist or psychologist. -Diabetes cover at weekends is in place at 1 in 5. 2.Regular NaDIA harms entry for the last 12 months. Two null months (Oct 21, June 22) 3.Networked BGL meters since 2008 -Not inclusive of blood gas glucose results or CGM -Means of identifying people with diabetes on admission (elective or emergency) 4.Self-management policy in place although uptake remains as variable.
#5348 British Thoracic Society National Smoking Cessation: National Smoking Cessation Audit 2021: Management of Tobacco Dependency in Acute Care Trusts: Audit Report	National figures are available. DCH lacks formal Smoke Stop provision, 35% of Trusts have a Smoke Stop member of staff. DCH No Smoking policy in place but lacks enforcement. **Action:** Recruit Smoke Stop Practitioners to fulfil the need for support on wards for targeted lung health checks.
#4796 Fracture Liaison Service (FLS) Database- Annual Report: Variable resilience of FLSs during the COVID-19 pandemic: January to December 2020	Fracture Liaison (FLS) team has performed strongly despite the Covid pandemic, the service continued through outpatient telephone contact. The FLS 2021 figures registered on the database show strong performance. 1. Junior Doctor's project reviewing electronic discharge (EDS) forms on ICE system found that the mention of prescribed bone sparing medications is often missed, these incidents are reported and raised with the Orthopaedic team. 2. Agreement to pull DEXA requests forward if the 12-week date is in jeopardy, should begin to show improvement from early 2023
#4796 Fracture Liaison Service (FLS) Database- Annual Report: Variable resilience of FLSs during the COVID-19 pandemic: January to December 2021	DCH patient capture rate achieved 76.2%, a decline of 8.9% from 2020. Spinal capture 52.1%, declined by 7.3%, all the same patient capture processes are in place and are above the expected achievement and well above the National Average of 20.8%. Time to DXA has vastly improved, to 44.2% (from 11.1% last year). DCH results are above the National Average. Patients follow up rate at 16wks – 76.9% - an increase of over 3%. A new clinic setup has been established, the FLS team are achieving 100% of follow up calls, but only 76.9% are meeting the correct timing. What does this mean for DCH? The DCHFT Fracture Liaison (FLS) team continues to perform strongly and is progressing towards achieving pre Covid pandemic performance, the service did not close as the outpatient contact is made via telephone contact, but outpatient services especially DXA are still struggling to catch up. Poor discharge summary information is impacting on time such as checking and chasing medications due reported as RISK events.
#5037 NAIF National Audit of Inpatient Falls (FFFAP) 2021: Annual Report 2022 Working together to improve inpatient falls prevention (2021)	Good performance: Cases where patients were checked for injury before being moved. DCH 75%. NAIF Overall 74%. Area of Concern: Multi factorial risk assessment (MFRA) quality score. DCH 25%. NAIF 30%. This will be addressed by changing our current PACT score to Fall Safe. Cases that received a medical assessment within 30 mins of a fall. DCH 38%. NAIF Overall 70%. What does this mean for DCH.

	Relaunch of Falls Action Group and encouragement of participation from all inpatient wards. Review of the Slips, Trips and Falls Policy. New MFRA (Fall Safe) to be implemented. New post-falls process. To implement the 'Hot Debrief' and 'After Action Review' in place of a post fall checklist. Action Plan in place for the next 12 months.
#0000 Pulmonary rehabilitation 2021 organisational audit Summary Report April 2020 to July 2021	Key Audit Results: 1.Provide Pulmonary Rehabilitation to all people with a COPD self-reported exercise limitation MRC grade 3-5: - Our local service specification supports this indicator and in practice we support patients MRC 3-5. 2.Conduct initial and discharge assessments for home-based programmes: - We have only offered home programmes since Covid lockdowns, and we conduct initial and discharge face to face assessments for patients who are offered a home-based programme. 3. Provide people with a written plan for ongoing exercise maintenance: - Ongoing exercise is discussed and documented on discharge from the course. Written resources are provided but there is an opportunity here to ensure the information we give is clear and has progressions for the patients. A plan is in place to update the ongoing exercise information given to patients on discharge by end of March 2023. 4. Ensure all PR services have an agreed standard operating procedure (SOP): - Our service currently does not have a SOP, producing an SOP is a priority for the service by June 2023.

Local Clinical Audits

Local Clinical Audits Local audits are carried out by the specialties in relation to areas of their work where they are wishing to explore quality improvement or risks in services for improving. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 233 local audits were registered during 2022-23 and work will continue to see these through to completion. The reports of 46 local clinical audits were reviewed by the provider in 2022-23. A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

#5689 Dorset County Hospital (DCH) Goals for Acute Kidney Injury (AKI) and AKI Check List 01/12/22 to 19/01/23
Intention of the audit
An Audit of the use of AKI protocol in patients developing AKI at or during admission. To offer appropriate initial and subsequent primary care management. To refer acute kidney injury patients to other health care professional when appropriate. To prevent the development of acute kidney injury in people at risk.
Standards Source: Trust Acute Kidney Injury Guidelines
How it was undertaken: Data was collected and analysed in Excel:
Documentations used for data collection: a. AKI Checklist b. Intake / Output charts c. Drug charts. d. Discussed with specialist team. e. Urine dip results documented in notes. On Clinical System - ICE – stage calculated on rise in creatinine.
Findings.
Standard Met
6.Early escalation to appropriate team was excellent = 100%
Standard not met.
1.Overall use of AKI Checklist & Urine Dipstick performance & documentation was poor = 0%
2.Appropriate fluid balance monitoring and assessment = 68%
3.Repeat U+E in 1st 24hr = 84%
4.Review of nephrotoxic medication needs improvement = 75%
4.Performance of USS KUB in 24hrs for AKI stage 3 = 17%
5.Satisfactory early senior review for AKI patients = 73%
Outcome and Improvement

To improve education and performance of urine dipstick and documentation in clerking Proforma on admission; and to document reason if this not done on admission. To clarify treatment escalation plan regarding dialysis management for CKD 3 patients. Education of junior Drs on Induction regarding AKI pathway bundle.

