University Hospitals Dorset
NHS Foundation Trust

Contents

What is a quality account?

All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS hospitals have had to publish a quality account.

You can also find information on the quality of services across NHS organisations by viewing the quality accounts on the NHS Choices website at www.nhs.uk.

The purpose of this quality account is to:

1. summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2021/22; and

2. set out our quality priorities and objectives for 2022/23.

To begin with, we will give details of how we performed in 2021/22 against the quality priorities and objectives we set ourselves under the categories of:

Patient Safety
Clinical Effectiveness
Patient Experience

Where we have not met the priorities and objectives we set ourselves, we will explain why, and set out the plans we have to make sure improvements are made in the future.

Secondly, we will set out our quality priorities and objectives for 2021/22 under these same categories. We will explain how we decided upon these priorities and objectives, and how we will aim to achieve these and measure performance.

Quality accounts are useful for our board, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the trust. We encourage frontline staff to use quality accounts both to compare their performance with other trusts and also to help improve their own service.

For patients, carers and the public, the quality account should highlight how we are concentrating on improvements we can make to patient care, safety and experience.

It is important to remember that some aspects of this quality account are compulsory. They are about significant areas, and are usually presented as numbers in a table. If there are any areas of the quality account that are difficult to read or understand, or you have any questions, please contact Joanne Sims, Associate Director of Quality Governance and Risk at Joanne.Sims@uhd.nhs.uk

This Quality Account is divided into three sections.

Part 1	Introduction to University Hospitals Dorset NHS Foundation Trust and a statement on quality from the Chief Executive
Part 2	Performance against 2021/22 quality priorities and our quality priorities for 2022/23
	Reviewing progress of the quality improvements in 2021/22 and choosing the new priorities for 2022/23
	Statements of assurance from the Board
Part 3	Other information

Part 1 Statement on quality from the Chief Executive

This Quality Report is first published by University Hospitals Dorset NHS Foundation Trust

The Trust quality strategy is supported by wide-ranging quality improvement and patient safety initiatives which cover a large range of specialties and topics. In this report we have outlined some of these activities.

The report outlines some of the main quality governance and patient safety projects that have been undertaken in year and celebrates the engagement of our staff to continually improve patient and staff safety, patient experience and clinical outcomes.

Whilst there is always more work to be done, I am pleased to confirm that University Hospitals Dorset NHS Foundation Trust has continued to make positive progress in improving the quality of its services in 2021/22, in extreme and challenging circumstances.

The most significant risk still facing the NHS and the Trust currently and in the future is the impact of Covid-19. It is clearly recognised that the standard ways in which the NHS operates have significantly changed as we all try to manage the impact of Covid-19 on the country and on the National Health Service. Normal business has been disrupted and new clinical pathways, policies and procedures have been introduced during the pandemic. We continue to adapt these daily in line with national, professional, and local guidance to ensure staff and patient safety and maintain high standards of patient care.

We know that Covid-19 has and will continue to provide significant challenges to key performance targets that will impact on our patients, such as cancer access times and referral to treatment targets. The Trust continues to work with partners in the Dorset integrated care system to address these risks as well as through its own quality improvement projects. We are proud of our quality improvement and clinical governance programmes and the enthusiasm of staff to look at new ways of working in order to continually learn, innovate, develop and sustain patient safety initiatives.

As well as operational pressures, we recognise that the pandemic has had, and will continue to have, a significant impact on our staff. We know that the pandemic has created workforce risks across the NHS and has had an impact on our ability to provide optimum staffing levels. We have identified a programme of workforce initiatives, mitigations and actions to support safe staffing. We have also put in place a raft of measures to support staff well-being including emotional, physical, and psychological support.

It is important to note that there are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported:

- data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit programme of work each year

- data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently

- national data definitions do not necessarily cover all circumstances, and local interpretations may differ

- data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

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

Paula Shobbrook, Chief Nursing Officer / Deputy and Acting Chief Executive

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

Progress against quality priorities set out in the Trust Quality Strategy for 21/22

The Trust identified the following key quality improvement priorities for 2021/2022

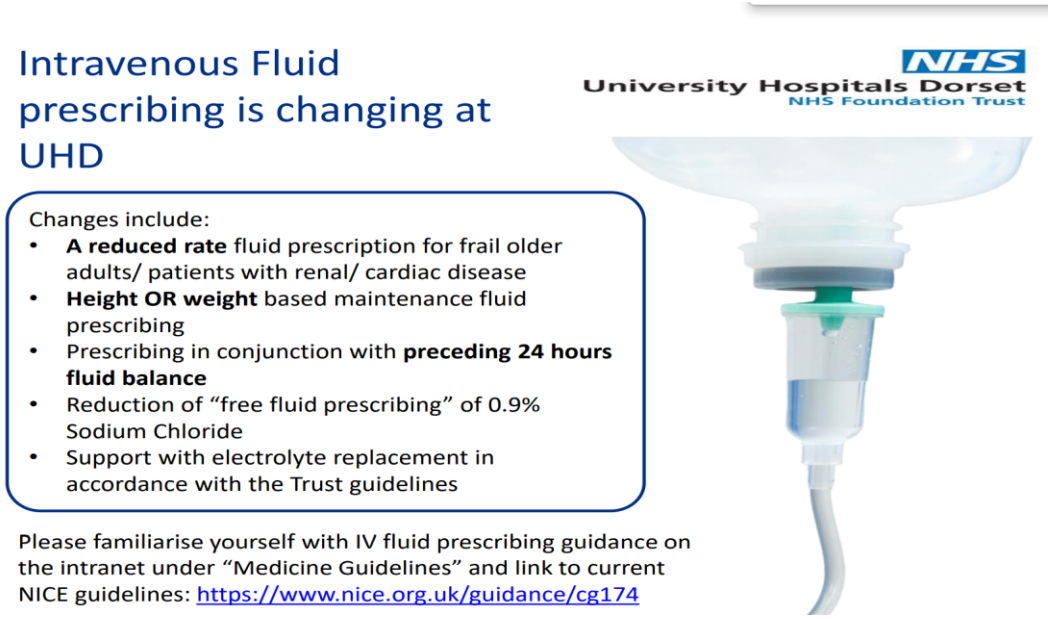
Surgical checklists.	**Identification and escalation of the deteriorating patient**
Fluid Management	**Difficult Intravascular Access (DIVA**

- **Fluid Management**.
- **Surgical checklists.** The aim of the project will be to standardise surgical checklist processes across UHD.
- **Identification and escalation of the deteriorating patient.**
- **Difficult Intravascular Access (DIVA)**. to devise a new UHD process, standardise devices and agree a policy for management of patients with difficult intravascular access

Monitoring of progress against each of these priorities has been undertaken by the board of directors and specific sub groups, including the Quality Committee, Clinical Governance Group and the Transformation and Innovation Committee. Where relevant, quality metrics have been incorporated into 'ward to board' quality dashboards and quality reporting processes.

Fluid Management

A new IV fluid prescription chart was launched in June 2021 including height and weight-based prescription/guidance for reduced rates for frail/renal and cardiac disease patients. The group also developed one set of electrolyte guidelines for UHD ensuring a standardised practice across UHD.



Audits show improvement against all 7 relevant NICE standards and a successful reduction in free prescribing of 0.9% Sodium Chloride. There is over 95% compliance to the new chart, and a revised chart is coming out in May 2022 following user feedback.

We have seen improvement against the standard of "Assess and manage patients' fluid and electrolyte needs as part of every ward review", which has risen from 52% of patients audited in April 2021 to 90% in October 2021.

A pilot of a digital fluid balance was piloted in February/March 2022. Following feedback additional functionality is required and there is an aim to produce a revised version for launch in summer 2022. Once this is in place, consideration will be given to potential digitisation of the prescription process to further support patient safety.

Safety Checklists

This has been a large-scale project across all clinical specialities. Actions have included:

- Collection and review of over 90 separate surgical safety checklists in use across the Trust.
- A review of external guidance and professional standards for surgical safety checklists.
- Completion of a staff survey to explore why staff use checklists and the barriers and opportunities they provide.

Putting safety first

Building on a safety checklist culture has been identified as a top quality improvement (QI) project for this year and we want your views on checklists - why you use them, what stops you from using them, what would you want changed?

The QI team has produced a short survey to find out your views.

- Identification of focus groups to further explore human factors around the effective design and use of safety checklists. Due to operational pressures & COVID this next phase has proven challenging for operational staff and will therefore be extended to 2022/23.

- Development of a Trust template for workstream groups to use as the main comparative checklist. This will form part of the standard operating policy for checklists – to be developed in 2022/23.

- Practice Educators from both sites have begun working together to look at the current process for checklists together with the different computer systems in use to record completion. The overall aim is the development of one joined up process once the new single Patient Administration System (PAS) is in place (due Summer 2022).

Difficult IV Access (DIVA)

- A cross site, multidisciplinary team was established to identify the requirements for a Difficult IV Access (DIVA) Team across UHD.
- New DIVA teams at Poole Hospital and Bournemouth Hospital were set up in early 2022. The teams are supported by the Clinical Site Management Team and Critical Care Outreach Team.
- A Trust Difficult IV Access Policy has been drafted and approved.
- A new DIVA pathway commenced across the Trust in April 2022.

- An e-form has been developed to automatically add a Critical Patient Information (CPI) Flag on the Electronic Patient Record (EPR) for identified DIVA patients.
- A new intermediate-length cannula is being introduced to support and improve difficult cases.
- A dedicated DIVA intranet page will be launched in May/June 2022.
- Communication around the awareness and promotion of the new DIVA service has been circulated across the Trust via posters, screensavers and newsletters.

Deteriorating Patient

This has been a large programme of 10 projects which started in July 2021. The programme has seen several developments including:

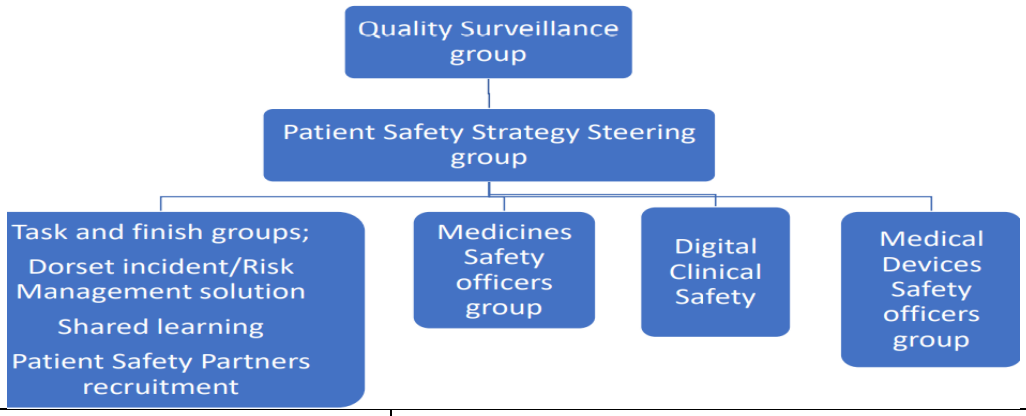
- The launch of a new pan-UHD Treatment Escalation Plan in January 2022. This provides a clear traceable history of decision making. The documentation is on the UHD Electronic Paper Record (EPR) and is therefore accessible 24/7 supporting patient care across all hospital sites.
- Considered and developed a new internal "2222" Emergency call structure for UHD. The team are now working up the detail in a project to implement in summer 2022.
- Established a new standard response for high New Early Warning (NEWS) results. A new form is being piloted having been adapted from learning from other Trusts.
- Design of a "Call-4-concern" direct phone line from relatives and patients concerned about their own condition may be deteriorating. Plan to be piloted by May 2022 with the ambition to roll out across UHD in the following months.
- Useful Data & Platform integration has started considering the implications for recording, reporting, and rapid learning.
- A new standard *UHD Referrals to ICU* procedure has been drafted and is currently undergoing consultation before intended implementation in summer 2022.
- As part of the *Safe Medical Staffing* QI project, initial per-Ward audits of actual vs planned (as per Royal College of Physicians recommendations) medical staffing deployment patterns were undertaken. As an outcome, actions to alleviate the demands placed on the Medical Registrar on-call are being progressed.
- The Poole Hospital and RBCH Deteriorating Patient intranet pages continue to be aligned and a new combined UHD training prospectus is being developed.
- A new UHD Sepsis policy and Assessment Tool have been developed and approved. A communications plan is in place to support implementation.
- A single UHD Sepsis intranet page will replace the existing Poole and RBCH Sepsis intranet pages.
- The Critical Illness Group (Poole) and Resus Committee (RBCH) Forums will merge in Q2 2022/23. The Terms of Reference for the new UHD group are being developed.

The Deteriorating Patient QI Programme will be extended throughout 2022-23 because of the scale and the detail involved in aligning practice across the two acute Hospitals

Other Quality Priorities for 2021/22

In addition to the above progress, the UHD Quality Strategy also set out several other priorities for patient safety, patient experience and clinical effectiveness in 2021/22. These are outlined in the following table with details of action taken in year.

DOMAIN	Priority for 2021/22	Progress made in 2021/22
PATIENT SAFETY	Appoint a Patient Safety Specialist for the Trust and participate in the Dorset ICS Patient Safety Strategy Steering Group (PSSSG)	The Trust appointed 2 Patient Safety Specialists – Dr David Morgan (Associate Medical Director – Clinical Governance) and Joanne Sims (Associate Director Quality Governance and Risk). Both participate in the ICS Patient Safety Steering Group and associate work programmes (see framework below).

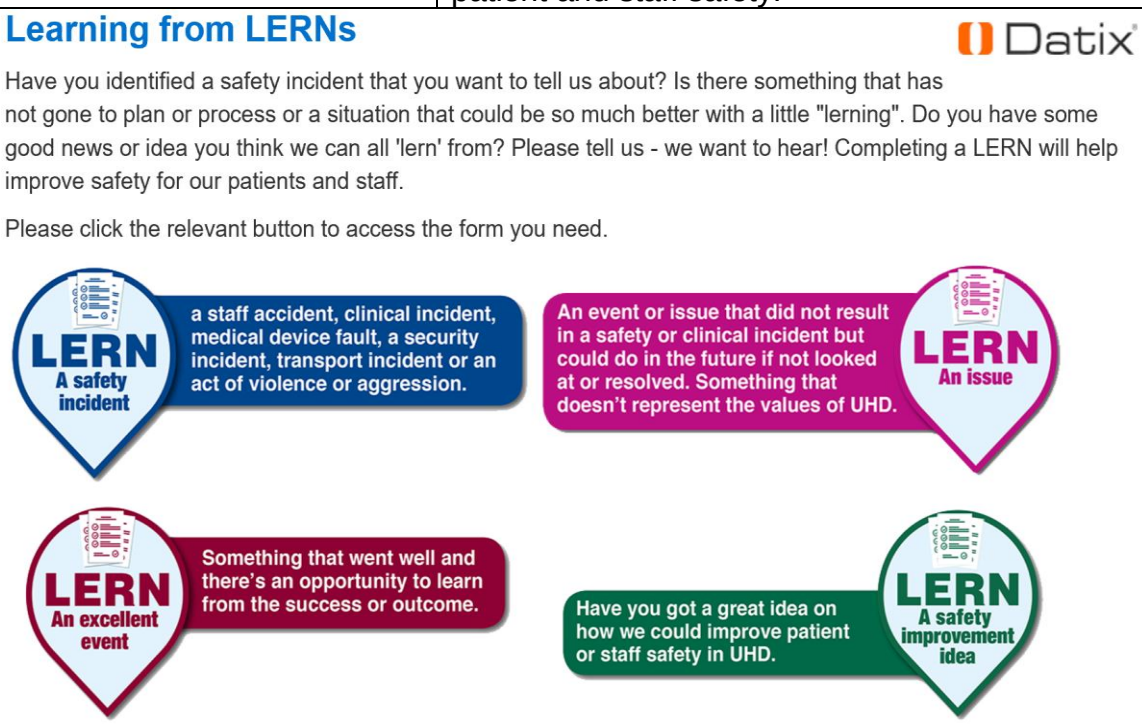


Participate in the work across the ICS (led by the CCG) to develop and adopt agreed principles and policies to support a Just Culture. This work will form part of the Trust People Strategy and support the Trust objective to support diversity, equality and inclusion	A set of core principles (see below) have been agreed and will be incorporated into disciplinary and grievance policies, safety culture and managers training across the system in 2022/23.

