NHS
University Hospitals Dorset
NHS Foundation Trust

Annual Report 2022/23
Quality Report

We are caring one team listening to understand open and honest always improving inclusive

1 April 2022 - 31 March 2023

Contents

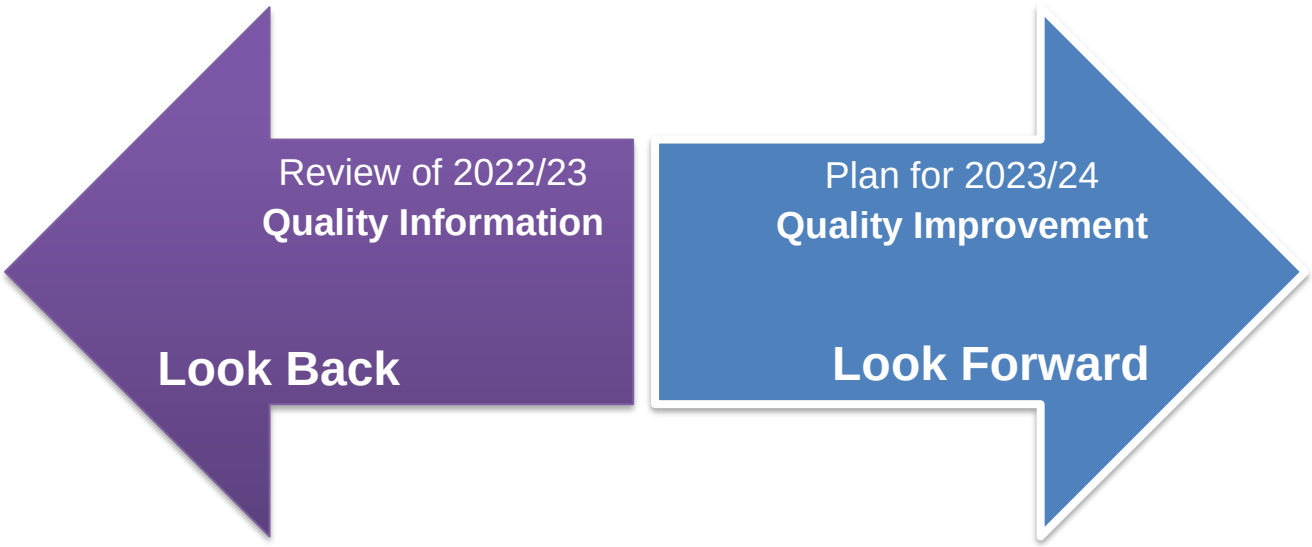
What is a quality account?

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.

The purpose of this quality account is to:

1. summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2022/23; and

2. set out our quality priorities and objectives for 2023/24.



To begin with, we will give details of how we performed in 2022/23 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 2022/23 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 2022/23 quality priorities and our quality priorities for 2023/24
	Reviewing progress of the quality improvements in 2022/23 and choosing the new priorities for 2023/24
	Statements of assurance from the Board
Part 3	Other information

Part 1 Statement on quality from the Chief Executive

This Quality Report is the second 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 progressed this year and celebrates the engagement of our staff to continually improve patient and staff safety, patient experience and clinical outcomes.

The report includes details of inspections by our regulators, the Care Quality Commission (CQC), during 202/23. It has been a busy time with three of our services inspected in September and November last year. These were medicine and surgery across Poole and RBH, and maternity at Poole. The CQC findings were reflective of the challenges across the Trust and across the healthcare system. Some themes in the reports are in common with other trusts across the NHS at the present time, which we are working hard to address.

Staffing has been highlighted in the reports as an issue to be addressed in terms of our both our care and governance, so we are investing to ensure safe staffing and to address some historic issues. Recruitment and retention are a priority. We are seeking all opportunities to find innovative ways to attract staff to our great organisation.

The reports are also clear regarding that the issues we face about getting patients safely discharged from our hospitals when medically ready to leave is affecting our capacity and performance. We know we need system change to make processes simpler and more streamlined. We are working collaboratively through the new Integrated Care Board (ICB) which came into place in July 2022. A new Discharge to Assess pathway is coming into place across Dorset which will have a positive impact and we are working closely with our Dorset partners to help with support in the community and for patients suffering mental health disorders to be cared for in a more appropriate setting.