#5463 Preoperative Thirst: a patient experience quality improvement project 28/02/2022 – 03/04/2022 and 30/05/2022 – 28/06/2022

Intention of the audit

Quality Improvement audit aimed to improve patient satisfaction and reduce patients reported levels of preoperative thirst by reducing patients reporting moderate or severe thirst at point of collection for surgery by 50% by 1st July 2022 for patients in the Surgical Admission Lounge (SAL).

How it was undertaken

The sample was a prospective data collection using a tool designed in conjunction with the Patient Experience team.

Findings showed significant Improvements in patient reported experience of thirst post change to 'Sip till Send' for adult patients in SAL – from a mean of 29.3% of 92 patients uncomfortable with thirst (moderate or severely) to 12.4% of 128 patients after change in practice (17.9% absolute and 67.9 % relative risk reduction). Nil by mouth mean time reduced from 5 hours 47minutes to 1 hour17 minutes with high levels of process adherence. Great reduction in number of patients with extreme (over 12 hour) fast times; and there were no reported adverse events (aspirations/cancellations).

Outcome and Improvement

Continuous monitoring for adverse events – continuous review of Incident Reporting on DATIX events by theatres management team and project lead.

Continuous review of patient health outcomes (already continuously collected Perioperative Quality Improvement Programme (PQIP)/ Patient Reported Outcome Measures (PROM Data) and association of any changes to implementation of 'Sip till Send';

Review of patient information pre arrival

#5558 Tackling the orthopaedic elective arthroplasty backlog due to COVID-19: Can weekend lists offer a solution? 25/02/22-6/05/22

Intention of the audit

The aim of this audit is to identify if elective joint replacement NICE guidelines are adhered during weekend arthroplasties and to identify any modifiable.

modifiable factors which cause a delay in recovery and reaching the discharge criteria.

Standards Source: Joint replacement (primary): hip, knee, and shoulder. NICE guideline [NG157] Published: 04 June 2020

How it was undertaken

It sampled 33 patients who underwent an elective arthroplasty over 6 months, on a weekend (Saturday) list at DCHFT.

Findings The findings showed 36% (12/33) of patients had a delay in reaching the criteria for discharge, of which 75% (9/12) had cardiovascular co-morbidities; The most common reason for delay was inadequate management of post-operative nausea, vomiting and pain, 42% (5/12), with a lack of weekend clinician review accounting for 33% (4/12) of delays; Average time to physiotherapy from operation was 23hrs and 8 patients received physiotherapy within 24hrs of operation, 1 of which had a delayed discharge.

Outcome and Improvement

Clinical review should not be omitted at the weekend. Manage pain and nausea. Ensure Early physio, aids prompt discharge and better outcomes from arthroplasty. Acting on these recommendations will improve patient flow throughout the orthopaedic department ensuring elective patients are discharged in a timely manner making room for more elective and trauma lists and result in better post-operative management.

#5570 Audit of Fetal Movement Discussions Taking Place Between Women and Clinicians from 28 Weeks of Pregnancy 01/01/2022 – 10/04/2022

Intention of the audit

A retrospective audit, its aim was to assess whether midwives and obstetricians are documenting that they have discussed fetal movements at every antenatal clinic appointment from 28 weeks of pregnancy, by checking the 'Fetal Movements Discussed' field in the digital notes.

How it was undertaken sampled 50 patients taken from BadgerNet inpatient lists between 01.01.22 and 10.04.22.

Findings
Most midwife clinic appointments had the fetal movement discussion field checked in the digital notes. The Consultants and registrars were less likely to check the fetal movement discussion field but had documented 'FMF' (Fetal Movements Felt) in some cases elsewhere in the notes.
Outcome and Improvement
To request the Digital Team to change 'fetal movement discussions' from optional to mandatory settings.
To raise awareness to midwives and obstetricians the importance of listening to a woman's account of her baby's movements, and to ensure that she is happy with the frequency, type, and pattern of movement.

#5634 Trans perineal Prostate (TP) Biopsies Under General anaesthetic: Experience of a Brand-New Operator 1st April 2022- 31st May 2022
Intention of the audit
A Retrospective audit; to review the outcomes of Trans perineal route as the sole method of prostate biopsy.
How it was undertaken
42 patients underwent TP biopsies of their prostates in the study period.
Findings
TP route of prostate biopsy should permanently replace the transrectal ultrasound (TRUS) guided approach in our trust; Patients should be involved in the decision-making process and made aware of what to expect after the procedure; The number of cases should be kept to the minimum required to make appropriate diagnosis and minimise its morbidity; and Junior Urologists joining the department should be allowed to gain skills in TP prostate biopsy, as it is a relatively straight forward but very important diagnostic tool in patients with suspected prostate cancer.
Outcome and Improvement
It is important to note the correct orientation of biopsy specimens before they are sent to the pathology department to exactly locate the cancer and make a correct surgical plan.