- *We should all be encouraged to live the values of compassion and kindness, every day*
- *We should all be able to work in an environment where we feel safe, supported and empowered to learn when things do not go as expected*
- *We should all be encouraged to speak the truth about something which did not go to plan, without fear of reprisal*
- *In the case of an adverse event, we should not instinctively ask 'who' was to blame but 'what' led to the event occurring*
- *Formal disciplinary processes and suspensions should be avoided wherever possible, in favour of explorative conversations which are informal and fair, adhering to just and learning principles*
- *When there is a need for formal processes, they should be undertaken compassionately, begin with an investigation of the facts and be undertaken in a timely manner*
- *Just and learning culture should not be mistaken for a culture where 'anything goes' – which can be as harmful and inexcusable as a 'blame culture'*
- *A just and learning culture emphasises the importance of treating people as human beings, creating a positive place to work where staff are attracted and retained*
- *Staff that are supported and feel psychologically safe, lead to better outcomes for patients and the wider population*

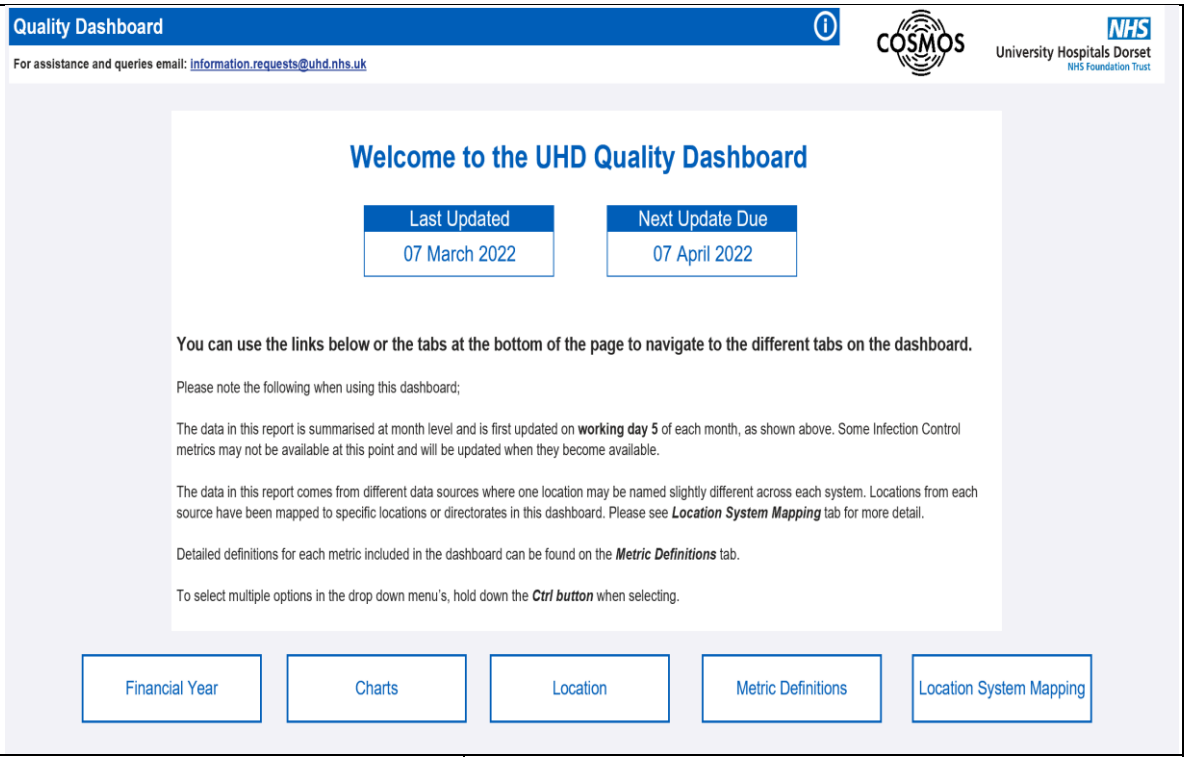
An external audit on Cultural Maturity across UHD (April 22) found that:

> *"colleagues we interviewed highlighted they felt a key strength of the Trust is that any errors/near-misses or incidents were investigated with a blame-free approach that aimed to look for the root cause of the issue, whilst maintaining appropriate accountability for individuals where appropriate. This is also reflected in the policy and procedure framework."*

	Achieve 100% compliance with National Patient Safety Alerts by their action complete deadlines	The Dorset system has been recognised by the NHS I South West Patient Safety Team for good practice in the cascade and monitoring of compliance with these alerts.
	Demonstrate improvements in the results of the NHS staff survey (safety culture questions)	The questions in the NHS staff survey changed in year meaning that a direct comparison to previous years was not available. The results for 2021 will be used as a baseline for improvement in 2022.
	Improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups	A new “Learning from LERNS” programme was introduced across UHD in November 2022 to raise awareness about the importance and value of reporting incidents, issues, excellent events and quality improvement ideas. The launch included videos from the Chief Medical Officer, Chief Nursing Officer and Risk Management Team outlining what happens to a reported incident and how learning is shared and used across the organisation to support patient and staff safety.
		
	Support transition from the National Reporting and Learning System and STEIS to the new national Patient Safety Incident Management System (PSIMS) as required and subject to local software compatibility	A national delay in development of the new patient safety incident management system has resulted in this objective moving to 2022/23.

	Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework as and when published.	The national delay in development of the new patient safety incident management system has resulted in this objective moving to 2022/23. Guidance on the proposed new framework is expected in July 2022.
	Support implementation of the new national Patient Safety Syllabus (outline launched May 21) as and when training materials become available	Level One 'essentials' training for all NHS staff was launched on eLearning for Health in October 2021 and included a separate module aimed at board members and senior leaders. Level Two 'gateway' training was also made available for staff more involved inpatient safety and quality improvement. The curriculum for levels three – five will be available in Q2 2022/23. Level 1 and 2 training is not mandatory. The Dorset PSSSG agreed that there should be a consistent approach in all organisations. Implementation was discussed at the Dorset Heads of Education meeting and it was agreed that in Dorset we would pause implementation at present to allow time for the module at level 1 to be evaluated and potentially changed following the Health Education England Core Skills review.
Patient Experience	implement the requirements of the NHS Patient Safety Partners Framework (due to be published Summer 21) including the appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system. Local systems should aim to include two PSPs on their safety related clinical governance committees (or equivalent) by April 2022 and elsewhere as appropriate.	A Dorset ICS Task and finish group (reporting to the ICS Patient Safety Strategy Steering Group) has been established. The objectives will be to review the requirements of the finalised framework, the impact on Trusts and to consider a recruitment strategy across the ICS for patient safety partners and ensure there is an effective peer support network from the outset.
	Maintaining high standards of patient information	The Acting Head of Patient Experience is currently establishing a new Patient Information Policy and process for UHD. This work will be a key priority for 2022/23.

	Involving patients and their families or carers in the response to a patient safety incident including any investigation	The UHD LERN Policy and Toolkit supports the involvement of patients and their families and/or carers as a routine part of patient safety investigations. A Dorset CCG audit of Duty of Candour compliance in 2021/22 found that the Trust had robust processes in place and an open reporting culture.
Clinical Effectiveness	Develop a UHD Consent policy	The Deputy Chief Medical Officer has lead a Task and finish group to produce a UHD Consent Policy and toolkit. The policy is expected to be formally approved in May 2022.
	Embed governance structures	A Governance toolkit has been issued to Directorates Care Group and Specialities. The Quality Governance team have supported Directorate leads to implement. An audit of progress was undertaken in Q4 2021/22 with results to be reported to the Quality Governance Group and Quality Committee in April/May 2022. The audit results will be used to support ongoing implementation and standardisation.
	Embed Morbidity and Mortality (M&M) framework	A standard M&M toolkit has been issued to Directorates Care Group and Specialities. The Quality Governance team will support Directorate Mortality leads to implement and embed during 2022/23.
	Standardise use of electronic nurse assessment (eNA) across UHD	The Head of Clinical Practice is leading on a review of current eNA metrics to standardise across UHD. Following this work, eNA metrics will be included in Ward to Board Dashboards in Q2 2022/23.
	Standardise Ward to Board reporting	The Quality Governance team and Care Group Directors of Nursing have worked with the Information Department to produce phase 1 UHD Ward to Board reporting on key quality and patient safety metrics in 2021/22. The new quality dashboard (see below) is available for all wards across UHD.

		
	Review Nursing documentation	The Head of Clinical Practice has been appointed as Chief Nursing Information Officer. The role focuses on the development of IT to support nursing and clinical practice, building on the work of our midwifery and allied health professional colleagues. The initial priority will be to look at the feasibility to digitise existing paper-based patient documentation and care planning, reducing the need to record information in multiple places while improving patient safety. The project will be monitored by the Strategic Nursing, Midwifery and AHP/HCS forum, chaired by the Chief Nursing Officer.
	Peer review	A new methodology for Peer review across UHD in line with updated CQC Key Lines of Enquiry was introduced in 2021/22. Completion of Peer reviews was reduced due to covid restrictions but it is hoped that update will increase during 2022/23 as these are lifted and operational pressures ease. Implementation will be monitored by the Strategic Nursing, Midwifery and AHP/HCS forum, chaired by the Chief Nursing Officer.
	Learning from Claims	Information on complaints, inquests, learning from death reviews and SI investigations is used to consider interventions to improve patient care. A quarterly "Learning from Claims" Forum is chaired by the Chief Medical Officer with Care Group and Directorate leads presenting cases and learning.

Our quality priorities for 2022/23

This vision is underpinned by the Trust's values and delivered through the five key strategic objectives:

- **To be a great place to work:** Nurturing staff wellbeing; having meaningful appraisals; acting on staff feedback; progressing the People Strategy; championing equiality, diversity and inclusion

- **Use our resources well**: Restoring our clinical sercives ; achieving our budget, maintaining consistent standards of care; starting our Green Plan

- **Continually improve quality**: delivering our priority clinical improvement programmes; transforming outpatinet pathways; improving elective and emergency care services,; discharging patients who are medically ready as quickly as possible.

- **Be a well-led and effective partner**: communicating more; fostering culture of imporvement; developing our leadership; partnering with Bournemouth University.

- **Transform our services**: creating emergency and planned hospitals; taking forward the Health Infrastructure Plan; developing our role in the Dorset Integrated Care system; implementing the digital transformation strategy.

In order to identify priorities for quality improvement in 2022/23 we have used a wide range of information sources to help determine our approach. These include:

- *gathering the views of patients, public and carers via real-time feedback and patient surveys*
- *collating information from claims, complaints, medical examiner reviews and incident reports, including no harm events*
- *using the results of clinical audits, external reviews and inspections to tell us how we are doing in relation to patient care, experience and safety*
- *using the Getting it Right First Time (GIRFT) and CQC insight Tool analyses*
- *listening to staff feedback during Action Learning weeks*
- *considering the views of our commissioners as part of our shared quality and*

performance meetings and their feedback following formal announced and unannounced inspections

- *listening to what staff have told us in staff briefings and "Ask the Exec" sessions*
- *listening to what governors have told us following their engagement with the public, patients and members*
- *canvassing the views of patients and staff through our organisational development and quality improvement work.*

We have also considered the results of the national staff survey to help us decide where we need to focus our quality improvement efforts and actions. We have also taken on board the national picture for patient safety and collaborated with Clinical Commissioning Groups (CCG), local and national Patient Safety Specialist networks as part of our patient safety strategy work.

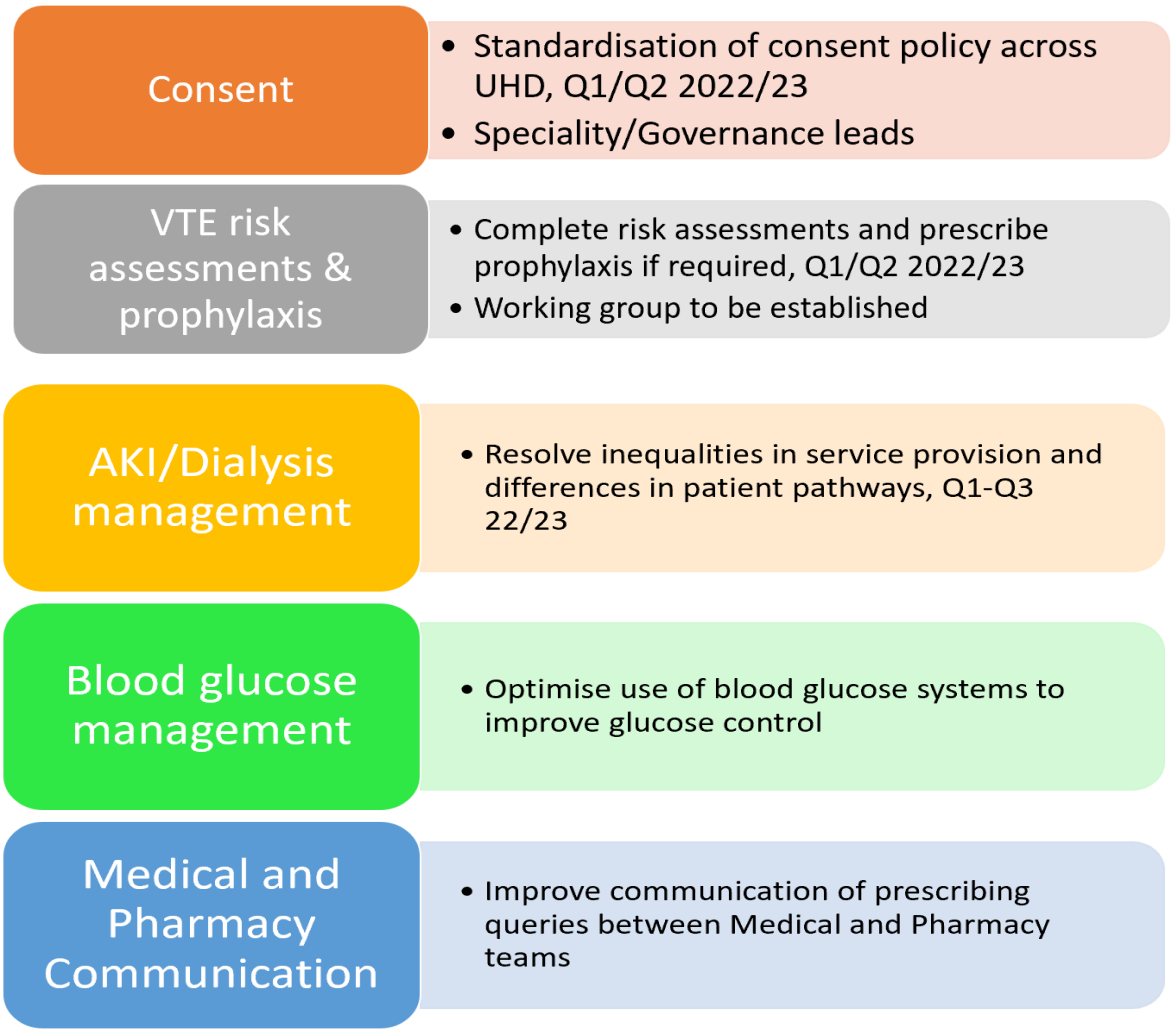
The Trust has consulted with key stakeholders (staff, patients, governors and commissioners) to help identify quality improvement and patient safety priorities for 2022/23.

We have considered any current action plans in place, for example those forming our Quality strategy and our responses to other national reports issued on patient safety and quality.

Our overall aim is to continue to improve the quality of care we provide to our patients ensuring that it is safe, compassionate and effective, whilst ensuring that it is informed by, and adheres to best practice and national guidelines. We will drive continued improvements in patient experience, outcome and care across the whole Trust using a standard quality improvement (QI) methodology. We will continue to support and develop our staff so they are able to realise their potential and further develop a Trust culture that encourages engagement, welcomes feedback and is open and transparent in its communication with staff, patients and the public.

The main patient safety quality priorities for 2022/23 are as follows:

IV Fluids	• Continuation of 21/22 priority, ends in Q2 2022/23
Deteriorating Patient	• Continuation of 21/22 priority, likely to continue for all of 22/23
Difficult IV Access	• Continuation of 21/22 priority, ends in Q2 2022
Safety Checklists	• Continuation of 21/22 priority, likely to continue for all of 22/23



In addition, additional specific priorities for 22/23 have been set out in the Trust Quality Strategy. These cover the other three domains of patient safety, patient experience and clinical effectiveness.

Patient Safety

Our main priorities for patient safety for 2022/23 continue to directly link to the key requirements of the National Patient Strategy including:

- Continuing to participate in the work across the ICS to develop and adopt agreed principles and policies to support a Just Culture.
- Continue to improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups.
- Support transition from the National Reporting and Learning System and STEIS to the new national Patient Safety Incident Management System (PSIMS).
- Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework as and when published (proposed July 22)

- Work with Workforce leads and colleagues across the system to consider the best approach to implementation of the new national Patient Safety Syllabus as and when training materials become available.

Patient Experience

Our main patient experience objective for 2022/23 is to work with colleagues across the system to implement the requirements of the NHS Patient Safety Partners Framework including:

- The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system.

Clinical Effectiveness

At University Hospitals Dorset NHS Foundation Trust, to reduce variation and ensure the best possible clinical outcomes, we strive to ensure our patients are provided the most effective evidence-based care. The Trust participates in a robust clinical audit and clinical outcomes programme and over the forthcoming years our quality priorities are to:

- Develop and implement a UHD Clinical Audit plan for 22/23
- Further develop ward to board reporting and expansion of existing quality metrics

Progress against these priorities will be monitored by the Board of Directors, Quality Committee and the Council of Governors Quality Strategy Group.

Statements of Assurance from the Board

This section contains eight statutory statements concerning the quality of services provided by University Hospitals Dorset NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that gives a local context to the information provided in the statutory statements.

1. Review of services

During 2021/22 University Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health services (in accordance with its registration with the Care Quality Commission):

- management of supply of blood and blood derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- maternity and midwifery services
- family planning
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury

The Trust has reviewed all the data available to them on the quality of care in these eight relevant health services. This has included data available from the Care Quality Commission, external reviews, participation in National Clinical Audits and National Confidential Enquiries and internal peer reviews.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2021/22.

2. Participation in clinical audit

During 2021/22, there were 50 national clinical audits and 3 national confidential enquiries which covered relevant health services that University Hospitals Dorset NHS Foundation Trust provides.