There are specific issues about UHD that we acknowledge and accept from the reports. We recognise that we need to have clearer and more effective ways of making improvement and learning from ourselves and others. Since I joined the trust last year, these issues have given rise to our plans for a Patient First programme. This will give staff the freedom and tools to make positive and long-lasting changes to work well with each other for the benefit of our patients. We recognise this requires strong visible leadership across the trust, where people feel safe to speak up and where we have a shared vision for the future about our services for patients and our staff.

Working with the trust Board and receiving insights from the Council of Governors, we will continue to strengthen our governance arrangements. We have many experienced managers and staff, and we are pleased to welcome new colleagues for their perspectives. Rob Whiteman joined as our new chair, last summer and Dr Peter Wilson joined us as our new chief medical officer on 3 April 23.

I have had a long career in the NHS in many organisations and from the moment I joined UHD I have been struck by the very special and kind staff here. I know that the values of the trust are important to you all. In light of the CQC's advice we now need to make sure we have everything in place to improve processes, management and leadership across the trust that have been impacted by the disruption of merger, pandemic and industrial action. We have already put improvements in place and fixed issues raised. We recognise though that there is more to do and will ensure we take the actions needed. With the wonderful people we have here I know we can do this.

	**Siobhan Harrington** Chief executive

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.

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

Performance against quality priorities set out in the Trust Quality Strategy for 22/23

The Trust identified the following key quality improvement priorities for 2022/2023

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
Consent	• Standardisation of consent policy across UHD, Q1/Q2 2022/23 • Speciality/Governance leads
VTE risk assessments & prophylaxis	• Complete risk assessments and prescribe prophylaxis if required, Q1/Q2 2022/23 • Working group to be established
AKI/Dialysis management	• Resolve inequalities in service provision and differences in patient pathways, Q1-Q3 22/23
Blood glucose management	• Optimise use of blood glucose systems to improve glucose control
Medical and Pharmacy Communication	• Improve communication of prescribing queries between Medical and Pharmacy teams

Progress has been as follows:

Qi Priorities for 2022/23

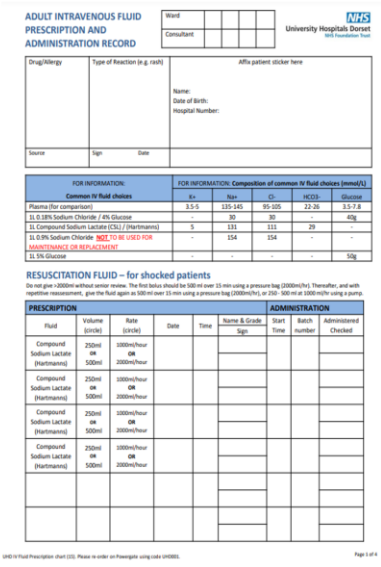
NHS University Hospitals Dorset NHS Foundation Trust

IV Fluids	• IV Prescription chart rolled out, reiterated, and has made a positive difference. Digital fluid balance is ready to deploy, awaiting IT fix	G
Deteriorating Patient Programme	• Complex programme; 4/10 projects already completed successfully; others in progress	A
Difficult IV Access (DIVA)	• New UHD policy agreed, service established, and longer dwell cannulas rolled out	G
Safety Checklists	• Ongoing work across UHD. New National standards introduced February 2023	A
Acute Kidney Injury	• Standardisation of various aspects across UHD has been done, especially intranet and patient information; checklist and education were not achieved. Wider work needed with team and vision / strategy / leadership	A
Blood glucose management	• Project initiated in August 2022 although progress has been inhibited by extended periods of operational pressures	A
Deteriorating patient in ED	• A new 22/23 priority (included within Trust DP Programme). Agreed way forward that now needs to be formalised.	A
Medical and Pharmacy Communication	• Improve communication of prescribing queries between Medical and Pharmacy Teams – 22/23 priority. **REPLACED WITH "THINK STEROIDS" Project.**	A

IV Fluid Management

IV Fluids

- Our new IV Fluid prescription chart for UHD has:
  - a **Reduced rate** fluid prescription for frail patients/renal/ cardiac disease
  - a choice of **Height or weight based** maintenance fluid prescription
  - amalgamated the guidelines for **electrolyte management** into new UHD ones
- We have audited against NICE standards and have
  - succeeded in reducing **"free fluid prescribing"** of 0.9% Sodium Chloride
  - we are at least as good / better on all the standards as we were previously
- Actual prescribed drugs and incidents are lagging indicators and will be reviewed soon, though anecdotal evidence is promising
- We iterated the form based on staff feedback, and the 2nd revision went live in June 2022