#5588 Dorset County Hospital (DCH) Pharmacy Ward Insulin Fridge Audit 2022 01/05/2022 – 31/05/2022
Intention of the audit
The aim was to check ward medicine fridges for diabetes injectables including patient's own, To Take Outs (TTOs), expired or undated opened insulin vial stock.
Findings
The findings showed 124 inappropriate insulin pens /vials were found. 41 were TTOs of discharged patients; 10 were patients own; 13 were expired stock; 5 were stock with no date; 27 were unlabelled; 28 were glucagon-like peptide-1 receptor agonist injections (GLP-1); No pens were found with needles attached. In conclusion Insulin and dulaglutide injections amounting to £816 and £615 respectively required destroying, at a cost of £1326 to the Trust,
Outcome and Improvement
This audit has the potential to reduce wasted insulin and pharmacy time, whilst ensuring that patients are discharged with an appropriate supply of insulin.
Medicine fridges still require weekly inspection by ward staff to ensure contents correlate with current in-patient list and that medicines are returned to pharmacy appropriately.

Clinical Research

The research department at Dorset County Hospital delivers clinical research and has been operational since 2001. The department currently has 20 whole-time equivalent staff based at Trust Headquarters and 10 volunteer Patient Research Ambassadors. It is part of the corporate service of the Trust, under the executive leadership of the Chief Medical Officer and the Clinical Director for Research.

Research is still very much centre stage on a national and international level and Dorset County Hospital continues to contribute to the RECOVERY, RESILIENCE, and GROWTH of research with the support of the NIHR. As well as this, Dorset County Hospital has had a focus on commercial research in line with the expediting of commercial studies directed by Department of Health Social Care, and NHS England.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2022-23 that were recruited during that period to participate in research approved by a research ethics committee was 920. The Trust actively recruited to 29 of approximately 46 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, six were in family services, four were in critical care with another four in renal disorders, six were in gastroenterology and one in anesthesia and surgery, three were in cardiovascular with another two in infection, six in stroke, and seven in cancer, two in trauma and emergency, and one in ophthalmology.

The most active recruitment areas were family services (recruiting 553 participants) with the next highest recruiting areas being anaesthetics (161) and surgery and gastro (114). The commercial areas were predominantly cardiovascular and renal, with a team of experienced clinical staff supporting strong portfolios in these areas. Maternity/Paediatrics had their first commercial study which recruited 80 patients. Our commercial recruitment last year was 95, nearly double our previous years commercial recruitment (50). The research department formed a quality group and is undergoing a review of its governance with a newly formed steering committee with the focus of improving accountability locally.

Finally, the research department has engaged with Dorset HealthCare in the set up and delivery of the Weymouth Research Hub to support the delivery of the vaccine innovation pathway. It is expected that this will be operational in summer 23-24.

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 2022- 2023.

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

CQC undertook a targeted Inspection of the Mental Health provision for Children and young People with Mental health conditions including Learning Disabilities and autism, who require admission to an acute Trust.

The Trust welcomed the opportunity to receive feedback from CQC in order to ensure safe care is provided to our population. No rating was applied to this targeted review, however as part of the published report the Trust is acting on recommendations provided by the CQC.

Dorset County Hospital NHS Foundation Trust has developed and shared an action plan with the CQC on the following areas:

Regulation 11. Need for consent –
Actions taken

- The Trust has reviewed and updated its Trust consent policy.
- The Trust has provided targeted update training on consent, capacity and competency by Trust solicitors to Emergency Department (ED), Paediatrics and Trust wide teams, including Maternity.
- In addition to hard copy consent forms, the Trust is to develop digital records to ensure consent is clearly recorded. Digital consent project to commence 2023.
- The Trust has developed a Competency template for use with Children and Young People.

Regulation 12. Safe care and treatment
Actions taken:

- The Trust will deliver Mental Health Act (MHA) 1983 Section 5(2) holding powers for inpatient training to targeted individuals. Training programme by Dorset Healthcare University Foundation Trust in place
- The Trust will deliver Safe Holding training in identified areas for both adults and children. Delivery by Dorset Healthcare University Trust. Safe Holding Training
- Utilisation of the Paediatric Reasonable Adjustment form. This assesses environment, cognancy and clinical risk.
- CYP Paediatric Reasonable Adjustment and Risk Assessment Care Plan (safety observation chart) is in place with recommended observation frequency and actions to implement following risk assessment for level of Mental Health observations required.
- Refurbishment of space is underway to provide a de-escalation room and ligature free bathroom. Full engagement with MH provider and specialist staff to ensure fit for purpose and inclusive for the variation in required need.
- The Trust will complete development and implementation of a Trust Ligature policy.
- PDOC (patient specific care plans)in place to ensure known risks are managed from the point of arrival to facilitate appropriate location if admission required and staffing levels that meet individualised care needs to ensure patient safety.

Regulation 13. Safeguarding service users from abuse and improper treatment
Actions taken:

- All ED/Paediatric Assessment Unit (PAU) attendances and admissions to Kingfisher Ward are subject to review by the Safeguarding Team.
- All interventions and advice, including MDT, Professionals and Strategy meetings are formally recorded in patient medical records and on Digital Patient Record (DPR)
- Oliver McGowan e-learning training launched to replace Trust local training programme for Learning Disability and Autism awareness.
- The Trust will improve Level 3 Children's Safeguarding training compliance.
- The Trust will continue to utilise the Dorset CYP Memorandum of Understanding
- The Trust has an established policy for supporting children, young people and adults who have a learning disability and or autism when accessing DCHFT services

Regulation 15. Premises and equipment

- At the time of the inspection, the Trust was undertaking a capitol build programme within the ED Department and mitigations were in place. All estates and building work is now complete. Dedicated Safe Room and Paediatric Waiting Room both in use.