During that period, University Hospitals Dorset NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that University Hospitals Dorset NHS Foundation Trust participated in, and for which data collection was completed during 2021/22 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits for Inclusion in Quality Report 2021/22	Eligible	Participated in 2021/22	% of cases submitted	Purpose of audit
Case Mix Programme	Y	Y	100%	The CMP is an audit of patient outcomes from adult general critical care units.
Chronic Kidney Disease registry	N/A	N		
Cleft Registry and Audit Network Database	N/A	N		
Elective Surgery (National PROMs Programme)	Y	Y	100% of all patients who consented to participate. Latest figures: Q1 (Oct-Dec 2021) 52% TKR 78% THR Q2 (Jan-Mar 2022) 50% TKR 38% THR	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; 1) Hip replacement 2) Knee replacement
Emergency Medicine QIPs Pain in Children (care in Emergency Departments)	Y	Y	100%	Identify current performance in Eds against nationally agreed clinical standards and show the results in comparison with other departments.
Emergency Medicine QIPs Severe sepsis and septic shock (care in Emergency Departments)	N	N		Project not running in 2021/22
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service (FLS) Database	Y	Y	100%	Measure against NICE technology assessments and guidance on osteoporosis and clinical standards for FLSs.
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Y	Y	100%	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals.

Falls and Fragility Fracture Audit Programme – National Hip Fracture Database	Y	Y	100%	Audits of patients with hip and femoral fractures aiming to improve their care through auditing which is fed back to hospitals through targeted reports and online reporting.
Inflammatory Bowel Disease Audit	Y	Y	100%	Reports on key clinical indicators which are compliance with ECCO guidance on pre-treatment screening and compliance with NICE recommendations for follow-up review of patients receiving biological therapies
Learning Disabilities Mortality Review Programme	Y	Y	100%	Programme to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice.
Maternal and Newborn Infant Clinical Outcome Review Programme	Y	Y	100%	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies
Mental Health Clinical Outcome Review Programme	N	N		
National Adult Diabetes Audit - National Diabetes Core Audit	Y	Y	100%	Measures the effectiveness of diabetes care compared to NICE guidance.
National Adult Diabetes Audit - National Pregnancy in Diabetes Audit	Y	Y	100%	As above.
National Adult Diabetes Audit - National Diabetes Footcare Audit	Y	Y	100%	As above.
National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	Y	Y	Poole 100% from 01/22, RBH 100% from 11/21	As above.

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Y	Y	100%	Aims to improve the quality of care, services and clinical outcomes for patients with asthma and chronic obstructive pulmonary disease (COPD).
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	Y	Y	100% Poole	As above.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	100% Poole	As above.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary Rehabilitation-Organisational and Clinical Audit	Y	Y	100%	As above.
National Audit of Breast Cancer in Older Patients	Y	Y	100%	Improves the quality of hospital care for older patients with breast cancer by looking at the care received by patients with breast cancer and their outcomes.
National Audit of Cardiac Rehabilitation	Y	Y	100%	Aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live
National Audit of Cardiovascular Disease Prevention	N	N		

National Audit of Care at the End of Life	Y	Y	RBCH 100% Poole 98% completed (19/20)	Focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals.
National Audit of Dementia	Y	Y	No mandatory data collection took place this year	Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.
National Audit of Pulmonary Hypertension	N	N		
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Y	Y	Limited data submission due to capacity issues.	Audit of organisation of paediatric epilepsy services, epilepsy care provided to children and young people and patient reported experience measures.
National Cardiac Arrest Audit	Y	Y	100%	Audit of in-hospital cardiac arrests in the UK and Ireland.
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	Y	Y	100% RBCH Poole: 100% Q1-Q3	To recognise areas of clinical excellence that can be adopted across the NHS. Standards should be used to determine local quality improvement aims for clinicians, service managers and commissioners.
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Y	Y	100%	As above
National Cardiac Audit Programme - National Adult Cardiac Surgery Audit	N	N		
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	100%	As above
National Cardiac Audit Programme - National Heart Failure Audit	Y	Y	100%	As above

National Cardiac Audit Programme - National Congenital Heart Disease	N	N		
National Child Mortality Database	Y	Y	100%	The National Child Mortality Database (NCMD) records comprehensive, standardised information collected by local the Child Death Overview Panels (CDOPs) as part of the Child Death Review (CDR) process.
National Clinical Audit of Psychosis	N	N		
National Comparative Audit of Blood Transfusion - 2021 Audit of Patient Blood Management & NICE Guidelines	Y	Y	100%	To provide evidence that blood is being ordered and used appropriately and administered safely, and to highlight where practice is deviating from guidelines to the possible detriment of patient care.
National Comparative Audit of Blood Transfusion - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	N	N	Audit not undertaken in 2021/22	
National Early Inflammatory Arthritis Audit	Y	Y	Plan;100% - submission partially suspended in year due to covid	Aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales.
National Emergency Laparotomy Audit	Y	Y	90-100%	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales

National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer	Y	Y	90-100%	The overarching aim is to improve the quality of services and patient outcomes for patients newly diagnosed with: a) bowel cancer, and b) oesophago-gastric cancer or high grade dysplasia of the oesophagus
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	Y	Y	100%	As above.
National Joint Registry	Y	Y	100%	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety
National Lung Cancer Audit	Y	Y	100%	Measure lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best
National Maternity and Perinatal Audit	Y	Y	100%	Evaluates a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.
National Neonatal Audit Programme	Y	Y	100%	The NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high quality care, and identify areas for quality improvement.

National Paediatric Diabetes Audit	Y	Y	100%	Audit of the care processes received and outcomes achieved by all children and young people attending paediatric diabetes units.
National Perinatal Mortality Review Tool	Y	Y	100%	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units.
National Prostate Cancer Audit	Y	Y	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes.
National Vascular Registry	Y	Y	100%	Established in 2013 to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals.
Neurosurgical National Audit Programme	N	N		
Out-of-Hospital Cardiac Arrest Outcomes Registry	N	N		
Paediatric Intensive Care Audit	N	N		
Prescribing Observatory for Mental Health - Prescribing for depression in adult mental health services	N	N		
Prescribing Observatory for Mental Health - Prescribing for substance misuse: alcohol detoxification	N	N		

Respiratory Audits - National Outpatient Management of Pulmonary Embolism	Y	Y	100%	The aim of the British Thoracic Society audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK.
Respiratory Audits - National Smoking Cessation 2021 Audit	Y	Y	100%	As above.
Sentinel Stroke National Audit Programme	Y	Y	95%	To provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided.
Serious Hazards of Transfusion	Y	Y	100% Poole	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety.
Society for Acute Medicine Benchmarking Audit	Y	Y	100%	A national benchmark audit of acute medical care. Provides a comparison for each participating unit with the national average (or 'benchmark').
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Y	Y	100%	The primary objective is to determine if audit and feedback can improve the quality of TURBT surgery and reduce early recurrence rates.
Trauma Audit & Research Network	Y	Y	100%	Analyses data of trauma care to improve emergency care management and systems.

UK Cystic Fibrosis Registry	Y	Y	100%	Non-identifiable Registry data is used to improve the health of people with cystic fibrosis through research, to guide quality improvement at care centres and to monitor the safety of new drugs.
Urology Audits - Cytoreductive Radical Nephrectomy Audit	N	N	Project closed December 2020	
Urology Audits - Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Y	Y	100%	To collect surgical and patient data, and to establish the recurrence and survival rates of patients who underwent procedures between 1 January 2017 and 31 December 2019

National Confidential Enquiries for Inclusion in Quality Report 2021/22	Eligible to Participate	Participated in 2021/22	% of required cases submitted
Child Health Clinical Outcome Review Programme – Transition from child to adult health services	Y	Y	Submission of Clinical Questionnaires ongoing
Medical and Surgical Clinical Outcome Review Programme - Alcohol Related Liver Disease	Y	Y	Organisational Questionnaire to be submitted
Medical and Surgical Clinical Outcome Review Programme – Epilepsy	Y	Y	Organisational Questionnaire to be submitted

Learning from National Audits

The reports of 58 national clinical audits were reviewed by University Hospitals Dorset NHS Foundation Trust in 2021/22 and, as examples, the Trust intends to take the following actions to improve the quality of healthcare provided as a result:

- British Thoracic Society National Smoking Cessation Audit 2021 - Trained smoking cessation / nicotine dependence workers appointed to support inpatients.

- Re-Audit of National Audit of Transforming MND Care - Various members of multidisciplinary team are being trained to assess cognitive function. Discussions ongoing about provision of neuropsychology support to supervise these assessments and also provide support to patients found to have severe cognitive impairment.

- National Audit of Seizure Management in Hospitals 3 (NASH3) - Review of Dorset-wide seizure strategy.

- Adult Asthma Combined Organisational Audit - Closer liaison with primary / community care discussed and Integrated care clinics planned.

- VTE Risk in Lower Limb Immobilisation - VTE prophylaxis guideline for the patients with lower limb immobilisation is being updated following the recommendation of RCEM.

- Sentinel Stroke National Audit Programme (SSNAP)– The Trust provides access to a specialist stroke service, including 7/7 consultant ward rounds, 7/7 therapy input, access to specialist levels of nursing staff and hyper acute care. The team monitor performance against SSNAP outcomes through operational leadership forums and the performance and delivery plan. Individual action plans for target areas are formed accordingly.

- Maternal, Newborn and Infant Clinical Outcome Review Programme Rapid report, 2021: Learning from SARS-CoV-2 – The Trust has implemented daily calls for all women that report a positive COVID result. This includes an updated VTE assessment and safety netting advice with liaison with the Obstetric team as required. Women are reminded at each antenatal contact to update us with positive COVID results.

- British Thoracic Society Non Invasive Ventilation (NIV) Audit - Respiratory high care environment to be developed on Bournemouth site. This should include negative pressure side rooms to allow NIV (and CPAP/nasal high flow) to be given to patients with infectious diseases such as COVID in a safe manner.

Learning from Local Audits

The reports of 151 local clinical audits were reviewed by the Trust in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Re-Audit of Hearing Screening for Neonatal Intensive Care Unit (NICU) Admissions – Action plan to teach more nursing staff to do hearing tests on the neonatal unit. Two additional staff have been trained to perform hearing screening and a third is currently undergoing training.

- Clinical Frailty Score (CFS) Assessment in Emergency Department (ED) – The ED Matron worked on raising awareness of CFS amongst ED nursing staff. Using CFS in triage is now mandatory for all patients. This is very effective in raising awareness amongst the ED nursing staff as everyone is now using the CFS score.

- An Audit to Determine if Morphine Sulphate 10mg/5ml Oral Solution Volumes Supplied on Discharge Were Appropriate Based on Inpatient Usage. The dispensary processes was updated for the supply of morphine sulphate oral solution to allow the splitting down of original packs into smaller quantities.

- Is Antibiotic Prescribing Duration in Line with Trust and NICE Guidelines? – The audit resulted in the introduction of auto-stop dates for UTI protocol prescriptions.

- Re-audit of the Use of the Abbey Pain Scale in Patients with Dementia - Action to incorporate training on the Abbey Pain Chart within induction teaching as well as other teaching sessions run for students and Healthcare Assistants.

- Re-audit of Hip Surveillance for Children with Cerebral Palsy (CP) – Action to develop a CPIP assessment video that staff can watch as a refresher or prior to clinics.

- Assessment and Information Given to Patients Post OASI (Obstetric Anal Sphincter Injury) - The development of a specialist clinic for patients with OASI.

- Reducing Delirium in Poole Intensive Care Unit - Purchase and installation of two new visual sound meters on ICU.

- A Retrospective Audit of Nursing Compliance in Completing Lying and Standing Blood Pressure Assessment in Neck of Femur Fracture Patients - Use of lying and standing Blood Pressure (BP) stickers presently being implemented by ward leads.

- Re-audit of the Baby Friendly Initiative (July 2021) - Patient information updated and new online resource available, mandatory infant feeding updates re-started following pandemic, updated discharge booklet.

- Recovery Handover 2020/21 – Display of new posters in recovery areas to remind team of standards.

- Prevention of VTE in Stroke Patients Re-Audit - Include information regarding when/how to prescribe VTE prophylaxis in the junior doctors induction pack.

- Nasogastric Documentation Audit - Education/ reminder to medical/ surgical teams that they are required to document in the notes the result of the NG X-ray before the tube can be used. Education/ reminder to the nursing teams that the tube cannot be used until it is documented as safe to use by the medical/ surgical team.

- Re-Audit: Has there been appropriate consent for risk of hernia post laparotomy? Creation of a new electronic/pre-formed consent form.

- CO Recordings in Pregnant Women – Improved documentation.

- Antibiotic Intravenous to Oral Switch Audit - Formation of a link group providing education at ward level to relevant staff. The staff will be provided with monthly education sessions and invited to 3 monthly meetings held by the microbiology consultant.

- Medical Gases – Removal of Airflow meters in all ward areas to reduce risk of misconnection. Provision of additional nebuliser boxes across the Trust, amendment to medical gas training plans and Estates to cap off air port terminals in all identified ward areas.

Meet Craig, our clinical audit and effectiveness manager

"Clinical audit measures current practice against best practice standards and addresses any shortfalls. The clinical audit team can help you design your project from the start – just email or call us for an initial discussion. We can help you set the standards against which you will be auditing. We can help to design your data collection questionnaire, and have software that can enable you to collect your data online. Once you have collected your data, we can help with collating the results, developing an action plan, writing your report, and preparing any presentations. For any completed projects, we would be more than happy to provide you with a certificate confirming your participation.

"I am very proud of our team as everything we do aims to make treatment safer and better for patients. It is great to help facilitate improvements that will make a difference and is really satisfying to see audits lead to positive changes for our patients.

3. Participation in clinical research:

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee and NIHR portfolio currently stands at 4,947.

In 2021/22 we continued to support the national vaccine work in the newly established research hub, with 255 participants recruited to covid-19 vaccine studies at UHD. We were one of the first centres in the UK open and recruiting to the Cov-Boost study which provided the evidence for the effectiveness of booster doses.

We were successful in securing a grant of just under £500k through the Dorset Local Enterprise Partnership (Dorset LEP)'s 'Getting Building Fund' to support the development of a new Clinical Trials Unit for Dorset (the DCTU). This project was undertaken and completed in 21/22.

The DCTU provides a specialist environment for patients to see expert staff with state-of-the-art equipment and will provide the infrastructure to increase the number and range of clinical trials offered to our patients, including developing and delivering research ideas homegrown in Dorset. The dedicated environment provides staff with the advanced facilities required to develop vital evidence for improved clinical outcomes. With a wide remit allowing the unit to investigate various health conditions and treatment strategies, the newest Clinical Trials Unit in the country will benefit the local community and provide the opportunity for patients to be involved in high calibre studies in safe and comfortable surroundings

How does this benefit staff?

The creation of the DCTU brings the opportunity to both retain talented staff interested in developing their research careers locally, as well as attracting new research experienced staff who share an ambition to strengthen and grow research culture in the region.

What does this mean for patients?

Patients will be invited to take part in crucial research projects in a variety of ways; helping to inform the development of the unit; inputting into the design of research studies; taking part as participants the research studies and assisting in sharing the results in patient groups and forums.

DCTU DORSET CLINICAL TRIALS UNIT

DCRC DORSET CLINICAL RESEARCH CENTRE

Terry Levy, R and D clinical director:

"Covid has highlighted to the world the importance of medical research. Our DCTU will allow us to support research ideas from our local community that hopefully will lead to wider benefits for society."

Nicki Lakeman, lead research nurse:

"This is an exciting era for research in Dorset. As well as creating a platform for local researchers to develop and explore their ideas, it opens the door for more people to become involved in this rewarding and important area."

Joanna Samways, lead research nurse:

"Evidence shows clinically research-active hospitals have better patient care outcomes and we look forward to delivering even more clinical research at UHD in the future."

4. Use of Commissioning for Quality and Innovation (CQUIN) payment framework

The Trust's income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because of the agreement reached with the Clinical Commissioning Group (CCG) to use the CQUIN payment to source a fund available non-recurrently to protect the quality of care and safety of the service with a particular focus on areas that are giving rise to the CQUIN areas. The Trust agreed use of this fund directly with the CCG.

5. Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. This means that the Trust does not have any current restrictions on its practice or services. The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

The Care Quality Commission (CQC) undertook an announced focused inspection of University Hospitals Dorset NHS Foundation Trust in April 2021. The inspection looked at leadership, culture, governance, information management and learning at the trust following concerns about the safety and quality of some areas.

The concerns related to high number of never events reported in the period from March 2020 to January 2021. Other concerns related to an incident of a breach of information governance; a small number of patients being referred to the trust whose treatment had either not been carried out, or not followed-up on in a timely way; and an incident which gave rise to concerns around employment of temporary staff.

The inspection focused on individual elements of the CQC well-led key lines of enquiry. The CQC did not rate the trust at this time.

During the inspection of University Hospitals Dorset NHS Foundation Trust, the CQC found leaders had the skills and abilities to run the service. Managers understood and managed the priorities and issues the service faced and were visible and approachable in the service for their staff. The CQC noted that the culture was open, and staff could discuss errors without fear of reprisal. There were effective processes focused on learning from mistakes and continuously improving practices.