ADULT INTRAVENOUS FLUID PRESCRIPTION AND ADMINISTRATION RECORD

Ward

Consultant

NHS University Hospitals Dorset NHS Foundation Trust

Drug/Allergy | Type of Reaction (e.g. rash) | Affix patient sticker here

Name:
Date of Birth:
Hospital Number:

Source | Sign | Date

FOR INFORMATION: Common IV fluid choices | FOR INFORMATION: Composition of common IV fluid choices (mmol/L)

	K+	Na+	Cl-	HCO3-	Glucose
Plasma (for comparison)	3.5-5	135-145	95-105	22-26	3.5-7.8
1L 0.18% Sodium Chloride / 4% Glucose	-	30	30	-	40g
1L Compound Sodium Lactate (CSL) / (Hartmanns)	5	131	111	29	-
1L 0.9% Sodium Chloride NOT TO BE USED FOR MAINTENANCE OR REPLACEMENT	-	154	154	-	-
1L 5% Glucose	-	-	-	-	50g

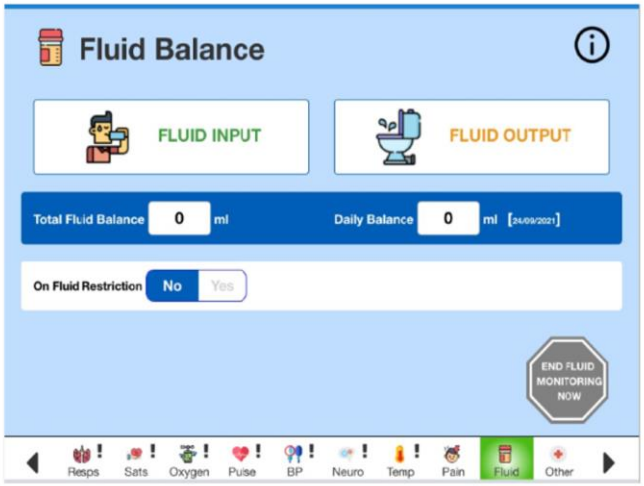
RESUSCITATION FLUID – for shocked patients

Do not give >2000ml without senior review. The first bolus should be 500 ml over 15 min using a pressure bag (2000ml/hr). Thereafter, and with repetitive reassessment, give the fluid again as 500 ml over 15 min using a pressure bag (2000ml/hr), or 250 - 500 ml at 1000 ml/hr using a pump.

PRESCRIPTION						ADMINISTRATION		
Fluid	Volume (circle)	Rate (circle)	Date	Time	Name & Grade Sign	Start Time	Batch number	Administered Checked
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						

IV Fluids

- A new Digital Fluid Balance was designed and developed on eObs in November 2022.
- The new form will make it easier for nursing staff to automatically plot clear charts for doctors to view.
- Implementation relies on configuration of IT systems across both hospital and this work has been delayed due to operational pressures.
- The plan is to pilot on Ward 1 and A4, then one more ward on each site, then roll out reasonably quickly across UHD.
- Roll out is planned for June / July / August 2023



Managing the deteriorating patient

Deteriorating Patient Programme – Executive Summary

Alignment of 2222 calls	✓	Launched successfully, review held at 6 month stage in May 2023 and deemed a successful change.
Alignment of Resus/CIG Groups	✓	Proposed UHD governance structure identified however existing site based groups remain in place pending overall UHD Governance structure review (Q1 23/24)
Treatment Escalation Planning	✓	Launched successfully in January; Phase II was implemented in March 2023
Sepsis	✓	Single UHD screening tool agreed. Policy ratified and approved. Single UHD Sepsis intranet page launched. UHD E-Learning adapted/launched
Comms between wards / ICU	✓	UHD ICU referral procedure agreed. SOP ratified and approved.
Soft signs / Call 4 Concern	✓	Rolled out across UHD successfully on 1 February 2023. Held 3 month review in May 2023. Working well..
Safe Medical Staffing	✓	The group delivered a standard methodology for safe staffing modelling and for submission for funding where needed.
Training	✓	Deteriorating Patient training content standardised within Induction and across UHD intranet. Training equally accessible across sites.
Useful data / platform integration	✓	Work in progress to standardise the recording of the 2222 calls and Outreach teams across UHD as business as usual.