The Trust is currently rated 'Good' overall by the CQC 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 current ratings given to the core services and five key questions:

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 2022-23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	National Average 2022/23
Admitted Patient Care*	99.9%	99.9%	99.9%	100%	99.9%	99.9%	99.6%
Outpatient Care*	100%	100%	100%	100%	100%	100%	99.8%
Accident and Emergency Care	99.1%	99.0%	99.2%	99.7%	99.7%	99.6%	95.3%

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

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	National Average 2022/23
Admitted Patient Care*	100%	100%	100%	100%	100%	100%	99.7%
Outpatient Care*	100%	100%	100%	100%	100%	99.9%	99.5%
Accident and Emergency Care	100%	99.8%	100%	100%	99.7%	100%	98.3%

The Trust was not subject to the Payment by Results clinical coding audit during 2022 – 2023.

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

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

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

Data Security

The Trust completed the interim Data Security and Protection Toolkit (DSPT) baseline submission to NHS Digital on 24th February 2023 and demonstrated that it was compliant with 18 of the 36 required assertions that comprise the 10 national data security standards.

An internal audit performed by BDO LLP in February 2023 confirms that the evidence provided for 45 of the 49 mandatory sub-assertions included in the sample were found to be satisfactory, and in line with the requirements of the Independent Assessment Framework. Using the risk and confidence evaluation methodology provided in NHS Digital's independent assessment guide, BDO conclude *Moderate* assurance over the design and operational effectiveness of the Trust's data security and protection controls, and *High* confidence in the Trust's 2022/23 DSP Toolkit return because the work so far completed on the Toolkit is in line with the requirements.

In order to comply with the DSP Toolkit, the Trust is required to meet all 36 assertions (a total of 113 mandatory sub assertions), therefore further work will be needed to ahead of the year-end submission due on 30 June 2023, the Data Protection Officer continues to gather the remaining 31 pieces of evidence.

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 2022 – March 2023 894 of DCH in-patients died. This compromised the following number of deaths which occurred in each Quarter of that reporting period:

- 197 First Quarter
- 219 Second Quarter
- 246 Third Quarter
- 232 Fourth Quarter

By 01/04/2023 XXX case record reviews and XX investigations (mostly related to deaths involving covid-19) have been carried out in relation to the 894 deaths included in item 27.1.
In XX 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:

- 77 First Quarter
- 83 Second Quarter
- 68 Third Quarter
- 46 Fourth Quarter (Completed SJR's)

0 representing 0% 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 197 representing 0% for the first Quarter
- 0 of 219 representing 0% for the second Quarter
- 0 of 246 representing 0% for the third Quarter
- 0 of 232 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. An audit of cardiac arrest carried out July 2022 showed

Specific areas of learning: - Quality Managers not involved in this audit

- Poor handwriting and filing. Evidence on electronic systems of failure to capture relevant clinical information but hasn't caused poor care.
- Loose notes not correctly filed and therefore difficult to collate.
- 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 – remain difficult to review and therefore resource intensive

This reporting period was less affected by the covid-19 pandemic than the previous year, but in-patient crude mortality across the UK is now higher than it was for reasons which are unclear. Many comments within SJRs related to the quality of documentation which has been noted in previous years. DCH invested in a new fully electronic patient record which was introduced in ED and Acute Medicine on 26/04/2022, and which has improved documentation standards in these areas. It is expected to also resolve most of these problems as it is rolled out to other parts of the Trust. 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
- 'Deaths of patients in hospital but awaiting more complex discharge plans' (no criteria to reside) are now monitored on a monthly basis, and will be reported to the Board within each quarterly Learning from Deaths report.
- Discussion around completeness of DNAR forms led the HMG to suggest mandatory completion of such forms for all patients before, or within 24 hours of, admission. Since the paperwork is 'pan-Dorset' this idea is being raised at an ICS level meeting May 2023.
- The redesigned patient record note paper containing printed watermark reminders to date, time, sign and record their PIN number with each entry remains in use across the Trust where AGYLE is not yet in use.
- VTE assessment recording was changed to a different IT system (EPMA) from mid-July 2020 and resulted in immediate achievement of the 95% recording target. A subsequent audit has shown that prescription of thromboprophylaxis is in line with this figure, but a separate audit of readmissions as a result of VTE occurrence demonstrated that such patients are more likely to have been prescribed prophylaxis incorrectly or not at all. This problem has now been referred on to the VTE committee for further action.

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

- Timing & signing of notes entries – Introduction of a partial Electronic Case Note Record (AGYLE) commenced 26/04/22 and has resolved these problems within ED specifically. As its coverage is increased across the Trust it is expected that the same improvement will be evident.
- Identification of deaths among patients awaiting discharge began in April 2023 and data quality issues are still being improved to enable a full analysis.
- 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 remains a taught session as part of FY1 education – usually delivered by the Trust Medical Director. Notes will be reaudited during 2021/22.