However, the CQC found that governance systems were not always effective in determining patients' pathways of care and treatment. In a small number of cases the systems used did not prevent cancer treatments from being missed, delayed or terminated in error. The CQC recognised that the trust had taken steps to address these gaps and noted further actions were in place to mitigate risk. It was recognised this was a new organisation and the trust leadership knew there were gaps that needed addressing in some areas, and processes that needed to be improved. The CQC were content with the action plans in place across the Trust to mitigate risks and ensure patient safety.

6. Data Quality

The University Hospitals Dorset NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service (SUS) 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 patients' valid NHS number was 99.9% for admitted patient care; 99.9% for outpatient care; and 99.5% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 100% for admitted patient care: 100% for outpatient care; and 99.7% for accident and emergency care. (Taken from the National M13 21-22 SUS DQ report)

Collecting the correct NHS number and supplying correct information to the Secondary Uses Service is important because it:

- is the only national unique patient identifier
- supports safer patient identification practices
- helps create a complete record, linking every episode of care across organisations

7. Data Security and Protection Toolkit attainment levels

All NHS trusts are required to complete an annual information governance assessment via the Data Security and Protection Toolkit (DSPT). This replaced the Information Governance Toolkit from April 2018 onwards. The self-assessment must be submitted to NHS Digital and for the last couple of years the DSPT deadline has changed owing to Covid-19. The deadline for the 2021/22 DSPT is the 30th June 2022.

However, in the 21/22 year the Trust did complete a self-assessment for the 20/21 DSPT. The submission deadline was the 31st December 2021. The following section provides details of the 20/21 DSPT submission.

The Data Security and Protection Toolkit (DSPT) is a self-assessment audit completed by every NHS Trust annually and submitted to NHS Digital; the purpose being to assure an organisation's Information Governance practices through the provision of evidence around 149 individual assertions which change slightly each year. For 2020/21 111 of these assertions were mandatory.

The DSPT sets the standard for cyber and data security for healthcare organisations and places a much greater focus on assuring against modern threats. Based around the National Data Guardian's 10 Data Security Standards, a significant portion of this audit is underpinned by work associated with information risk assurance.

During 2020/21, the Trusts aim was to achieve compliance with all of the mandatory assertions by the end of June 2021. Trusts for whom this was not possible were permitted to agree an action plan with NHS Digital, confirming that they would reach the required standard by the end of December 2021. Accordingly, UHD submitted and agreed such an action plan.

By the end of December 2021, the Trust was able to declare compliance with 106 of the 111 mandatory assertions. Areas requiring further work was the proactive audit of user account permissions and removal of unnecessary permissions, “whitelisting” of applications that can be downloaded to Trust IT devices, and risk assessment and removal of unsupported software.

As a result the Trust was not able to submit a completed action plan, and its DSPT status for 2020/21 was “Approaching Standards”.

In 2022/23, work will continue to establish and firmly embed the principles of information risk management and IG throughout the organisation, in order to ensure that the Trust is complying with its legal obligations. Key to this is the engagement and continued co-operation of subject matter experts and Information Asset Owners (IAOs), who provide assurance of practices within their respective departments across the organisation. Significant strides were made during 2021/22 with the roll out of the Trust’s Information Asset Register, and work will continue within year to embed and enhance this critical compliance tool.

8. Learning from deaths

All inpatient deaths receive a consultant review against a specific questionnaire. Reviews are discussed at specialty Mortality and Morbidity meetings and the chairs of these meetings attend the Trust Mortality Surveillance Group. This ensures that the reviews of all deaths within the hospital are discussed centrally and ensures actions for improvement are identified.

The Learning from Deaths pro forma also includes a nationally recognised grading system to ensure that avoidable mortality is clearly categorised. The tool used codes the reviews into one of the following categories:-

- Grade 0-Unavoidable Death, No Suboptimal Care.
- Grade 1-Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2-Possibly Avoidable Death, Suboptimal care, but different care might have affected the outcome.
- Grade 3-Probable Avoidable Death, Suboptimal care, different care would reasonably be expected to have affected the outcome.

Once any death is categorised as grade 2 or 3, a Patient Safety Incident LERN Form is completed and a full root cause analysis investigation process is undertaken.

In October 2018 the Trust introduced a new Medical Examiner process. Part of the Medical Examiner process includes completion of an initial case note screen by a senior clinician. The aim of the screening process is to highlight any cases that require an urgent case note review/ or root cause analysis investigation.

The Trust has a multi-disciplinary Mortality Surveillance Group (MSG), chaired by the Chief Medical Officer, to review the Trust's Hospital Standardised Mortality Ratio (HSMR) and internal and external mortality risk reports. The group discusses areas of potential concerns regarding clinical care or coding issues and identifies further work, including detailed case note review and presentations from relevant specialties. The Group also undertakes a monthly review of all e-mortality data and any learning points are disseminated through Directorate Mortality and Clinical Governance meetings. A regular newsletter following discussions at the Mortality Surveillance Group is produced. The newsletter is an opportunity for wider dissemination of the learning captured through mortality reviews.

Process for learning from deaths are in place at Poole Hospital, Royal Bournemouth Hospital and Christchurch Hospital Macmillian Unit. Currently the use of multiple different IT systems means that UHD are unable to provide accurate data on the number and gradings of deaths reviewed. A UHD project is currently in place to implement a new learning from deaths system across the Trust by the end of Q3 22/23.

Themes for action and learning from mortality case note reviews and investigations have linked to the development of quality priority and quality improvement initiatives for 2021/22 and 2022/23.

9. Delivering Seven Day Services

The Trust is committed to providing high quality consistent care, whatever day patients enter the hospital. Job planning and consultant recruitment has ensured formal provision for most inpatient specialties 7 days per week.

There has not been a formal requirement to undertake a seven-day service audit in 2021/22 (similar to 2020/21). However, the Trust has made the decision to undertake the audit in 2022 and plans to undertake a seven-day service audit in April 2022. The results of the audit will be presented to the Workforce Committee and Trust Board in June/July 2022. Learning will be shared with Care Group leads and Trust Management Group.

Medical staffing is monitored through the MSTEG which looks to identify rota gaps and areas of high cost spend with the aim to securing substantive workforce and different models of working where appropriate.

There are no significant consultant gaps at the current time although some vacancies are emerging in histopathology. Additional investment in Obstetric posts has been identified through our response to the Ockenden report. There are some gaps identified in middle grade Rotas particularly in the emergency department and obstetrics putting pressure on acting down.

The Trust has a has a safe medical staffing work stream aiming to provide a framework for best staff utilisation and a 'red flag' system similar to nursing to ensure safe levels of staffing across the seven days.

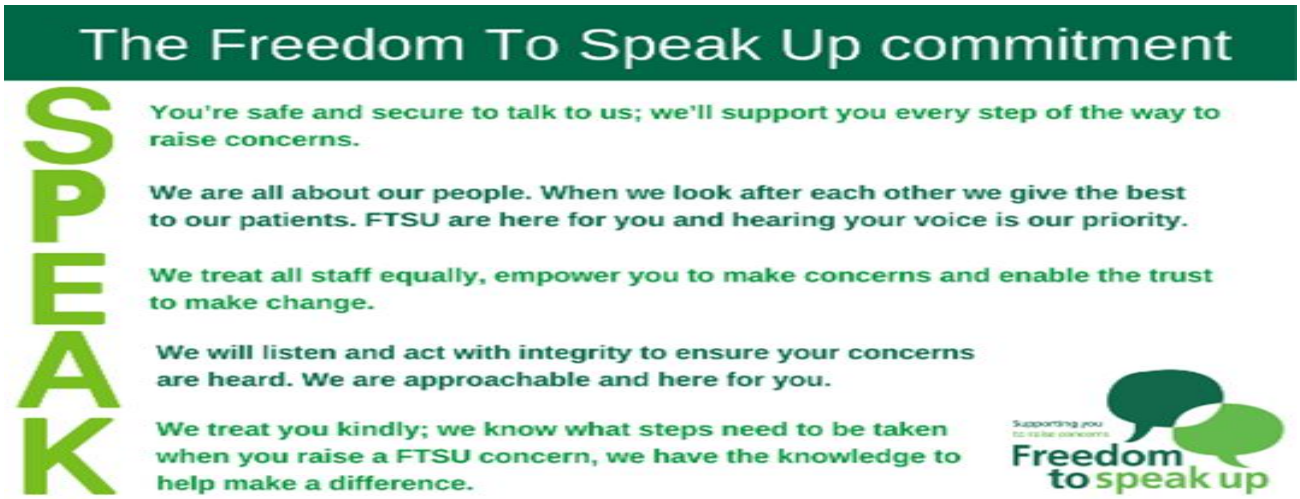
9. Freedom to Speak Up

Six years have passed since the publication of the Francis Freedom to Speak Up Review. The speaking up culture within the health sector in England has changed with a network of over 700 Freedom to Speak Up Guardians (FTSUG) in over 400 organisations hearing over 50 000 cases in the last 3 years. Such an increase of cases reflects how trusted FTSUG are as additional channel for speaking up.

Speaking up at University Hospital Dorset (UHD) is the cornerstone of our culture as a new trust. This is reflected in our new set of values following the cultural review undertaken by our cultural champions. Our people clearly described the need for a learning rather than blame culture, whereby we are able to make mistakes without feeling afraid to discuss them. Psychological safety and feeling confident to speak up were seen as contributing to safer, excellent quality care. As a result UHD are proud to have "I will be open and honest" as one of our values.

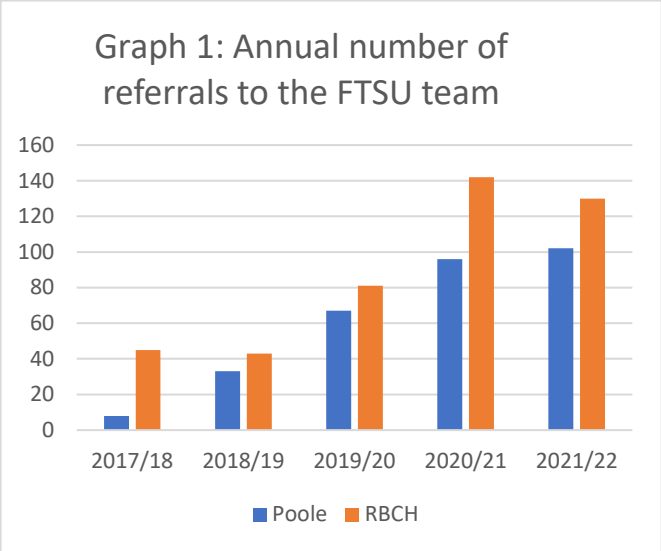
The Vision of Speaking up and Commitment from the FTSU team is as follows:

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.



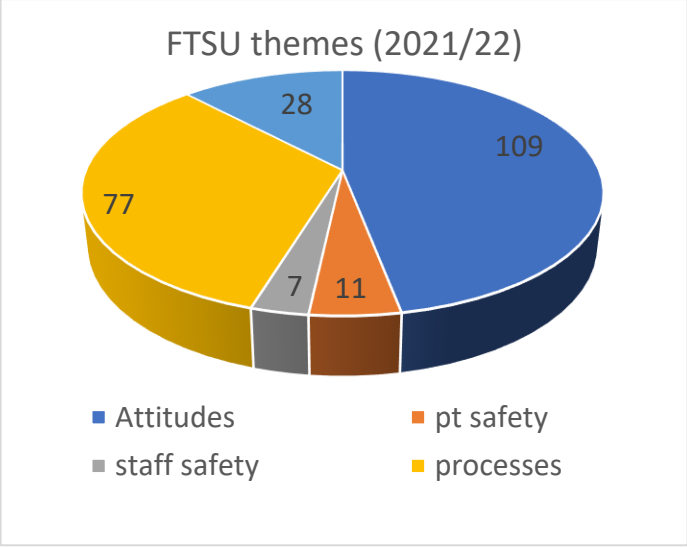
The UHD FTSU was established to raise awareness and promote the value of speaking up, listening up and following up. This network has helped address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success

The following table and graph provide details of the case referral to the F2SU Team during 2021/22:-



Graph 1 shows that the number of referrals to the FTSU team has maintained its activity to that seen in 2020/21 following a number of year on year increases.

Forty-four per cent of referrals come from staff at our Poole site and 56% from RBH



Staff approach the FTSU team for a number of reasons.

The greatest theme had an element of attitudes and behaviours (47%). This is following by process and procedures (33%) and then workload and burnout (12%).

Whilst each referral will have its own learning, themes can be drawn to help develop and embed our culture as a new merged organisation.

Compassionate and Inclusive leadership and People Management

It is well documented about the importance of delivering compassionate and inclusive leadership. It is encouraged that our leaders, and particularly our junior leaders, listen to our teams, acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change. The Trust is committed to create cultures where staff feel cared for and our leaders "*attend, seek information, empathise and help".*

Our data from quarter 4 show that in over 50% of referrals made to the FTSU team came because the line manager is part of the concern. Often this is a miscommunication, poor message delivery or in 22% not acting or addressing the concerns.

Delivering compassionate leadership and care requires investment in time, in skill and an appreciation of the benefits for our people and ultimately the care we give to our patients.

Developing a civil and respectful culture

Developing a civil and respective culture is another learning theme. Behaviours including disrespect and rudeness, can create an environment where quality of work reduces, people are less likely to help each-other and there are more errors as people are afraid to speak up. Patients also feel more anxious. Having the tools to feedback poor behaviours in a respectful and compassionate way is needed to ensure that issues are dealt in a quick and informal way with a mutual understanding.
Early data is of the just culture in HR, is showing good results for those involved and more satisfactory outcomes are found. Clearly there are times we need to escalate some behaviours to a more formal intervention. We now have our data from our staff survey and see that the gaps are how we are with each-other, fellow colleagues but also more emphasis and support for colleagues from black and minority ethnic backgrounds.

Team integration

Another emerging theme has been the impact of 2 teams coming together and the anxiety that this is causing our staff. There are a number of reasons as to why teams coming together can find it difficult. These can include teams not knowing each-other, everyone thinking their way is best, hierarchical interests, lack of respect for each other, lack of clarity of objective and team role. Other factors can also be at play especially if a team is also moving location including transport, impact on home balance and uncertainty. An emerging theme has been that staff feel their voice and concern is not being heard or being dismissed without discussion. This has creating a number of staff to become so unsettled and undervalued. They have felt that if they had been listened to and adjustments made to implement this change, the levels of anxiety could have been avoided. Providing our line managers with the skills of holding these conversations and listening actively will be key going forward.

Next Steps

We are #TeamUHD

University Hospitals Dorset's values celebrates the importance of having an open and honest culture. Speaking up has never been as important as it is today. It is everyone's business to encourage speaking up. We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

The F2SU Team can be contacted via the Freedomtospeakup@uhd.nhs.uk email, by telephone leaving a confidential message on 0300 019 4220, via the LERN – raise an issue forms or via the @UHDapp.

Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report against a set of core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator the number, percentage, value, score or rate (as applicable) for the last two reporting periods (where available) are presented in the table below. In addition, where the required data has been made available by the HSCIC, a comparison with the national average and the highest and lowest national values for the same indicator has been included. The Trust considers that the data presented is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Summary hospital level mortality indicator (SHMI)	Health and Social Care Information Centre (HSCIC)	January 21 – December 21 0.9037	1.000	1.1897	0.7127
University Hospitals Dorset NHS Foundation Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission to HSCICS. The data has been extracted from available Department of Health information sources. The SHMI data is taken from https://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi					
University Hospitals Dorset NHS Foundation Trust has taken the following actions to continue to improve this rate, and so the quality of its services, by routinely monitoring mortality rates. This includes looking at mortality rates by specialty diagnosis and procedure. A systematic approach is adopted whenever an early warning of a potential problem is detected – this includes external review where appropriate. The Trust Mortality Surveillance Group (chaired by the Chief Medical Officer) routinely reviews mortality data and initiates quality improvement actions where appropriate.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	NHS Digital	January 2021 – December 2021 45%	39%	64%	11%

The Trust considers that this data is as described for the following reason. The data has been extracted from available Department of Health information sources. Publication of data is found here https://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi
Figures reported are 'diagnosis rate' figures and the published value for England (ENG) is used for the national value.

University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: - Routine review of mortality reports at the Trust Mortality Surveillance Group.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Patient Reported Outcome measures (PROMS)	Case mix adjusted average health gains i) groin hernia ii) varicose vein iii) hip replacement iv) knee replacement	Latest data published (Feb 22) is for April 2020 – March 21. 2021/22 data for UHD is not available			

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (i) aged 0 to 15 (ii) aged 16 +	NHS Digital	April 2020 – March 2021 (i) = 13.3% (720) (ii) = 14.3% (8955)	(i) = 12.5% (ii) = 13.0%	(i) = 64.4% (**) (ii) = 11.2% (**)	(i) = 2.8% (**) (ii) = 1.1%

* indicates suppressed values between 1 and 7
** indicates national dataset has marked this data item with 'caution in interpretation of data. Numbers of patients discharged too small for meaningful comparisons'

The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely audited prior to submission.

University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: - Undertaken routine monitoring of performance data and root cause analysis investigations where appropriate.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Responsiveness to the personal needs of patients	National Inpatient Survey – NHS Digital	Published August 2021 Poole Hospital NHS FT – 68.5% Royal Bournemouth & Christchurch NHS FT – 71.7%	67.1%	84.2%	59.5%

The Trust considers that this data is as described for the following reason. The data source is produced by NHS Digital.