Deteriorating Patient Programme

- We have aligned all emergency calls for UHD (2222 / 5555 / (9)999) together with the processes behind these calls.
- 6 month review held in May 2023. Noted the change has been successful

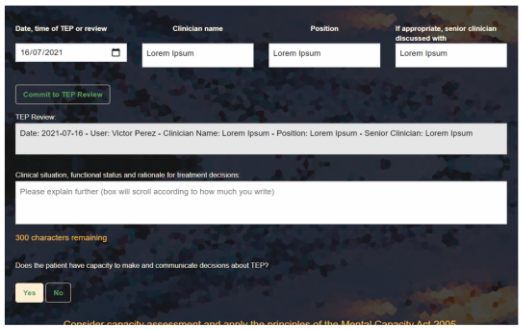
✓

Successful bids for **safe medical staffing** funding 2022/23:

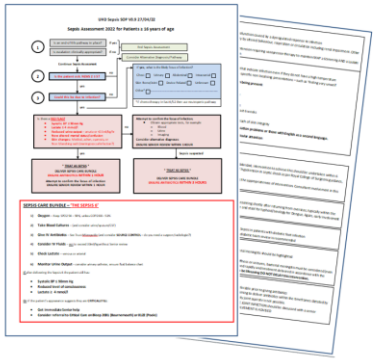
- £450K for Paediatrics
- £670K for Gynaecology
- £240K for Urology
- £1.1M for ED on top of £450K winter funding
- £3M phased for medical staffing in response to HEE

- Standard safe medical staffing modelling and rationale established
- Business Case structuring and content support provided

Deteriorating Patient Programme



- New UHD-wide digital TEP launched in January 2022
- Phase II was implemented March 2023 – enhancements making it easier for clinicians to edit or revise a TEP and flagging when a TEP is out of date



- Aligned **UHD Sepsis policy** created and formally approved
- UHD Sepsis intranet page in place
- Sepsis E-learning adapted and rolled out across UHD

Deteriorating Patient Programme

Previously discussed with ICU and an agreement made that the patient is appropriate for escalation in this admission (depending on the circumstance)	A doctor of registrar level may contact ICU without needing to inform the consultant overseeing that patient's care.
Not previously discussed with ICU but has an up-to-date digital TEP signed off by a consultant in this admission	Consultant to consultant discussion should be the default process. The *Referral to ICU* eForm to be completed at the earliest opportunity.
Not previously discussed with ICU and does not have an up-to-date digital TEP signed off by a consultant in this admission	Consultant to consultant discussion should be the default process. If out of hours, the on-call consultant must be phoned by a doctor of at least registrar level. This should not delay patient care but must be done at the earliest opportunity. The *Referral to ICU* eForm to be completed at the earliest opportunity.

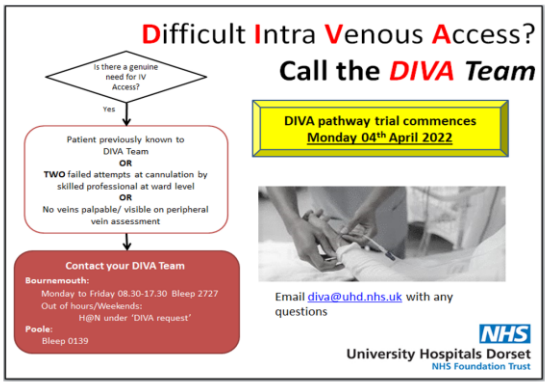
- Aligned UHD Referrals to ICU SOP created and formally approved
- SOP posted to existing Critical Care intranet pages

- Call-4-Concern is an important new safety net - a rapid referral system for patients and their carers to report physical deterioration
- We launched in February 2023 and is being used appropriately. To be reviewed in 6 months.

Managing difficult IV Access

Difficult IV Access (DIVA)

- Aligned UHD DIVA Policy and SOP created and formally approved
- DIVA Team membership and service Poole/Bournemouth established
- Trial of service commenced April 2022 – now Business as Usual
- Roll-out of training of DIVA teams and other key staff



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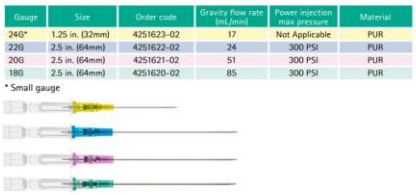
Difficult IV Access (DIVA) (cont'd)

• New intermediate length ultra-sound guided cannula (longer dwell time) introduced to coincide with the DIVA service trial.