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

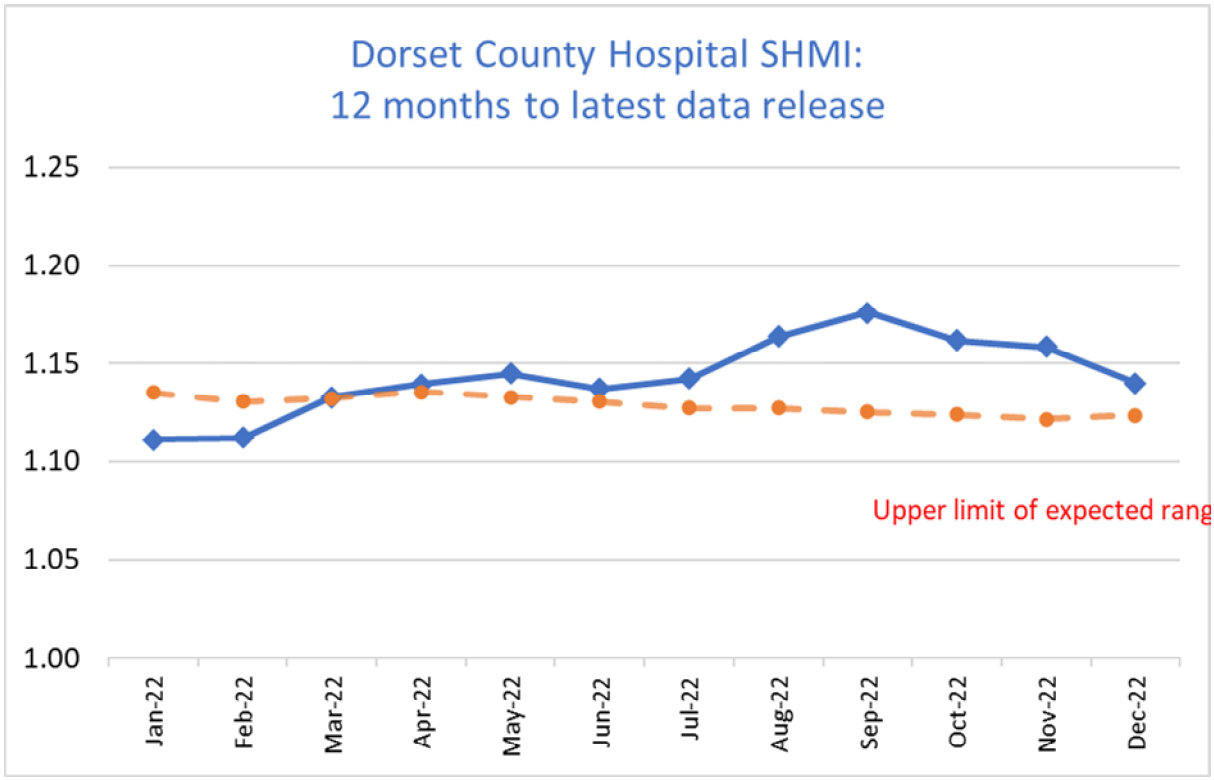
The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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).

	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
DCH SHMI 2022	1.111	1.112	1.133	1.139	1.145	1.137	1.142	1.164	1.176	1.162	1.158	1.140
DCH SHMI Banding	1	1	2	2	2	2	2	2	2	2	2	2
% Deaths with palliative care coded	40	43	45	44	45	46	46	47	47	47	47	47

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	2022/23*	Trend
Banding	**2**	**2**	**2**	**1**	**2**	**1**	**1**	**2**	**1**	**1**	**N/A**	
Value	**1.07**	**1.11**	**1.10**	**1.16**	**1.12**	**1.17**	**1.19**	**1.13**	**1.14**	**1.13**	**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%**	**45.0%**	**N/A**	
National Average	*19.9%*	*23.6%*	*25.7%*	*28.5%*	*30.7%*	*32.5%*	*35.0%*	*37.0%*	*38.0%*	*40.0%*	*N/A*	
Lowest	*0.1%*	*0.0%*	*0.0%*	*0.6%*	*11.1%*	*12.6%*	*12.0%*	*9.0%*	*8.0%*	*11.0%*	*N/A*	
Highest	*44.0%*	*48.5%*	*50.9%*	*54.6%*	*56.9%*	*59.0%*	*60.0%*	*58.0%*	*63.0%*	*66.0%*	*N/A*	

Latest publication up to November 2022. Full year 2022/23 data published August 2023

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

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

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

Patient Reported Outcome Measures (PROMs)

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

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

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

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

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

Source - Click link and find latest financial year report, scroll down to the SHMI palliative card coding contextual indicators and select the Excel Doc called % of deaths with palliative care coding

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	2022/23	Trend
Aged 0 to 15 years												
Total Spells	5,147	4,749	4,676	4,948	4,975	4,778	4,677	4,568	3,165	4,260	4,702	
Of which, readmitted as an emergency within 28 days	456	393	442	471	488	478	508	573	372	527	584	
Dorset County Hospital	**8.9%**	**8.3%**	**9.5%**	**9.5%**	**9.8%**	**10.0%**	**10.9%**	**12.5%**	**11.8%**	**12.4%**	**12.4%**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Aged 16 years and over												
Total Spells	16,832	16,103	17,567	18,263	18,837	17,957	17,920	18,196	14,439	17,081	15,588	
Of which, readmitted as an emergency within 28 days	1,741	1,695	1,994	2,222	2,295	2,142	2,316	2,504	2,087	2,204	1,787	
Dorset County Hospital	**10.3%**	**10.5%**	**11.4%**	**12.2%**	**12.2%**	**11.9%**	**12.9%**	**13.8%**	**14.5%**	**12.9%**	**11.5%**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*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: indirectly standardised percentage, <16 years, annual trend, P" (Indicator P00913) from the NHS Digital Indicator Portal and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.
To find the percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percentage, 16+ years, annual trend, P" (Indicator P00904) and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.
Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

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

Responsiveness

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

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

2021/22 and 2022/23 data not published.

Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators.
As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made in due course.

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

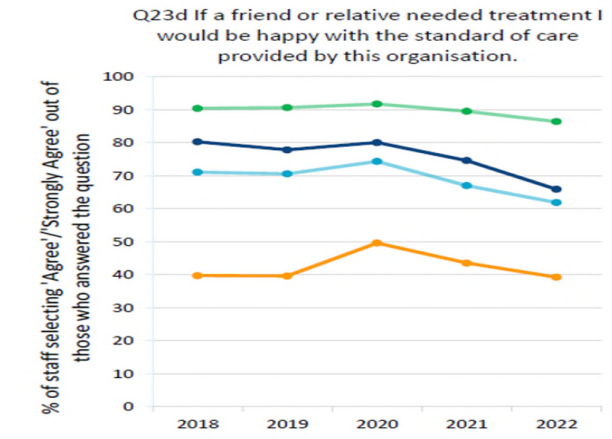
The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.
NHS OF will be published on an annual basis from March 2022 onwards. The August 2021 release was the final quarterly publication.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

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

Staff Friends and Family Test (SFFT)

This test forms part of the national NHS Staff Survey undertaken in quarter 3 of each year. These figures are taken from the 2022 survey.

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



	2018	2019	2020	2021	2022
Your org	80.3%	77.8%	80.0%	74.6%	65.9%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1307	1206	1346	1506	1397

Venous thromboembolism (VTE)

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

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

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

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

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

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

Clostridium difficile C-Diff

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

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

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

2021/22 and 2022/23 data not published.

Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made in due course.

Source

NHS Outcomes Framework (NHS OF) - NHS Digital

Part 3

Quality Performance Information

This section of the report provides further detail on the quality of services provided or subcontracted by the Trust in the period 2022/23.

Patient Safety – Reducing avoidable harms from Hospital Falls

In the past 12 months the primary focus has been on the implementing the recommendations from the National Audit of Inpatient Falls (NAIF / FFFAP) 2021 audit. This includes the launch of a Multifactorial Falls Risk Assessment and the launch of a dedicated group, focussed on falls prevention, falls reduction and quality improvement.

The new Fall Safe assessment, Hot Debrief and After-Action review are now in use on Abbotsbury, Purbeck, Barnes, Day Lewis, Evershot and Ilchester wards. The new Slips, Trips and falls policy has recently been reviewed.

The Falls Action Group is now set up and meetings have commenced with variable attendance from clinical areas, good attendance is dependent of safe staffing. The Falls Action Group is now ready to evolve and this includes the review of a falls quality report provided by our risk department to target our areas most in need of quality improvement.

Patient safety – All Cause Deterioration

A Governance structure review has taken place which has meant the implementation of a Deteriorating Patient Group and a Patient Safety Committee is now in place. Both have multi-professional membership and a comprehensive workplan in place for the coming year.

With a gradually return to normal practices following the pandemic, work has recommenced to embed the All-Cause Deterioration flowchart and associated Clinical Deterioration Episode (CDE) form into practice. Use of the CDE form is not only beneficial for patient management but is also helpful data as part of our CQUIN Quality Improvement work. The Deteriorating Group is currently exploring the scope for adding a trigger for this to the Agyle system as it is rolled out.

The workplan will also include examining the use of DNACPR/TEP forms, with particular reference to the timing of completion in the patients journey, in order to eradicate previous issues identified

The group now reports directly to the Patient Safety Committee which takes a broad overview of patient safety issues including feedback from subgroups, learning from incidents and monitoring any action plans. They also have input into the Patient Safety Incident Response Framework (PSIRF) plan.

Clinical Effectiveness – Promoting the Health and Wellbeing of staff

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.

DCHFT Wellbeing Visual Identity

To assist staff in more easily finding support a visual identity has been created including a bright green recognisable pallet and logo, this will be supported by Health & Wellbeing folders which will be circulated across the organisation during the summer 23.

The Trust offers the current initiatives and support:

Health & Wellbeing Group

The Health & Wellbeing Group will work to implement elements of the NHS Health and Wellbeing Framework. Key stakeholders from across the organisation will work together to support the improvement of staff health & wellbeing at DCHFT aligned to a newly developed Staff Health & Wellbeing Strategy. The first meeting will take place in May 23.

Health and Wellbeing Coaches

The network of staff Health & Wellbeing Coaches (HWCs) is growing, supported by a community of practice. HWCs help signpost and support colleagues. The HWCs form an internal Community of Practice and receive training opportunities including Mental Health First Aid, Suicide Awareness, Trauma Risk Management and Behaviour Change.

Physiotherapy

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

Wellbeing Conversations

Throughout the last year the appraisal process has primarily focused on wellbeing conversations. Managers are offered the NHS Safe & Effective Wellbeing Conversations course to develop skills and approaches to further support staff as part of the Management Matters Programme.

Trauma Response (TRiM)

Staff are supported by a trauma response network across the Trust. TRiM (Trauma Risk Management) is a peer delivered assessment tool, used to determine by what degree, if any, a colleague has been affected by a potentially traumatic incident, and to ascertain whether they would benefit from further support. The network of trained TRiM practitioners will increase during 23/24, to strengthen the trauma response capacity

Charity Funding Support

If successful charity funding will support 10 DVR Virtual Reality Headsets for staff which can be issued in a prescription style basis for staff who need help with mindfulness, grounding or are generally struggling with their mental health. Funds will be made available for staff who would like to provide free classes for colleagues such as yoga and Pilates, to pay for venues.