University Hospitals Dorset NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services – Development of an appropriate action plan which is overseen by the Quality Committee, which is a sub-committee of the Board of Directors.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average	Highest value	Lowest value
Staff who would recommend the Trust to family or friends	National Staff Survey	2021 – 73.0%	66.9%	89.5%	43.6%

The Trust considers that this data is as described for the following reason. The exercise is undertaken by an external organisation with adherence to strict national criteria and protocols.

University Hospitals Dorset NHS Foundation Trust intend to take the following action to improve this percentage, and so the qualities of its services, by implementation of a detailed action plan. The results of the survey have been presented to the Workforce Committee (a sub-committee of the Board of Directors) and key actions agreed.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The rate per 100,000 bed days Of cases of C difficile infection reported within the trust during reporting period.	Public Health England (PHE)	2020/21 – 10.49 per 100,000 overnight bed days	15.79	80.65	0

The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors.

University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by ensuring high standards of infection prevention and control are implemented, monitored and maintained.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value (non-specialist acute trusts)	Highest value	Lowest value
Number of patient safety incidents reported during the reporting period	NRLS	See section in report	Not available	Not available	Not available

The Trust considers that this data is as described for the following reasons. All data is validated prior to submission to the National Reporting and Learning System (NRLS). The NRLS enables all patient safety incident reports, including near miss and no harm events, to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. The data presented is from the most recent NRLS report issued.

University Hospitals Dorset NHS Foundation Trust has taken action to improve this indicator, and so the quality of its services, supporting an open culture for incident reporting and investigation and has embedded learning event notification (LERN) processes and investigation 'Toolkits' in 2021/22 to further enhance learning and improvement.

Part 3 – Other information

Review of quality performance in 2021/22

The data reviewed for the Quality Account covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Information reviewed included directorate clinical governance reports, risk register reports, clinical audit reports, patient survey feedback, real time monitoring comments, complaints, compliments, incident reports, quality dashboards and quality and risk data.

This information is discussed routinely at Trust and Directorate quality, risk and clinical governance meetings. There is a clear quality reporting structure where scheduled reports are presented from directorates and specialist risk or quality sub groups to the Quality Committee, Clinical Governance Group, Trust Management Group and Board of Directors. Many of the reports are also reported monthly and/or quarterly to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

The Trust has a Quality Strategy split into three distinct sections - Patient Safety, Clinical Effectiveness and Patient Experience. This is reviewed and refreshed annually.

The Quality Strategy sets out the strategic quality goals of the Trust in relation to clinical priorities set against the previous year's risk profiles, patient outcomes and new clinically based evidence or published guidance. Each of the three sections has distinct quality patient focussed goals to achieve to deliver the strategic aim, and sets out how this will be monitored and the governance framework within which it will be monitored against. This is developed with key internal and external stakeholders and is approved and monitored by the Quality Committee as a committee of the Board of Directors. The Quality Committee scrutinises the plans and approves them, monitoring monthly the quality performance, together with the risk profiles and the Trust's Board Assurance Framework.

The following section provides an overview of the performance in 2021/22 against some of the quality indicators selected by the Board of Directors for the year. The indicators have been selected to demonstrate our commitment to patient safety, clinical effectiveness and enhancing the patient experience.

PATIENT SAFETY

The following table provides details of the patient safety incidents reported during 2020/2021 and uploaded to the national reporting and learning

The following table provides details of the patient safety incidents reported during 2021/2022 and uploaded to the national reporting and learning

2021/22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
No Harm/ Near Miss	747	952	965	932	989	867	1053	931	822	975	764	820	**10817**
Minor	402	384	375	437	432	404	393	486	417	435	420	395	**4980**
Moderate	10	12	10	22	11	10	8	8	7	9	2	3	**112**
Severe	5	7	2	3		2	2	1	3	1	2		**28**
Grand Total	**1164**	**1355**	**1352**	**1394**	**1432**	**1283**	**1456**	**1426**	**1249**	**1420**	**1188**	**1218**	**15937**

Table: Patient safety incidents reported during April 2021 to March 2022 and uploaded via the national reporting and learning system (NRLS) (as at 31/03/2022)

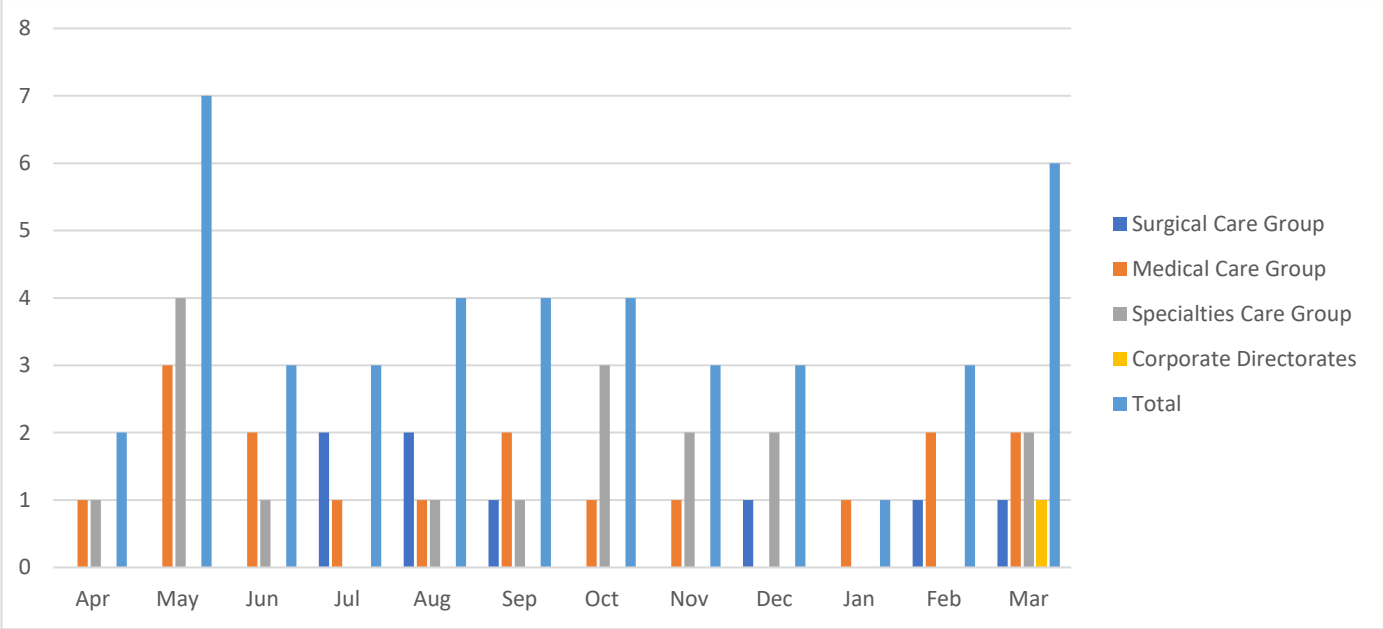
NHS England defines Serious incidents in broad terms as events in health care where the potential for learning is significant or the consequences to patients, families and carers, staff or organisations. There is no definitive list of events / incidents that constitute a serious incident. The circumstances in which an incident would be considered include:

- unexpected or avoidable death;
- unexpected or avoidable injury which resulted in serious harm or required treatment to prevent death or serious harm;
- A Never Event
- Actual or alleged abuse
- Incidents that prevent or threaten an organisations ability to deliver an acceptable quality of care.

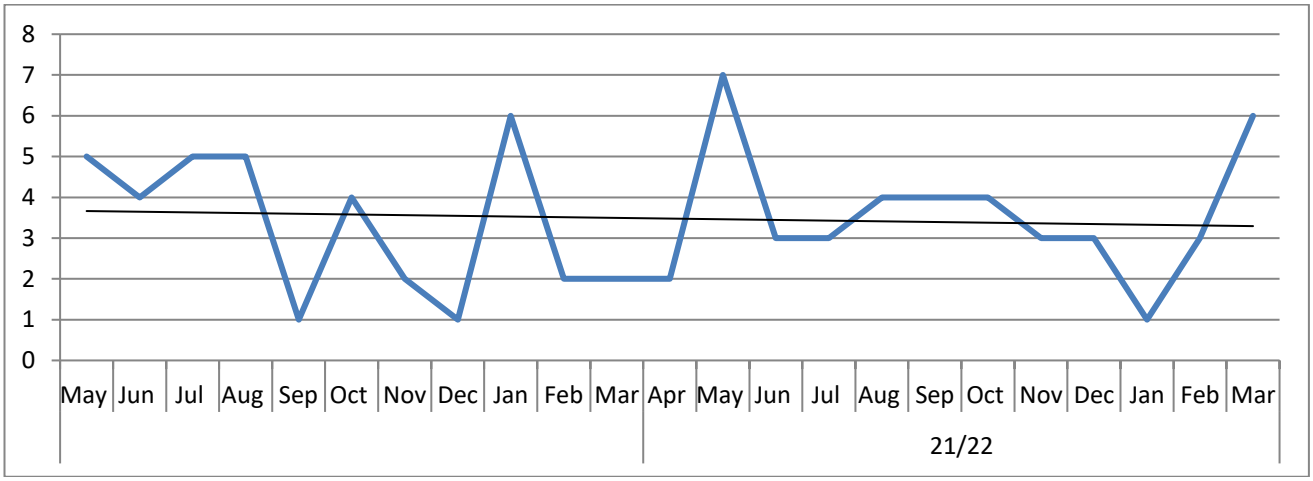
The Trust has a policy that describes the process governing the investigating and reporting of all incidents which supports an open and honest culture and facilitates learning and improvements in clinical care and guidelines.

In 2021/2022 the Trust reported 42 serious incidents.

UHD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Surgical Care Group	0	0	0	2	2	1	0	0	1	0	1	1	**8**
Medical Care Group	1	3	2	1	1	2	1	1	0	1	2	2	**17**
Specialties Care Group	1	4	1	0	1	1	3	2	2	0	0	2	**17**
Operational	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Total	**2**	**7**	**3**	**3**	**4**	**4**	**4**	**3**	**3**	**1**	**3**	**6**	**42**



All External reports by date reported on STEIS (Month and year) (comparative 20/21 and 21/22)



Key learning and actions from serious incident investigations during 2021/22 have included:

Slips, Trips and Falls
Key Learning and Actions
• Increased education regarding early recognition of developing delirium • Clear standards for timing, completion, updating risk assessments and how to evidence mitigation of risk • Increase awareness on the importance of completing and escalating results of lying and standing blood pressure • Documenting and escalation of bowel assessments • Review timing and frequency of safety huddles

- Completion of neurological observations post fall and ensuring medical staff understand their joint responsibility of reviewing any results
- Raise awareness about the use of under bed lighting
- Increased awareness and education on pain relief and monitoring for those patients especially with confusion or dementia.
- Staff to complete documentation as per Nursing and Midwifery Council Guidelines and as per Trust policy.
- Increased education on the responsibilities of staff in assessing and increasing Enhanced Observation for those patients identified as at risk of falls or deteriorating cognitively.
- Education on responsibility of completing duty of candour post fall

Administrative processes

Key Learning and Actions

- To advise patients that if they do not receive the appointment within the allotted timeframe discussed then to contact a specified number or give an email address. Information to be added to the standard letter template and patient information leaflet. To raise in Endoscopy meeting with a view to adding timescales to the discharge leaflet with space for the timescale to be added by hand.
- Clinically led review of referral protocols for eye Emergency Department (ED) and grading to consultants from eye ED attendances
- Greater education in eye ED about monitoring number of patient visits & post-operative complications.
- Regular review of protocols and impact assessment on waiting times and accessibility to consultant services
- Ensure junior staff are aware of escalation triggers and processes.
- Review of multiple electronic patient record (EPR) platforms internal and Trust feedback, and analysis of paper dependencies

Diagnostic Processes/Procedures

Key Learning and Actions

- To implement 24/7 translation service in ED
- To implement process for providing a printout of discharge summary containing information of diagnosis/follow up to foreign nationals/ those not registered with a GP
- To ensure leads are aware of responsibilities and to ensure all clinicians present at multidisciplinary team meeting (MDT) understand their role in discussion of differential diagnoses and determining patient management discussion and agreed actions. Complex cases to be flagged by clinician to signpost facilitator more time required Surgical team to provide protected time for clinicians to prepare for the MDT.
- Review the MDT documentation and remind clinicians of responsibilities for ensuring details are recorded accurately. Ensure MDT summaries are comprehensive and clearly show management intentions.

Maternity Care
Key Learning and Actions
• To implement 24/7 telephone triage services to meet the needs of the maternity service and women • To implement a documentation process standard operating procedure (SOP) to record risk assessment & clear care standards to ensure appropriate risk basement and referral - Audit of documentation to be uploaded once SOP implemented. • To implement a of SOP for Doppler Ultrasound in Obstetrics with relevant training for the Teams. • To clarify documentation pathway with all staff to ensure the documentation of clinical assessment of ultrasound, review and plan are recorded on Medway and/or electronically on scan record. Audit to confirm compliance
• Clearer guidance is required on the prescribing and administering of opioid analgesia for women in labour. • More effective communication between the MDT in emergency situations and the neonatal SBAR to be completed • Neonatal teams to review options for babies affected by opioid administration. • Implementation of white board to record mothers opioid pain relief during labour
• Ensure that staff are supported to consistently use CTG categorisation tools to aid decision making and escalation, in line with national guidance (NICE, 2017, FIGO, 2015). • Ensure staff are supported to recognise, escalate and act upon a pathological CTG in a timely manner, and that there is a process of continual risk assessment in the second stage of labour. • Implement a robust system is in place to categorise the urgency of the trial of instrumental deliveries, with clear timescales from the decision to delivery interval (RCOG, 2017, Each Baby Counts 2015)
• Staff to have access to electronic records at the time of giving clinical care to ensure all relevant information is available. • Ensure that the practice of referral to obstetric led care occurs if there is reduced fetal movements over 39 weeks and/ or within 24 hours of labour to discuss the options of induction of labour, in line with national guidance. • Improve handover processes to ensure all relevant clinical information from the records when mothers are transferred between clinical areas. • When pain in the latent phase of labour is not relieved by simple oral analgesia or is prolonged, obstetric review with a full assessment and a management plan should be considered. • The Trust should ensure that there is a robust mechanism of communication that supports handover of clinical information between all members of the multi-disciplinary team • The Trust to ensure that all mothers have an individualised risk assessment and plan of care which takes into consideration the mother's history, number of admissions and her personal needs when admitted and or discharged in the latent phase of labour.

Medical Gases/Oxygen
Key Learning and Actions
• Clearer guidance in the wording of policies regarding specific tasks associated with oxygen delivery and which staff are covered to undertake these tasks. • To liaise with cylinder manufacturer to raise questions regarding cylinder design • To increase awareness of/remind all registered staff of the need to switch on oxygen cylinder at the handwheel prior to administration. • To consider displaying cylinder use posters at/on all cylinder storage points. • To review documentation of Band 4 job titles to ensure standard and correct and that the two types of Band 4 nurse roles are distinguishable. • To align medical gases learning packages across UHD and clarifying process of completing this as part of the non-IV medicines management competency.
Medicines Management
Key Learning and Actions
• Add a mandatory field to the Venous Thromboembolism (VTE) risk assessment stating, 'patient requires VTE prophylaxis 'Yes / No' • Continue to request the providers of EPMA to link the VTE assessment to VTE prophylaxis prescribing • Provide a report to all wards using EPMA which highlights patients not yet prescribed VTE prophylaxis for use during ward rounds / by clinical pharmacists • Consultants to include a check of VTE risk and VTE prophylaxis prescriptions to ward rounds • Continue to raise awareness of importance of completing the VTE risk assessment in full and prescribing VTE prophylaxis where indicated through regular training, memos, screensavers, safety letters, Grand Round, Pharmacy Department meetings, ward team meetings etc. • Training and opportunity for junior doctors to be made aware of VTE risk assessment and risk factors • Ensure that 'reassessment of VTE risk' at 48 hrs after admission is a highlighted on the drug chart/proforma • Ensure that patients are assessed by senior doctor in a case of deterioration • Develop a protocol for VTE treatment in spinal trauma patients
• Improve awareness of hypokalaemia/DKA and options for treatment as per national guidance, which has sections on electrolyte complications (e.g. the option to stop insulin infusion rate). Suggest inclusion of case as scenario in simulation training regionally with focus on deteriorating potassium levels in sick DKA children • Review Magnesium guidelines • Review locally guidance on dosing and administration of Magnesium in Child Health. • Improve documentation of infused fluids • Share case example to regional critical care network and regional paediatric diabetes network. Propose adding the scenario as a learning simulation on regional and local courses to ensure wider recognition of this potential complication and management.
• Circulation of an internal safety alert to surgical staff re prescribing variable rates of insulin infusions if the patient is going to have emergency surgery, with relevant guideline attached.

Never Events

Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

The full list of Never Events is available on the NHS England website https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf

In the last 12 months (1 April 2021 – 31 March 2022) the Trust reported 2 never events.

Retention of a Foreign Body
Part of surgical retrieval basket was retained. This was not noticed at the time of surgery but was later identified as a result of further treatment. To address the risk of recurrence of this never event, retrieval baskets are now checked pre and post procedure for signs damage.