• E-form created to automate DIVA Critical Patient Information (CPI) flag to EPR

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<td>Safety Checklists</td>
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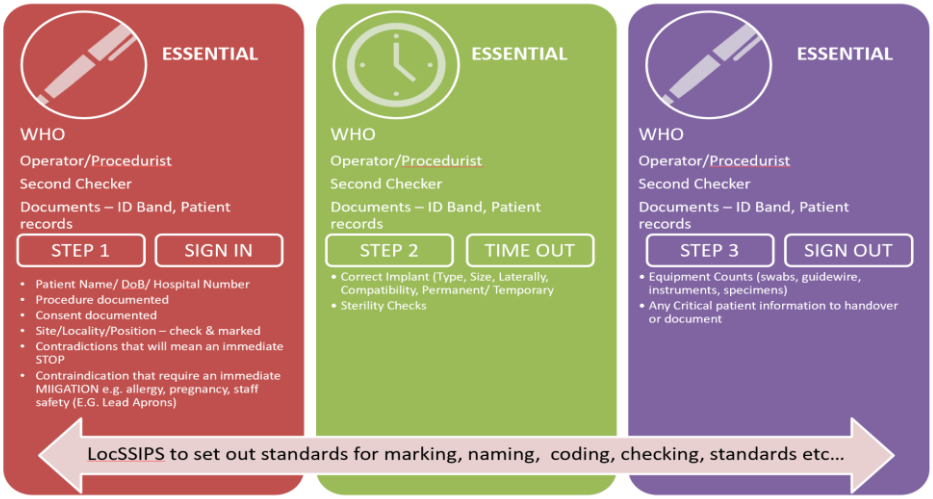
Safety Checklists

The Checklist Review Group has been brought together to review the existing checklists at UHD. To compare across sites and specialties and to look at the wider ICS view.

The existing checklists have been grouped into the following categories:
– Dermatology
– Endoscopy
– Theatres
– Day Theatres
– Outpatients

The smaller teams have been tasked with comparing their checklists to the following criteria – this is work in progress



Update: New National Guidance launched February 2023. All teams are currently reviewing impact as likely to change configuration of current checklists and local safety standards for invasive procedures.
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<td>Consent</td>
<td>A new UHD Consent Policy was approved in July 2022. The Policy included a template and toolkit for the development of local standard operating procedures for consent.</td>
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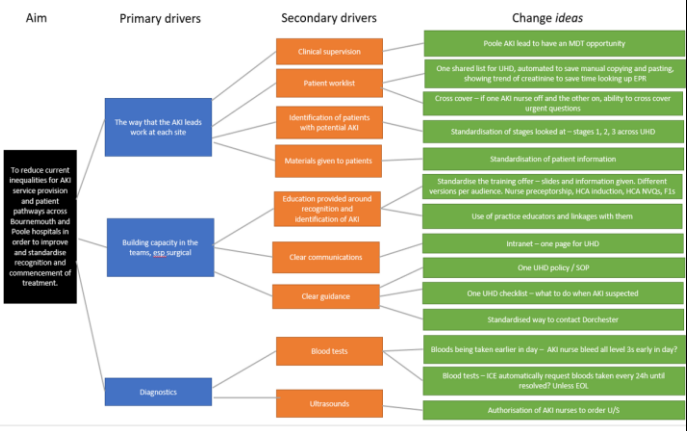
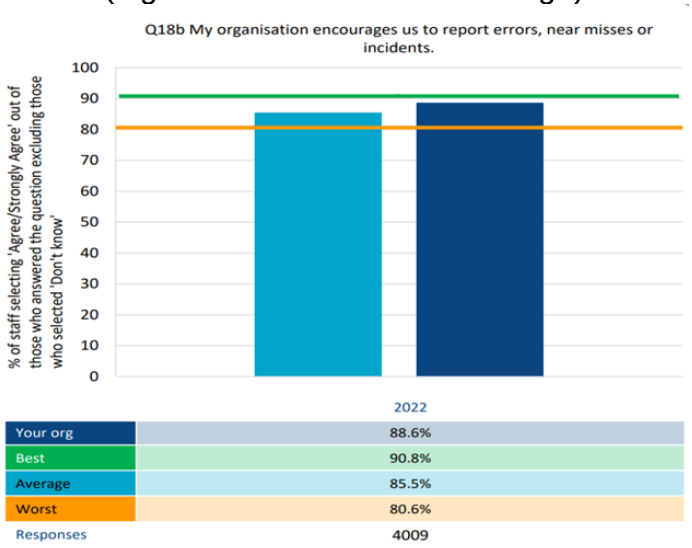
	To support the implementation of the policy a new Level 1 elearning programme for consent was launched and Level 2 training commissioned from an external provider.
Management of Acute Kidney Injury (AKI)	**Acute Kidney Injury** • Standardisation of various aspects across UHD has been done, especially intranet and patient information • UHD AKI checklist was discussed, with the aim of being digital, to provide standardised reminders for clinical actions at commencement of treatment • Education on AKI was discussed and ideas are being worked up. 
Blood glucose management	**Blood glucose management** • Project initiated in August 2022 • Senior involvement/sponsorship provided by Medical CG Director of Nursing and UHD Medical Examiner • Aim is to capitalise on the existing access to AEGISPoC data – to improve/automate bespoke analytical outputs to improve patient safety • A 'grass roots' Blood Glucose Management QI project has been registered by Dr Ammar Hilali – aimed at improving the consistency of recording across all UHD wards. This has since been included within the project to improve the quality of data available within AEGIS PoC  Dr Hilali receiving the prize for *Qi-Project of the Month* (August 2022) from Alan Betts, Director of Improvement
Medical and Pharmacy communication	This project was replaced in year with the 'Think Steroid' project and is about the safe administration and management of steroids. The Medical Care Group are currently leading on this important work in 23/24.