Menopause Forum

Formed in 2022 the Menopause forum has a healthy membership of individuals who would like support or would like to influence the organisational position on Menopause. This group meets monthly where staff can receive relevant inputs or simply would like to reach out and talk to other colleagues.

Your Care

Launching in May 23 staff will have access to an online website portal called Your Care which will enable staff to take assessments against their holistic health, it will advise and support staff to self-help, or signposting where needed. Statistical measures of staff activity and wellness will be accessible for the development of organisational responses to need.

Vivup Triage Staff Triage Process

Financial Wellbeing

Staff can now call Vivup 24/7 for information and advice from professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues. Staff are now safely referred to counselling via a clinical to ensure need. They support in both work and non-work related matters including (but are not limited to) Debt, disability & illness, bereavement & loss, stress, elder care information, life events, and consumer rights.	DCHFT is partnered with Money and Pensions Service for staff advice and support and the Serve & Protect Credit Union for salary deduction based consolidation loans and savings. Staff have access to confidential foodbank referral and in May will receive free breakfasts, female hygiene products and £25 shopping voucher support for those in need. During 2023 we will launch a staff hardship grant to support staff who need immediate support.

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

Dementia screening for patients over the age of 75 admitted as an emergency has met the 90% trust target 9 out of the last 12 months. (The three months where this has not been met was due to annual leave, bank holidays or sickness). This improved screening has led to patients with either a delirium or an undiagnosed cognitive impairment being assessed earlier. Much improved links with community services including referral to Dementia co-ordinators in the community has led to improved support for carers and patients living with dementia.

Support workers continue to visit every patient on the inpatient wards with a known diagnosis of Dementia to ensure that a support bundle is placed in the notes which signposts staff for additional support.

Advanced Nurse Practitioner for Dementia/Frailty (ANP) continues to deliver education across the trust to all members of the Multi-Disciplinary Team to ensure that staff feel confident and supported looking after patients living with dementia as well as patients with a cognitive impairment who may present with behaviours that are challenging. At least one session a week is provided to the Mary Anning Unit, assisting the medical colleges in term of assessment and treatment of older people's mental health. A specific session on Delirium was presented by the ANP at the trusts first frailty conference In October 2022 which was well attended by internal and external partners with some extremely positive feedback. A further conference has been planned for May 2023. ANP – Dementia/Frailty completed a 6-month internship to carry out research related activity and is in the process of writing a further application for pre-doctorate funding.

Patient Experience – Improved Learning from Complaints

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 & Public Engagement Committee and escalated to the Quality Committee.

Complaints are an important way for the organisation to continually 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.

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.

Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings 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 in making videos narrating their experience of the care that they received; these videos are shown to the relevant divisional leads and are available for presentation at Board when required.

Learning and actions from complaints are included in complaint responses and digitally allocated the relevant department to completion. Actions 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 has embedded the identification of learning from complaints and using the digital system to help capture this, there is still more that could be achieved to fully embed and monitor learning outcomes from complaints in the Trust.

Patient Experience – Volunteer Report

Proud to Volunteer at DCH

The Trust's Volunteer Service has had another busy year with a key focus on moving forward with plans to expand and develop our Volunteer Team, so that we are in a stronger position to support the hospital with what is needed and when it is needed most. Demand for our service has seen the team still very much in firefighting mode, but we have made some significant progress over the year to move forward with projects to develop service efficiency and volunteer roles. With a current team of approximately 200 volunteers– key achievements this year for the service have included:

- Increase in numbers of Healthy Stay volunteers which means we have been able to increase support to our Inpatient Wards and the Emergency Department.
- Increase in numbers of Healthy Visit volunteers supporting meeting and greeting at main entrances.
- Development of a new role to support the Pharmacy.
- Continued volunteer response to support the Trust with COVID / flu vaccinations and industrial action.
- Reintroduction of volunteer roles in Kingfisher ward.

- Further development of the Activity offer to patients taking a more proactive and volunteer-led approach. Our new Activity Squad is also currently being recruited and on track to launch in May 2023.
- Continued support to the Outpatient Assessment Centre with volunteers continuing to support the development and shaping of the volunteer role.
- Partnerships with local schools which has helped increase numbers of Young Volunteers we are recruiting.
- Budmouth Academy Employability Diploma – Health Project: We have been working with Year 12 at Budmouth Academy in Weymouth to support them with their Employability Diplomas. During the 1st half term in 2023 they have been working on solving Healthcare related problems linked mostly to Patient Experience. The winning team in the school recently presented their solutions at their Academy's HQ in London winning first place in the country for their work.
- We continue to work in collaboration with teams at NHS Dorset and the Dorset Youth Association to develop a Youth Voice both within the Trust and across Dorset.
- We continue plans with St Johns Ambulance to launch a NHS Cadet Unit within the Trust. This has seen some setbacks over the last 12 months due to problems recruiting SJA staff to run the programme. We hope to have this up and running later in 2023.
- A successful return of the volunteer Summer Tea Party and Mince Pie Mingle giving us the opportunity to thank our volunteers for the support they give to the Trust.
- Our volunteers recognised both at the Trust GEM awards and the Volunteer Centre Dorset annual awards.
- Continued support and oversight of our Patient Voice volunteers which saw some substantial change during 2022 with the request to support the development of the new NHS Patient Safety Partner role. To accommodate this and consolidate Patient voice roles under one umbrella, the Patient and Public Voice Partner Process was developed by the volunteer lead. The process is currently being trialled and is supporting the recruitment of PPV Partners into a number of roles supporting patient representative across the Trust. The PPV Partners include the following roles: Patient Safety Partners, Patient Research Ambassadors, Your Voice, Patient Representatives and Patient Experience Champions.