Incorrect placement of a Nasogastric tube
The investigation identified gaps in Trust processes and training. An updated training program across UHD has been imp0lmeneted as a result of learning from this Never event.

Duty of Candour

The Duty of Candour requires healthcare providers to respond to safety incidents that result in moderate or severe harm or death in line with Statutory Duty of Candour as detailed in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Any patient safety incident meeting the criteria must be notified to the patient or the 'relevant person', as soon as the organisation is aware. Organisations have a duty to:

- apologise
- inform patients that an investigation will be undertaken
- provide the opportunity for them to be involved in that investigation
- provide patients and their families with the opportunity, and support, to receive and discuss the outcomes of the investigation

Duty of Candour is managed within the structure of the Trust's web-based risk management reporting system and is an integral part of the reporting and subsequent incident management process.

All investigation processes require consideration and undertaking of the Duty of Candour in accordance with national legislation. A Duty of Candour "Toolkit" is available to support staff.

During 2021/22 Dorset Clinical Commissioning Group (CCG) undertook an audit of the Trust arrangements for duty of candour. The Audit reported that the Trust "*has effective, recognised systems in place to monitor incidents, serious incidents, and Never Events".*

The audit also reported:

- The Trust has an electronic system that is able to effectively store data and correspondence in relation to compliance with the elements of duty of candour;

- Expressions of regret regarding any incident are personalised and expressed in human and straight forward terms;

- There is continued assurance around the use of duty of candour in relation to Serious Incidents and Never Events. This is evidenced not only in the standardised investigatory reports received by the CCG, but also at scoping meetings, Serious Incident panels and post-event reviews, held by the Trust are attended by clinicians and managers and by representatives of the CCG's Patient Safety and Risk team.

National and Local Staff Survey

The **NHS Staff Survey** is the largest survey of staff opinion in the UK where staff are given the opportunity to share their views of experiences at work. It gathers views on staff experience at work around key areas, and including appraisal, health and wellbeing, staff engagement and raising concerns.

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

The national survey centre publishes full and summary reports of core survey responses appropriately benchmarked against national data for all trusts in England. The survey data is used in a variety of ways including:

- Care Quality Commission for ongoing monitoring of registration compliance.
- Department of Health for the development of NHS workforce policies.
- The Social Partnership Forum, where Unions, NHS Employers and the Department of Health, meet regularly to consider the results and influence national workforce policy.

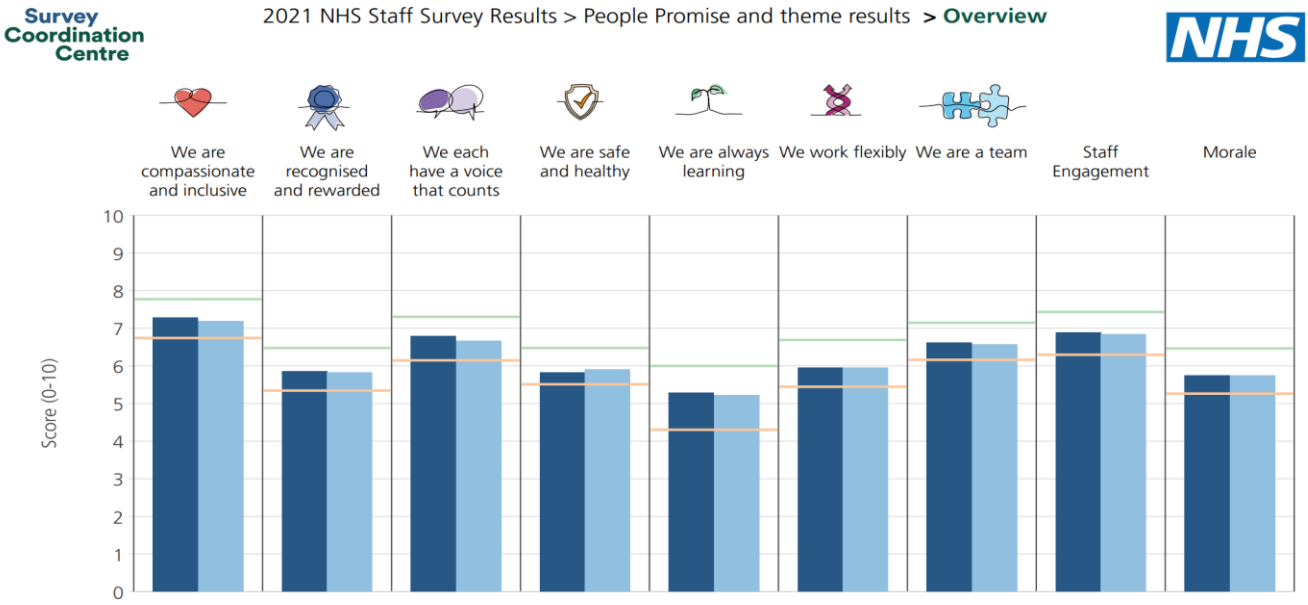
- The survey provides valuable information about staff working conditions and practices, which are linked to the quality of patient care.

Within the Trust we analyse our data at team, subject and Trust level in order to understand:

- How we can celebrate and share good practice.
- How we can communicate results in a meaningful way and in the context of change to come.
- How we can channel resources to best support our teams.
- Areas and issues for particular attention.

The 2021 survey results were announced at the end of March 22. This was the first UHD NHS Staff Survey and provides an important baseline position for our new organisation. The survey was completed just after our merger and during the height of the Covid pandemic.

Our staff survey response rate was 37.1% - higher than our 2020 legacy trusts' combined rate of 35.7%, but lower than the national average for comparator trusts.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	5.9	6.8	5.8	5.3	5.9	6.6	6.9	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7

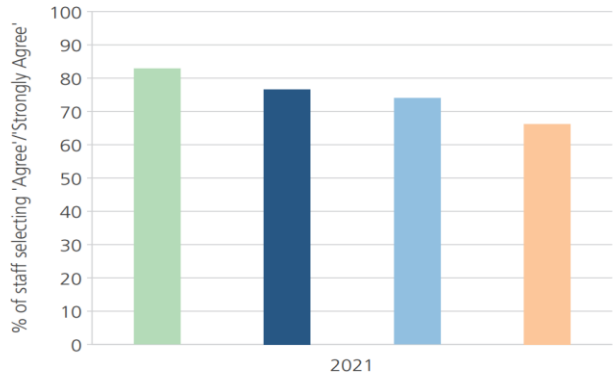
Our results show that, alongside merger, we were continuing to perform well alongside other comparable trusts and doing better than other trusts in some areas. The results also largely reflect the informal feedback that staff have shared with the organisational development team and culture champions over the past few months.

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

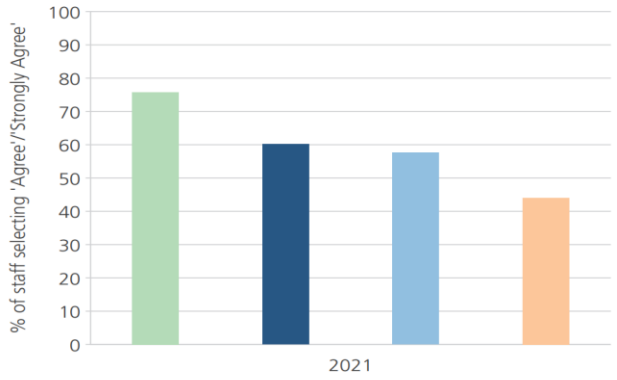
NHS

Q17a
I would feel secure raising concerns about unsafe clinical practice



Best	82.9%
Your org	76.6%
Average	73.9%

Q17b
I am confident that my organisation would address my concern



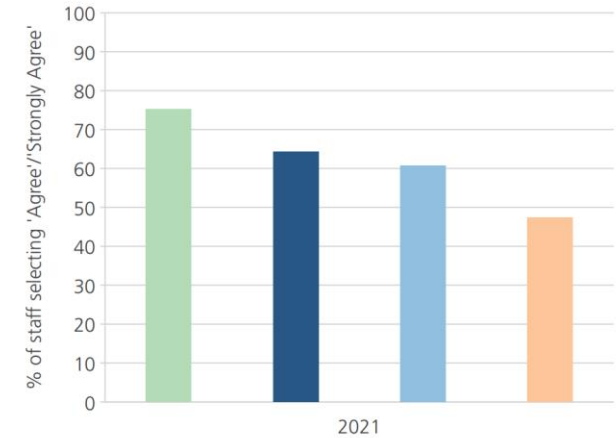
Best	75.7%
Your org	60.2%
Average	57.6%

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

NHS

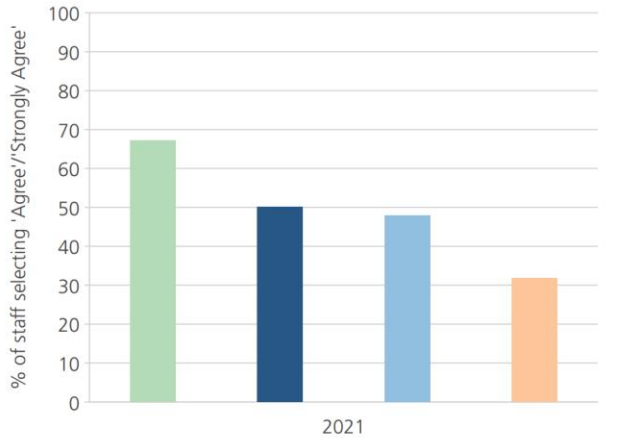
Q21e
I feel safe to speak up about anything that concerns me in this organisation



Best	75.3%
Your org	64.4%
Average	60.7%

Q21f
If I spoke up about something that concerned me I am confident my organisation would address my concern

No trend data are shown as this is a new question



Best	67.2%
Your org	50.1%
Average	47.9%

The Organisational Development team will look closely at the areas we need to celebrate, and those where we can make changes to improve staff experience at UHD.

2021 NHS Staff Survey
People Promise element and theme
Detailed information – benchmarked score comparison
*** denotes result areas including questions where lower scores are better**

People Promise and theme result areas	UHD 2021 Total Scores Better than comparator	UHD 2021 Total Scores Equal to comparator	UHD 2021 Total Scores Lower than comparator
We are compassionate and inclusive*	14	2	1
We are recognised and rewarded	3	1	1
We each have a voice that counts	10	0	1
We are safe and healthy *	10	7	1
We are always learning	6	3	0
We work flexibly	1	1	2
We are a team	9	3	0
Staff Engagement	5	4	0
Morale*	6	6	1
Total	**64**	**27**	**7**

We want to improve on our results by involving and encouraging teams in departments to understand their local results in the heat maps reports and implement and share local Staff Survey action plans. Progress will be monitored by our Workforce Strategy Committee.

Infection Control

This year has continued to see the impact of SARS-CoV-2 on many aspects of healthcare. Whilst the severity of illness associated with cases has been dramatically reduced the number of cases seen within the local community and those admitted to healthcare beds has continued to remain considerably high.

The time taken to manage, investigate, communicate, report and analyse the volume of information associated with this has meant that many of the quality improvement projects aligned with reducing healthcare and community associated infections have not moved forward as much as we had planned for.

However, the Infection Prevention and Control Integrated Care System has continued to move forward projects related to reducing infections particularly related to Clostridioides Difficile. This is in response to a national increase in cases and is supported by a South West NHS E/I led project group looking to understand the relevant risk factors around our increased case number and severity of illness.

The NHS Standard contract includes quality requirements for NHS Trusts to minimise rates of Clostridioides Difficile and gram negative blood stream infection to threshold levels set by NHS England and NHS Improvement. All thresholds are derived from a 2019 calendar year baseline to avoid capturing changes related to the pandemic. Trust level cases include only those that are healthcare associated.

Pathogen	C. Difficile	E. coli	P. aeruginosa	Klebsiella
Threshold	55	194	34	56

Table 1 Thresholds by pathogen for UHD

For aiding interpretation of case rates and attribution the following is how cases are allocated to healthcare providers based upon test result dates and previous hospital admissions.

Allocation	Definition
Hospital-Onset, Healthcare Associated (HOHA)	No Community-onset, date of specimen is taken on day 3 (day 4 for CDI) or later after admission, where day 1 is the first day of admission.
Community-Onset Healthcare-Associated (COHA)	Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient was discharged from the reporting organisation within 28 days prior to the current specimen date (where date of discharge is day 1).
Community-Onset, Indeterminate Association (COIA)	Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient was discharged from the reporting organisation within 28 days prior to the current specimen date (where date of discharge is day 1).
Community-Onset, Community Associated (COCA)	Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient has not been discharged from the reporting organisation within the past 84 days, to the current specimen date (where date of discharge is day 1)

Table 2 Definitions of allocation for pathogens

Clostridium Difficile.

Table 3 is a breakdown of the cases for UHD throughout 2021/ 2022

	COCA	COIA	COHA	HOHA
UHD	42	13	32	41

Table 3 Breakdown of Clostridioides difficle cases for UHD by date of sample taken and exposure to healthcare

The trajectory for UHD was set as 55 for 2021/22. Currently there are 59 cases allocated to the trajectory out of a total of 73 cases. Due to the increase in pressures on the clinical teams and the IPC Team there are a number of CDI cases remaining outstanding for review and presentation to the CCG for removal from trajectory so the overall cases for UHD will not be confirmed until the end of Q2 22/23. There are currently 25 cases to review and assessment (the red circle in figure 1 indicates the date from which cases are awaiting assessment).

Cases need reviewing at PIR level from November onwards.

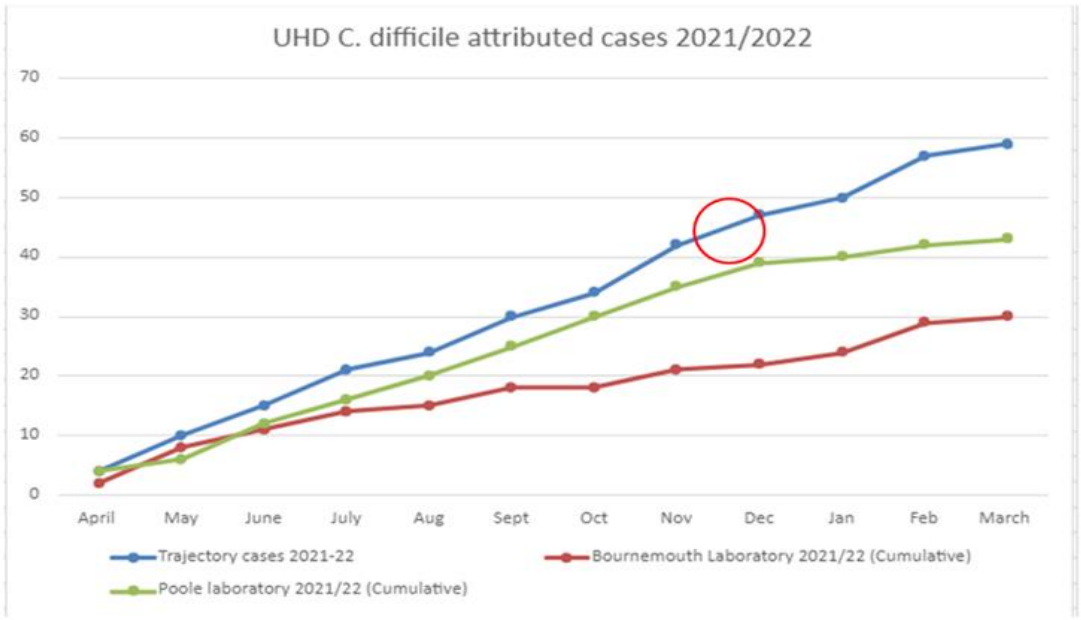


Figure 1 Healthcare Associated C. Difficile cases within UHD

Thorough analysis and ribotyping of clostridioides difficile cases is undertaken. This process has identified that there has not been any patient to patient transmission of clostridium difficile in hospital in 2021/22. However there have been opportunities for learning including:

- ensuring that specimens are sent as soon as possible which will support the timeliness of isolation
- continue the focus on accurate documentation and hand hygiene.

When compared nationally, the Trust has low rates of clostridioides difficile and we will continue to strive for further improvements. The Trust works closely with healthcare providers and commissioners in Dorset and Hampshire to continuously improve patient safety in this area.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

There is a zero case tolerance towards MRSA bacteraemia cases therefore no threshold is set for this pathogen.

UHD reported 1 hospital acquired MRSA bacteraemia and 1 Community Acquired bacteraemia at the Trust during 2021/22. A root cause analysis was completed to ascertain the source of infection for both cases.

The Hospital acquired case patient has not isolated MRSA on any of their swabs throughout investigations which would suggest that this bacteraemia was transferred to the patient by possible self inoculation (chronic rash) or an iatrogenic infection (bacteria introduced on cannulation or use of cannula).

There is no documented or suspicious sources of infection for this patient - these are only possible hypotheses/ supposition.

The Community acquired case was attributed to complex wound care in a patient with multiple co-morbidities. No lapses in care were reported that may have contributed to the infection.

The Trust worked closely with the CCG to ensure accurate follow up of these cases.

MSSA

There is not a threshold set for this pathogen, however each cases is assessed, investigated and reported based upon their threshold.

	COCA	COHA	HOHA
UHD	85	18	43

Table 4 Breakdown of MSSA cases by date of sample taken on and exposure to healthcare.

This year we have seen a reduction in case numbers identified as COCA and HOHA.