Other Quality Priorities for 2022/23

In addition to the above progress, the UHD Quality Strategy also sets out several other priorities for patient safety, patient experience and clinical effectiveness in 2022/23. These are outlined in the following table with details of action taken in year.

DOMAIN	Priority for 2022/23	Progress made in 2022/23
PATIENT SAFETY	Continuing to participate in the work across the ICS to develop and adopt agreed principles and policies to support a Just Culture.	We have incorporated just culture principles into our HR Policies. A Restorative Just and Learning Culture session was held at our LERN conference on the 3/11/22. The session was multi professional and made the link with patient and staff safety culture. We have reduced our formal disciplinary cases by around 45%.
	Continue to improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups.	The Trust continues to promote an open culture for reporting and learning from patient safety incidents. The national staff survey results 2022 reported that the Trust had a good reporting culture (higher than the national average). 
	Support transition from the National Reporting and Learning System and STEIS to the new national Learn from Patient Safety Events (LFPSE) service.	The Trust successfully submitted a “test” version of the new reporting form by the deadline of 31/3/23. Although with other Trusts, UHD is now waiting for software updates to the reporting system (Datix) in order to complete the final design work required to go live before the Sept 23 deadline. It is anticipated that Datix will release the required upgrades to users in late July/early August.

	Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework (PSIRF) as and when published.	The Trust is working on the development of a PSIRF Plan before the end of Autumn 2023 deadline.
	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.	The Trust piloted Level1a and Level 1b training in 22/23. Plans are now in place to include Level 1 and Level 2 training in mandatory essential core skills training in 2023/24. The Trust will also be developing a training plan to support PSIRF implementation.
Patient Experience	The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system.	Patient Partners are essential part of the UHD Patient Engagement strategy. Patient partners support a wide range of activities across the Trust including patient safety and patient experience.
Clinical Effectiveness	Develop and implement a UHD Clinical Audit plan for 22/23.	A Clinical Audit plan for 22/23 was approved by the Audit Committee and Trust Management Board in May 2022. Details of improvements made following the completion of national and local clinical audits are provided in the statements of assurance section of the report.
	Further develop ward to board reporting and expansion of existing quality metrics.	A new Integrated Performance report has been produced and new Ward to Board quality reporting across UHD has been implemented.

Our quality priorities for 2023/24

UHD is changing and our culture will be changing to focus on improvement and better supporting staff to put our patients at the forefront of everything we do.

This is a journey over 3 to 5 years and starts with setting our ambition high and recognising our current realities. Taking the Patient First approach, we will look to continually improve, and to focus on making a bigger impact on a smaller number of strategic themes. We will continue to uphold our values in how we do this work. We will constantly learn and adapt in how we do this. All of this is summarised in the "UHD pyramid" below.

Our strategic goals at trust level focus on where we most want significant improvements delivered in a sustained way over the next three years. These fit within our Dorset-wide role in the health and care system. This means we are all pulling in the same direction.