Summary

We head into the next financial year with more confidence in what we can achieve within our service and that we can continue to work to ensure we can provide the best service possible. Maintaining a solution focused approach, with a priority to provide the support we are being asked to support, whilst maintaining a positive volunteer experience remains at the core of what we do.

Patient Experience – Stakeholder Engagement

Your Future Hospital 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.

Stakeholder engagement is an important part of our communications and engagement strategy for the Trust's Your Future Hospital programme.

As well as keeping stakeholders informed about what's happening through various channels, it's important that staff, patients, and other stakeholders have opportunities to share their views and experiences with us, as well as shape and influence how Dorset County Hospital looks and operates in the future.

Here are some examples of activity in 2022/23

- We co-produced an easy read version of our masterplan with Dorset Abilities & People First Dorset to help explain our aims.
- Information shared via local Patient Participation Groups
- Visits and feedback from Dorset Abilities & People First Dorset looking at the Emergency Department and how it can be improved for people with disabilities – in May and December 2022
- Pre-occupancy surveys with patients and staff that are helping inform design of the NHP scheme.
- We recruited additional patient representatives for South Walks House and our NHP scheme (one for CrCU and ED)
- Regular updates with the Trust's Your Voice patient group, including taking on board their feedback.
- Site tours with Governors, councillors, young volunteers, and patient groups
- Updates to local councillors
- Information posters/boards around the hospital site about ED15 works and the wider masterplan.
- Article in DCH Way 2022

Further engagement is planned for 2023, including roadshows across the county involving our wider system partners about developments across all NHS services in Dorset, and using augmented reality software to allow people to virtually tour our new Emergency Department and Critical Care Unit as it is designed and built.

Freedom to Speak Up

It is a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian (FTSUG). The Guardian's key role is to support the creation of a positive, open learning culture where people feel listened to, and feedback is welcomed, and acted on. The Trust have designated FTSU roles including the FTSUG, 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. The FTSUG also explores barriers to speaking up

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. Staff also have the option of speaking up anonymously via either our Incident Reporting System (Datix) or the FTSU post-box.

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 are 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.

2. Performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement:

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

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

DCHFT Lead Governor

I am pleased to have been given the opportunity to review and comment on this report on behalf of the Council of Governors. It gives me a great deal of reassurance and confidence to read that so many of the issues that we care about and that concern us are being handled by the Trust in the depth that is described in the report, even if we are not always where we would want to be. It has of course been another difficult year for the NHS and DCH cannot escape that. Indeed, some of these difficulties are set out in the report including the ongoing problems around patients with no reason to reside, the many target times that are being missed and the financial constraints. These are some of the issues that we, as the Council of Governors, hold the Board to account on and will continue to do so.

The report also sets out some of the very positive initiatives that are taking place in the Trust, and I am particularly pleased to see the progress that has been made working with young people with long term health conditions and their transition to adult care. Similarly, the introduction of the Carers Passport and support provided for this often unseen and unheard group of people is most welcome. These are both great examples of the Trust living up to its mission statement of "providing outstanding care for people in ways which matter to them", a phrase that I am keen to remind the Board of when they are concentrating on the big picture.

Another highlight in the report for me was to see the continued importance and significance of research and the investment in this service. Research and quality of care are intrinsically linked and I am pleased that DCH recognises this.

Finally, I am delighted to see that the report pays tribute to the work of the incredible team of volunteers at DCH and the fantastic work that they do which undoubtedly plays a very important part in the quality of care that is provided.

Kathryn Harrison
Lead Governor

NHS Dorset

14 June 2023

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PRIVATE AND CONFIDENTIAL
Jo Howarth
Chief Nursing Officer
Dorset County Hospital NHS
Foundation Trust
Williams Avenue
Dorchester
Dorset DT1 2JY

Dear Jo,

Re: Quality Account 2022/23

Thank you for asking NHS Dorset to review and comment on your Quality Account for 2022/2023. Please find below the ICB statement for inclusion in the final document:

NHS Dorset welcomes the opportunity to provide this statement on Dorset County Hospital's Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of information we have received during the year as part of monitoring discussions during 2022/2023.

In 2022/2023 Dorset County Hospital NHS Foundation Trust set priorities focusing on people, place and partnerships. Dorset County Hospital is working with system partners to understand and reduce Population Health Inequalities. Work has recommenced to improve All Cause Deterioration processes with further work planned. Dorset County Hospital have been active members of the Integrated Care System Infection Prevention and Control group focusing on quality improvement and learning across the system. Dorset County Hospital have undertaken significant work to ensure services are accessible to their patients and population.

NHS Dorset supports the three key strategic priorities of patient safety, patient experience and clinical effectiveness and supporting detailed actions that follow these to improve the quality of care being delivered in 2023/2024. We look forward to receiving regular updates on the progress in these areas, whilst recognising that the NHS continues to face a challenging backdrop from increased demand alongside recovery of services from the impacts of the Covid-19 pandemic. NHS Dorset

remains committed to work with Dorset County Hospital NHS Foundation Trust, over the coming year to ensure all quality standards are monitored.

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

Yours sincerely,

Debbie Simmons
Chief Nursing Officer

Annex 2 Statement of Directors' Responsibility for the Quality Report

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

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

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

By order of the board:

Chairman
David Clayton-Smith

Chief Executive
Matthew Bryant