Qtr 4 saw similar trends to previous qtrs

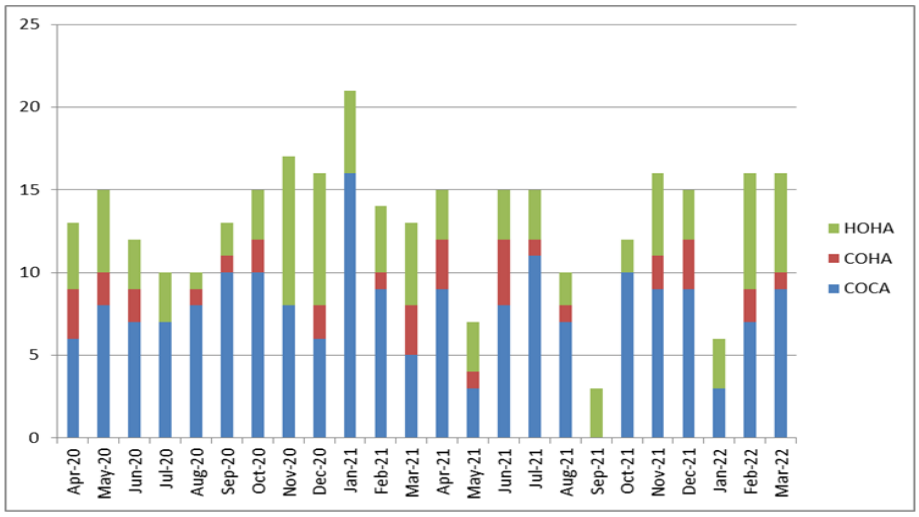


Figure 2 Trends in data for MSSA

Learning from the follow up of these cases remains similar to previous year reports. The maintenance of skin integrity is key in reducing infections.

The development of a UHD and hopefully Dorset wide cannulation policy will help to drive forward the electronic recording tool. This will enable Ward leaders to have greater oversight on patients with cannula, ensuing that regular and timely assessment is delivered.

E coli

The threshold for this pathogen is set at 194, within UHD we identified 132 cases. We were therefore below the threshold set but did see an increase in the number of cases identified as HOHA.

	COCA	COHA	HOHA
UHD	327	42	90

Table 5 Breakdown of E. coli cases by data of sample taken and exposure to healthcare

Qtr4 saw similar trends to previous quarters

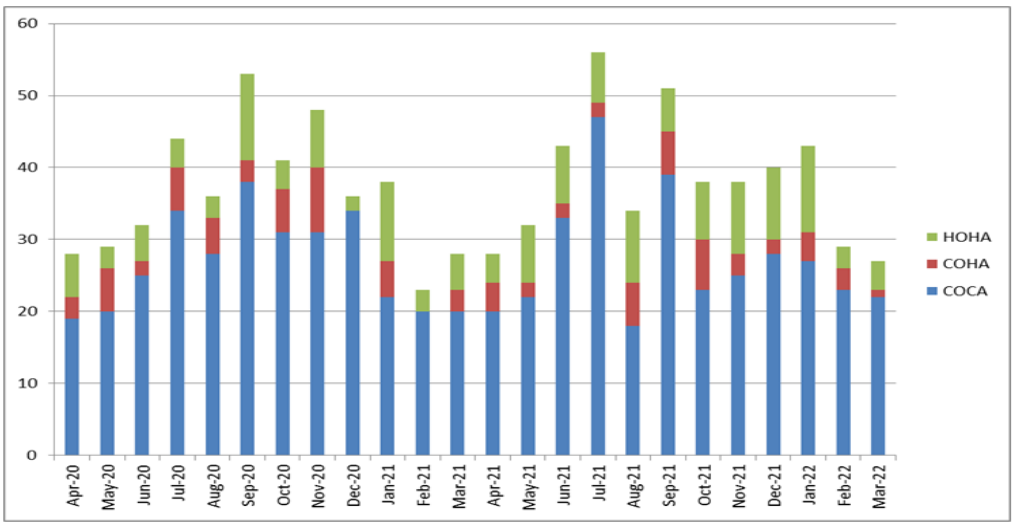


Figure 3 Trends in data for E.coli

Key headlines:

- Threshold 132/195 healthcare associated cases (HOCA and HOHA) but an increase from the previous 12 months
- Key learning themes for UH to focus upon in the next 12 months are mouth care, hydration and the catheter collaborative.

Klebsiella

There has been an increase in cases in community and healthcare cases across Dorset in 2021/22. Analysis is underway to understand the risk factors for this. As a Trust, UHD remains below trajectory (52 out of 56).

	COCA	COHA	HOHA
UHD	85	11	41

Table 6 Breakdown of Klebsiella cases by data of sample taken and exposure to healthcare

Numbers are in line with seasonal reporting but there has been an overall increase cases compared to last year.

Pseudomonas

Cases numbers appear to show a slight shift from previous years indicating a higher number of HOHA cases and lower COCA cases. Further investigation is required to understand this in greater detail. We remain below trajectory however (19 out of 34).

	COCA	COHA	HOHA
UHD	19	6	12

Table 7 Breakdown of Pseudomonas cases by data of sample taken and exposure to healthcare

Overall low numbers

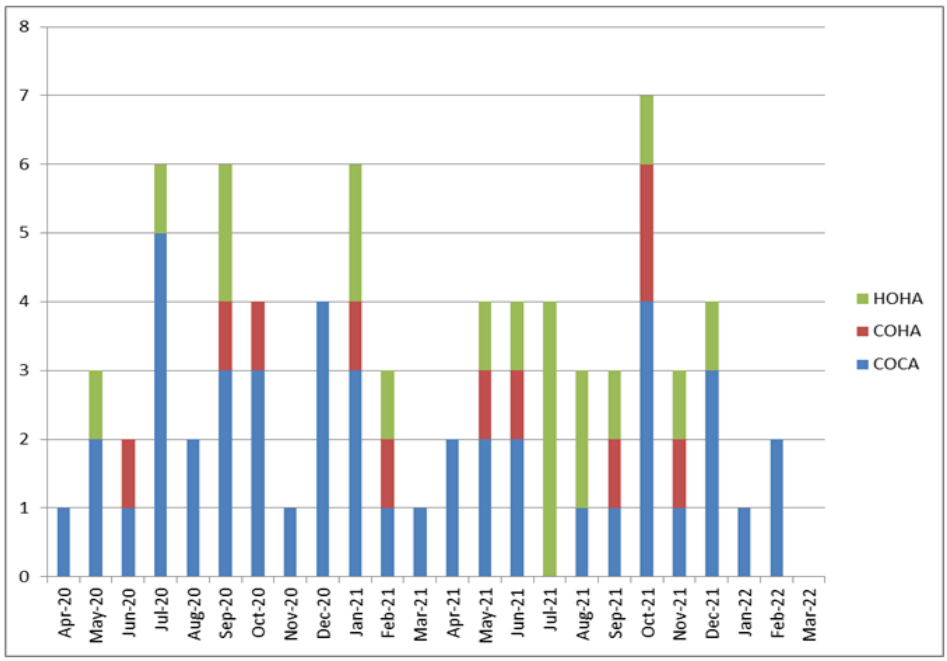


Figure 4 Trends in data for pseudomonas

Key headlines:

- Trend in line with seasonal reporting but overall increase

During this year an outbreak of MDR Psuedomaonas was identified on the Poole Critical Care Unit. Two patients were involved in this outbreak with no transmission identified beyond these two cases within the unit. Investigation did not manage to identify a clear link between the 2 patients identified. A targeted IPC programme was delivered to the Critical Care Staff by Dr Bushra Chaudhry and supported excellently by the Matrons, Consultant body and all the staff working on the ward.

The excellent application of standards seen in all areas on the unit should be acknowledged as directly impacting on the success of the outbreak measures.

Catheter related urinary tract infections (CA UTIs)

CAUTI data has not been reviewed or analysed through the pandemic period.

Hand Hygiene

Hand hygiene surveillance has continued to be completed and assessed throughout the pandemic.

Month	Surgical Care Group Hand Hygiene Audit Compliance	Medical Care Group Hand Hygiene Audit Compliance	Specialties Care Group Hand Hygiene Audit Compliance
April	99.8%	98.6%	99.5%
May	98%	97.6%	100%
June	99.1%	99.6%	98.8%
July	99.7%	98.8%	99.8%
August	99.8%	93.4%	100%
September	99.8%	92.2%	99.7%
October	97.6%	96.8%	100%
November	97.4%	96%	99.8%
December	97.6%	96.4%	100%
January	96.7%	98.5%	100%
February	99%	95.3%	99.75%
March	98.5%	93.7%	93.7%

Over all these reports show continued audit findings indicative of staff meeting the requirements of the hand hygiene policy. Where required, audit action plans are created at care group level and reviewed by Ward leads and Matrons at the Care Group Infection prevention and control group meetings.

Falls Prevention

A fall in hospital can be devastating. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also affects the family members and carers of people who fall, and has an impact on quality of life, health and social care costs. (NRLS)

Falls are particularly common among older patients (aged 65 and above), with estimates suggesting this group account for approximately 80% of all falls in hospital. Falls in hospital are the most commonly reported safety incident in acute trusts (RCP 2015). Based on data submitted to the National Reporting and Learning Systems (NRLS) around 250,000 falls are reported annually across acute, mental health and community hospital settings.

In Bournemouth, Christchurch and Poole the patient demographic has a very high proportion of people aged 65 years and older. Patients often attend our Trust with multiple, complex long-term conditions and are already at a very high risk of falling on admission. Our primary focus has been recognising these high risk patients and their falls risk factors directly on admission using a multi-factorial risk assessment; and even in some areas, prior to admission; and then introducing multifactorial interventions to mitigate any risks.

National Audit of Inpatient Falls 2020/21

National Organisation:	Royal College of Physicians
Audit cohort dates:	1st January 2020 – 31st December 2020
Report Publication Date:	Site level report issued: 18th March 2022 Full national report available at: National Audit of Inpatient Falls (NAIF) 2020 Annual Report | RCP London

The Trust performed well against national average results. UHD results were as follows:

Number of cases	Measure	Poole 2021 Report	RBCH 2021 Report	National 2021 Report
4 PH 8 RBH	A Multi-factorial Risk Assessment (MFRA) was performed in the hospital before the patient sustained the Inpatient Femoral Fracture (IFF)	Undertaken on average 1 day before the fall that caused the fracture	Undertaken on average 1 day before the fall that caused the fracture	Undertaken on average 3 days before the fall that caused the fracture
4 PH 8 RBH	Percentage of patients who, following their IFF, had a documented check for injury and injury was suspected before moving	75%	100%	71%
4 PH 8 RBH	Percentage of patients who were moved from the floor using flat lifting equipment following the fall that caused the IFF	100%	100%	26%
4 PH 8 RBH	Percentage of patients who were assessed by a medically qualified professional within 30 minutes of the fall that caused the IFF	75%	100%	62%

Falls prevention initiatives in 2021/22 have included:

- Following the merger, the Falls Teams at both hospitals have worked closely together to provide a strong, consistent UHD Falls Team and cross site working.
- The Falls eLearning programme was introduced across Poole Hospital in January 2022
- Falls Improvement Plans were rolled out across Poole Hospital ward areas
- Increased focus on training new starters to the Trust in falls prevention. The Falls Team now training on programmes for healthcare support workers (HCSW), International Nurse Recruits and Student Nurses
- Provision of bespoke ward training sessions as requested
- Formation of a UHD Falls Steering Group
- On-going recruiting and training of Falls Champions, supported by a monthly programme of themes and learning from current incident reviews

- Undertaking proactive audits in clinical areas to support the improvement plans
- Proactive reviews of identified patients known to have a history of falls on admission
- Updated the UHD post fall document bundle to reflect NICE guidance on falls management and head injury
- Purchase of additional flat lifting equipment to be able to safely recover patients from the floor
- Purchase of additional hoisting equipment to reduce manual handling and improve patient and staff safety.

CLINICAL EFFECTIVENESS

Reducing Mortality

The Dr Foster mortality metric, known as Hospital Standardised Mortality Ratio (HSMR) has become a recognised way of assessing hospital mortality. An HSMR value of 100 represents an average "expected" value and therefore a score below 100 demonstrates a better than average position. The NHS, via NHS Digital, has also developed a slightly different metric Summary Hospital Mortality Indicator (SHMI) which additionally includes patients that have died within 30 days of being discharged from hospital. SHMI is also calculated slightly differently.

The table below show the latest SHMI and HSMR figures, the latter both for the whole Trust and Poole Hospital and the Royal Bournemouth Hospital site alone.

HSMR February 21 to January 22 (UHD) SHMI Jan 21 to Dec 21

Indicator	Site	Value	Range
HSMR	RBH	85.3	Better than expected
	Poole	98.5	As expected
	UHD	97.3	As expected
SMR	RBH	83.5	Better than expected
	Poole	93.8	As expected
	UHD	93.9	Better than expected
SMHI	RBH	84	As expected
	Poole	88	As expected
	UHD	90	As expected

UHD HSMR and SHMI figures are within the expected range.

Poole site ratios and Royal Bournemouth Hospital site ratios are all within the better than expected or expected range.

The Trust has a multi-disciplinary Mortality Surveillance Group, chaired by the Chief Medical Officer, which reviews the Trust Mortality metrics on a monthly basis. Themed reviews are carried out following any alert using NHSI methodology and review of a minimum of 25 random cases by independent clinicians. During 2021/22 the following reviews have been undertaken:

- Covid-19 outbreak, hospital acquired Covid-19 mortality.
- Pneumonia pathway review
- Fracture Neck of Femur mortality review
- Deep dives for alerts with smaller number of deaths e.g. intestinal obstruction without hernia.

Themes around consistent senior involvement, improved seven day working and opportunities for standardisation of clinical pathways across UHD have been identified and will form part of the Trust QI priorities and programme for 2022/23.

Meeting National Institute for Health and Care Excellence (NICE) Guidance

This annual report is the first NICE guidance report for UHD since the merger of Royal Bournemouth and Christchurch Hospital (RBCH) and Poole Hospital (PH) on 1st October 2021 to create UHD. The annual report covers the NICE process at UHD including the NICE procedure. The report provides: an overview of guidance published by NICE; an overview of the process for dissemination and reporting of NICE guidance; the status of all current guidance as at 1st April 2022; developments undertaken in 2021/22; developments planned for 2022/23.

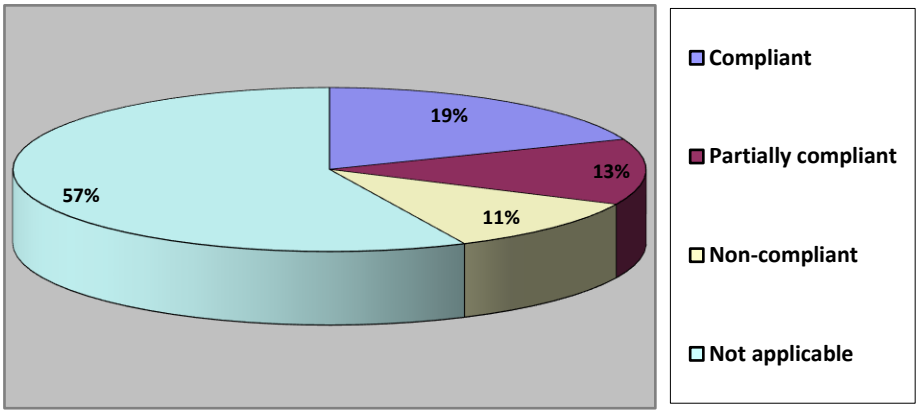
NICE guidance does not replace the knowledge and skills of individual health professionals who treat patients; it is still up to them to make decisions about a particular patient in consultation with the patient and/or their guardian or carer when appropriate. To achieve compliance the health professional should fully take into account available NICE guidance when deciding what treatments to give patients.

The final reportable position on current NICE Guidance for UHD (published from 1st May 2021 to 31st March 2022) for the financial year at Q4 2021/22 is as follows:

Care Group	Compliant	Partially Compliant	Non-Compliant	Not applicable	Total
Medical	5	1	3	14	23
Surgical	2	1	1	9	13
Specialties	2	3	2	8	15
Corporate	1	2	0	0	3
Grand Total	**10**	**7**	**6**	**31**	**54**
Percentages	**19%**	**13%**	**11%**	**57%**	**100%**

*This figure does not include Technology Appraisals, updates to guidance that was previously published or guidance awaiting review of compliance.

Chart: UHD NICE Guidance compliance assessments for guidance published from 1st May 2021 to 31st March 2022



At the close of 2021/22, the number of guidance classed as “compliance to be determined” for UHD was 17 (for the last financial year that number was 22 for PH and 23 for RBCH site).

Work to determine the level of compliance continues to be carried out within the clinical or corporate directorates and represents an on-going commitment to what is a growing NICE programme. NICE guidance can be and often is complex, taking time to scope and become compliant. It is noted that NICE now have a programme of revising previous NICE guidance which requires further review to clarify the level of compliance.

Case studies of improvement

MTG 43 PICO negative pressure wound dressings for closed surgical incisions;

PICO negative pressure wound therapy system is a single use dressing for the management of many types of wounds. In maternity the primary use is for closed caesarean section wounds in those who have high wound infection risk factors. Nationally the caesarean section wound complication rate is 9.6%. At UHD from March to October 2020 the average wound complication rate was 14% in BMI>30 and 13.6% in BMI >35. With the use of PICO dressings, the infection rate could be halved (as shown in units were PICO is well established).

Following review of the guidance the PICO dressing has now been introduced. From a patient’s perspective there will be healthier wound healing, improved wound scarring and a better experience of becoming a new mother as there will be less complications from their caesarean wound. Local data on wound complications will be re-evaluated 6 months after implementation of the new pathway.

NG199 Clostridioides difficile infection: antimicrobial prescribing;

The Trust is now compliant with this guidance and a new corresponding policy has been written by the Gastroenterologists and the antimicrobial management team. This ensures patients receive the most up-to-date and evidence-based care

Development work in year

The clinical audit department have worked on streamlining NICE processes in 2021/22. As part of this the following developments have been made:

- A new Standard Operating Procedure for processing NICE Guidance is now in use.
- A new Policy and Procedure for the Implementation of NICE Guidance has been approved.
- A UHD wide NICE database is in use. This database reflects the flow of the NICE guidance review template, to allow greater efficiency when inputting responses received.

Plans for 2022/23

- To further work on maintaining the level of compliance to be determined at less than 10%.
- To seek compliance updates from lead clinicians for guidance that the Trust was previously marked as partially compliant against.
- For 2022/2023 quarterly updates will continue to be given via the Quarterly Audit Report and the Quarterly NICE Report to CAEG, as well as via dissemination to Clinical Directors, Speciality Clinical Audit Leads and General Managers. This process ensures that all levels of non-compliance (partially, non-compliant) and guidance awaiting review are kept on the governance agenda.

PATIENT EXPERIENCE

Measuring patient experience for improvement is essential for the provision of a high quality service. It is important to ensure that patients and the public are given an opportunity to comment on the quality of the services they receive.

Patient experience work at the Trust over the last year has included:

- National annual inpatient surveys, National cancer patient surveys, National Friends and Family Test monitoring
- Internal feedback via the use of real time patient feedback, patient surveys and focus groups
- Monitoring for any emerging issues via formal and informal complaints, issues raised by letters and compliments from patients, carers, relatives and the public.

Learning from complaints and concerns

Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the Trust must prepare an annual report each year. This must specify the number of complaints received, the number of complaints which the Trust decided were well-founded and to summarise the subject matter of complaints, any matters of general importance arising from those complaints, or the way in which they have been managed and any actions that have been, or are to be taken to improve services as a consequence of those complaints.

Complaints made to the Trust are managed within the terms of the Trust's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion. It is important to note that the two Trusts had different approaches to managing and investigating complaints prior to the merger.

The number of formal complaints received and investigated in 2021/2022 can be seen below.

Formal complaints received	**2021/22**	**2020/21 Q3 &4**	**2020/21 Q1 &2**		**2019/20**	
	UHD	**UHD**	**RBCH**	**PH**	**RBCH**	**PH**
	491	447	169	75	498	221

*UHD – University Hospitals Dorset, RBCH – Royal Bournemouth Hospital and Christchurch Hospital, PH – Poole Hospital

The Trust has implemented an early resolution of complaints process. This is part of the formal complaint process but is intended to provide a quicker response within 10 working days. Over the past year the Trust has also investigated 120 complaints under this process.

The focus of the Patient Advice and Liaison Service (PALS) is to resolve concerns informally with front line staff. The table below shows that there has been an increase in the number of concerns being raised informally over the past year.

PALS concerns	2021/22	2020/21 Q3 &4	2020/21 Q1 &2		2019/20	
	UHD	UHD	RBCH	PH	RBCH	PH
	5200	2347	1072	741	2426	1997

Complaint outcomes

At the close of the complaint investigation the investigation and findings are reviewed, and an outcome reached as to whether the complaint is upheld (well-founded), partially upheld or not upheld. The % of complaints upheld and not upheld can be seen in the Table below, together with a comparison against national average.

Outcome of complaints	2021/22	2020/21 Q3 &4		2020/21 Q1 &2			2019/20		
	UHD	UHD	National Average	RBCH	PH	National Average	RBCH	PH	National Average
Upheld	14%	21%	24.6%	14%	20%	28%	14%	25%	31%
Partially upheld	34%	29%	37%	33%	39%	35%	37%	36%	33%
Not upheld	52%	50%	38.4%	53%	41%	37%	49%	39%	36%

Subjects of complaints

Every complaint is assessed at the outset and the key themes extracted. The themes, based on the Department of Health submission dataset can be seen in the table below; recorded by number and % of total.

Any emerging themes or hotspots are identified and escalated to the Directorate or Care Group triumvirate or to the relevant Director, depending on the seriousness, complexity and/or frequency of complaint theme monitored. Complaints can have more than one theme assigned to them for example the complaint could be about the clinical treatment and communication and administration.

A full summary is reported on a quarterly basis to the Quality Committee.

Complaint Themes	2021/22 UHD	2020/21 UHD Q3&4	2020/21 Q1&2		2019/20	
			RBCH	PH	RBCH	PH
Clinical treatment	**373 (44%)**	138 (32%)	103 (38%	61 (30%)	266 (36%)	199 (38%)
Access to treatment	**2**	23 (5%)	14 (5%)	1 (0.5%)	41 (6%)	5 (1%)
Admission, discharge, transfers	**37 (4%)**	27 (6%)	13 (5%)	7 (4%)	27 (4%)	20 (4%)
Delays & cancelled appointment	**16 (2%)**	12 (3%)	4 (2%)	3 (2%)	22 (3%)	14 (3%)
Communication	**1**	92 (21%)	41 (15%)	37 (18%)	173 (24%)	59 (11%)
Consent	**211 (25%)**	1 (0%)	1 (0.5%)	1 (0.5%)	1 (0%)	1 (0%)
End of life care	**6 (0.5%)**	3 (0.5%)	0 (0%)	2 (1%)	2 (0.5%)	2 (0.5%)
Facilities	**0**	3 (0.5%)	1 (0.5%)	5 (3%)	4 (0.5%)	10 (2%)
Integrated care	**7 (0.5%)**	2 (0.5%)	0 (0%)	0 (0%)	8 (1%)	0 (0%)
Patient care	**0**	97 (23%)	86 (31%)	35 (17%)	179 (24%)	85 (16%)
Prescribing	**0**	3 (0.5%)	0 (0%)	8 (4%)	5 (1%)	21 (4%)
Privacy, dignity and wellbeing	**81 (10%)**	3 (0.5%)	1 (0.5%)	5 (3%)	2 (0.5%)	8 (2%)
Restraint	**0**	0 (0%)	0 (0%)	0 (0%)	1 (0%)	0 (0%)
Staffing numbers	**4**	0 (0%)	0 (0%)	1 (0.5%)	0 (0%)	0 (0%)
Administration	**39 (5%)**	12 (3%)	0 (0%)	15 (8%)	1 (0%)	22 (4%)
Values & Behaviours	**39 (5%)**	13 (3%)	1 (0.5%)	20 (10%)	3 (0.5%)	65 (13%)
Waiting Times	**32 (4%)**	0 (0%)	3 (1%)	0 (0%)	1 (0%)	8 (2%)

The PALS concerns are themed using the same assessment used for formal complaints. The PALS themes are similar to the above percentages. The Trust also received concerns regarding communication which include for example relatives having difficulties in getting through to wards during the height of the Covid-19 pandemic, having difficulties in getting through to various departments across the Trust that are short staffed or patients concerned regarding text messages received asking for information which were sent out by the Trust to patients on waiting lists.

Changes resulting from Complaints

One of the main purposes in investigating complaints is to identify opportunities for learning and change in practice to improve services for patients.

Examples of changes brought about through complaints

You said "I was not informed that I had been discharged from the care of the Consultant"

We did "Apologised to for the lack of communication, a letter had been sent to the GP and not to them. This is being reviewed to ensure that communication is shared with the patient."

You said "My mother had no support, no one was there to help us through the End of Life process for my father"
We did "Sincerest apologies offered. Advised that Ward Sister has arranged to take part in an End of Life education pilot with the End of Life Specialist Nurse. This is a new service, giving the ward access and support to educate, review and offer feedback to help support patients through the End of Life journey"

You said "I did not receive any information about the request I had made for a letter regarding my ICD."
We did "Patient has been issued with a letter from his consultant regarding considerations to his care if he further presents to ED. This has also been added to the patient records as an alert for the staff awareness."

You said: "There was a lack of follow up when I was transferred from another NHS Trust back to University Hospitals Dorset."
We did: "We identified that referrals had been made but had not been received by Poole Hospital and therefore unfortunately, there was a lack of follow up. We are working hard to improve this and have a system in place to ensure that children are not "lost" within the referral system"

You said: "There was a lack of facilities for me to breastfeed my son when I attended for tests"
We did: "Whilst staff tried to provide support, unfortunately there are currently no designated breastfeeding facilities. Plans are in place to build a designated area for breast feeding as part of the new Children's Unit"

You said: "The phones are never answered on AMU"
We did: "apologised and explained the call volume on AMU has increased by 139% since Covid-19 and visiting restrictions were implemented. We have also added this to our Risk Register and commenced an improvement project."

Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

Complainants who remain dissatisfied with the way the Trust has handled their complaint at local resolution level are able to request an independent review to be undertaken by the Parliamentary and Health Service Ombudsman (PHSO). Complainants are made aware of their right to take their complaint to the PHSO through the Trust information leaflet and in the written response to their complaint.

During 2021/22 the PHSO did not open any cases for investigation.

Performance against national priorities 2021/22

National Priority	2021/22 Target	2021/22 Actual
18 week referral to treatment waiting times – admitted (31/03/2022)	92%	**45.5%**
18 week referral to treatment waiting times – non admitted (31/03/2022)	92%	**65.1%**
18 week referral to treatment waiting times – patients on an incomplete pathway (31/02/2022)	92%	**61.0%**
Proportion of patients staying for over 12 hours in Emergency Departments	<2%	**1.85%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85%	**73.8%**
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	90%	**85.3%**
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	96%	**97.0%**
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	94%	**88.8%**
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti-cancer drug treatment	98%	**99.6%**
Clostridium difficile year on year reduction	64	**70**
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance certified	**Compliance certified**
Maximum 6 week wait for diagnostic procedures (31/03/2022)	>99%	**84.1%**

External Commentary

healthwatch Dorset

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

This year we've worked with University Hospitals Dorset to gather feedback on A&E services at Poole Hospital. Our volunteers carried out phone interviews with 147 people who visited Poole Hospital A&E. Most people were happy with the service, but there were areas for improvement around waiting times, facilities, staff attitude, and clear information: https://healthwatchdorset.co.uk/wp-content/uploads/HWD-AE-report-Final-Sept21.pdf

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

www.healthwatchdorset.co.uk

NHS
Dorset
Clinical Commissioning Group

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

In 2021/2022 University Hospitals Dorset identified 4 themes for quality improvement: surgical checklists, identification and escalation of the deteriorating patient, fluid management and difficult intravascular access. The CCG acknowledges the challenges that responding to the Covid-19 pandemic has presented to quality improvement. It is positive to see despite this, progress was still made in all identified areas. In some areas the work did not progress as was hoped due to operational pressures and in other areas is still underway due to the scale of work needed but these will now continue into 2022/2023. The commissioners support the strategic quality priorities for 2022/23.

The quality priorities from 2021/2022 will be carried forward. In addition, five new priorities have been identified which are: consent, venous thromboembolism risk assessment and prophylaxis, acute kidney injury/ dialysis management, blood glucose monitoring and medical and pharmacy communication. We look forward to receiving regular further updates on the progress in these areas, whilst recognising that the NHS faces a challenging backdrop from increased demand alongside recovery of services from the impacts of the Covid-19 pandemic. The CCG/ ICB remains committed to work with University Hospitals Dorset, over the coming year to ensure all quality standards are monitored.

Vanessa Read

Director of Nursing and Quality

Annex A

Glossary of Terms

ACP- Advance Clinical Practitioner

AMU – Acute Medical unit

BAUS – The British Association of Urological Surgeons

BEAT- Blended Education and Training team

CA UTI - Catheter Associated Urinary Tract Infections

CEPOD – Confidential Enquiry into Perioperative Deaths

Clostridium difficile, -also known as C. difficile, or C. diff, is a bacterium which infects humans, and other animals. Symptoms can range from diarrhoea to serious and potentially fatal inflammation of the colon. ... C. difficile is generally treated with antibiotics

COPD/COAD - Chronic Obstructive Pulmonary Disease/Chronic Obstructive Airways Disease

CQUIN The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care

CT – Computed tomography scan

ECG – Echocardiogram

ED – Emergency Department

EMIS – EMIS Health, IT Software company

eNA – Electronic nurse assessments

eMortality - Electronic Mortality capture form

GIRFT Get It Right First Time is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice

ITU – Intensive Care Unit

LERN – Learning Event Report Notification system

MRSA - Methicillin-resistant staphylococcus aureus. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MUST – Malnutrition Universal Screening Tool

MSU – Midstream Specimen of Urine. The aim is to obtain a sample (specimen) of urine from the middle of your bladder. A midstream specimen of urine (MSU) is best, as the first bit of urine that you pass may be contaminated with bacteria from the skin.

NEWS - National Early Warning Score - An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital signs (Respiratory rate, Oxygen saturations, Temperature, Blood pressure, Heart rate, Alert/Voice/Pain/Unresponsive scale). This gives a numerical score.

National Institute for Health and Care Excellence (NICE) – NICE is sponsored by the Department of Health to provide national guidance and advice to improve health and social care. NICE produce evidence based guidance and advice and develop quality standards and performance metrics for organisations providing and commissioning health, public health and social care services.

NICE guidelines (NG) are recommendations for care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. Since October 2014 NICE have published guidelines as a unified group of NICE Guidelines (NG), however, before this time they were published in a number of different categories. For further details see 1.2 below

NICE Technology Appraisals (TA) are recommendations on the use of new and existing health technologies. The Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by NICE technology appraisals normally within 3 months (unless otherwise specified) from the date that NICE publishes the guidance (3).

NICE Interventional Procedure Guidance (IPG) covers the safety and efficacy of procedures that gain access to the patient's body via surgery, endoscopic instruments or radiation for the purpose of diagnosis or treatment.

NICE Medical technologies guidance (MTG) are "designed to help the NHS adopt efficient and cost effective medical devices and diagnostics more rapidly and consistently. The types of products which might be included are medical devices that deliver treatment such as those implanted during surgical procedures, technologies that give greater independence to patients, and diagnostic devices or tests used to detect or monitor medical conditions"

NICE Diagnostics Guidance (DG) designed to help the NHS adopt efficient and cost effective medical diagnostic technologies more rapidly and consistently.

NICE Quality Standards (QS) are a set of specific, concise statements and associated measures collated from best evidence. The quality standards set out priority areas for quality improvement in health and social care, and give a set of statements intended to help improve quality. Quality standards are based on NICE guidance and other NICE-accredited sources.

NICE Clinical guidelines (CG) provide guidance on the appropriate treatment and care of people with specific diseases and conditions.

NICE Medicines practice guidelines (MPG) provide recommendations for good practice for those individuals and organisations involved in governing, commissioning, prescribing and decision-making about medicines.

NICE Safe NHS Staffing guidance (SG) Following the Report of the Francis Inquiry and the Berwick Review into Patient Safety, NICE produced 2 guidelines on safe staffing capacity and capability in the NHS, but from June 2015 SSG was taken on by NHS England as part of a wider programme of service improvement.

NRLS – National Reporting and Learning System

Never Event - Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as wrong site surgery, retained instrument post operation and wrong route administration of chemotherapy. The full list of Never Events is available on the NHS England website.

NCEPOD - National Confidential Enquiry into Patient Outcome and Death

NIHR - National Institute for Health Research (NIHR)

OPM – Older Persons Medicine

OPS coding – OPCS Classification of Interventions and Procedures is a World Health Organization measurement for all patient procedures.

Patient Reported Outcome Measure Scores - Patient reported outcome measures (PROMS) are recorded for groin hernia, varicose vein, hip replacement and knee replacement surgery.

National data (HSCIC) compares the post-operative (Q2) values, data collected from the patients at 6 months post-operatively by an external company. The data is not case mix adjusted and includes all NHS Trusts, Foundation Trusts, PCT and NHS Treatment Centre data. Private hospital data is omitted.

EQ-VAS is a 0-100 scale measuring patients' pain, with scores closest to 0 representing least pain experienced by the patient.

EQ-5D is a scale of 0-1 measuring a patient's general health level and takes into account anxiety/depression, pain/discomfort, mobility, self-care and usual activities. The closer the score is to 1.0 the healthier the patient believes themselves to be.

The Oxford Hip and Oxford Knee Score measures of a patient's experience of their functional ability specific to patients who experience osteoarthritis. The measure is a scale of 0-48 and records the patient ability to perform tasks such as kneeling, limping, shopping and stair climbing. The closer the score is to 48 the more functionally able the patient perceives themselves to be.

PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). Used in Quality Improvement

R&I – Research and Innovation

RATS – Rapid Assessment and Treatment area in Emergency Department

RCOG – Royal College of Gynaecologists

RCP – Royal College of Physicians

Serious Incident - In broad terms, serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. In general terms, a serious incident must be declared for where acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) result in:

- o Unexpected or avoidable death of one or more people.
- o Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- o A Never Event

Full details of the NHS England Serious Incident Reporting Framework can be found on the NHS England website.

UKAS – United Kingdom Accreditation Service UKAS is the UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering testing, calibration and certification services.