UHD's 2023 to 2024 trust objectives are based upon the five strategic themes:

- Population Health and System working
- Our People
- Patient Experience
- Quality (Outcome and Safety)
- Sustainable Services

These goals are broken down into annual trust objectives, which are SMART (specific, measurable, achievable, resourced and timely). Every team and individual will be asked to consider how they can contribute to these objectives in their own area. Every team in UHD can contribute to the objectives.

Themes	Goals (over the next 3 years)	Annual objectives 2023/2024
Patient Experience	Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.	Family and Friends Test (what our patients say) Feedback rates increase from baseline in all services over the next year Is in the top 20% rated good over a 3 year period Every ward/clinical service has access to monthly Have your say survey information and data
Quality (Outcomes and Safety)	To achieve top 20% of Trusts in the country for mortality (HSMR) To reduce moderate/severe harm patient safety through the development of an outstanding safety culture	To reduce HSMR over the next 18 months (by Sept 2024)

Patient Safety

Our main priorities for patient safety for 2023/24 continue to directly link to the key requirements of the National Patient Strategy including:

- Transition from National Reporting and Learning System (NRLS) and Strategic Executive Information Service (StEIS) to the new Learn from Patient Safety Events (LFPSE) service
- Implement the new Patient Safety Incident Response Framework (PSIRF)
- Improve Safety culture (moving towards a proactive and generative approach)

- Respond to National Patient Safety Alerts (ongoing)
- Improve Patient safety education and training
- Prioritise patient safety improvement (ongoing)
- Implement Medical examiners (completed)

Patient Experience

Our main patient experience objective for 2023/24 is to work with colleagues across the system to implement the requirements of the NHS Patient Safety Partners Framework including:

- Implement the Framework for Involving Patients in Patient Safety

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 with 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 23/24

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 2022/23 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 2022/23 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2022/23.

2. Participation in clinical audit

During 2022/23, there were 53 national clinical audits which covered relevant health services that University Hospitals Dorset NHS Foundation Trust provides. During that period, University Hospitals Dorset NHS Foundation Trust participated in 92% of national clinical audits 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 2022/23 are listed below.

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
Breast and Cosmetic Implant Registry	Y	Y	The registry collects data on all types of breast implant and explant (removal) surgery. This includes revisions and reconstructions, such as temporary tissue expanders
Case Mix Programme (CMP)	Y	Y	The CMP is an audit of patient outcomes from adult general critical care units
Child Health Clinical Outcome Review Programme	Y	Y	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities
Cleft Registry and Audit Network Database	N	N	
Elective Surgery (National PROMs Programme)	Y	Y	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	Identify current performance in Emergency Department (ED) against nationally agreed clinical standards and show the results in comparison with other departments
Emergency Medicine QIPs - Infection Prevention and Control	Y	N	As above.
Emergency Medicine QIPs - Mental health self harm	Y	N	As above.
Epilepsy 12 - National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	Audit of organisation of paediatric epilepsy services, epilepsy care provided to children and young people and patient reported experience measures
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service (FLS) Database	Y	Y	Measure against NICE technology assessments and guidance on osteoporosis and clinical standards for FLS
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Y	Y	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
Falls and Fragility Fracture Audit Programme – National Hip Fracture Database	Y	Y	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
GastroIntestinal Cancer Audit Programme: National Bowel Cancer Audit	Y	Y	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
GastroIntestinal Cancer Audit Programme: National Oesophago-gastric Cancer	Y	Y	As above
Inflammatory Bowel Disease Audit	Y	Y	Reports on key clinical indicators which are compliance with 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	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	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities
Mental Health Clinical Outcome Review Programme	N	N	
Muscle Invasive Bladder Cancer Audit	Y	N	Management and outcomes of patients diagnosed with muscle invasive bladder at transurethral resection of the bladder and variations in pathways and treatment

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Adult Diabetes Audit - National Diabetes Core Audit	Y	N	Measures the effectiveness of diabetes care compared to NICE guidance
National Adult Diabetes Audit - National Diabetes Footcare Audit	Y	Y	As above
National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	N	N	As above
National Adult Diabetes Audit - National Pregnancy in Diabetes Audit	Y	Y	As above
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	Y	Y	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) - Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	As above
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Y	Y	As above
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary Rehabilitation- Organisational and Clinical Audit	Y	Y	As above
National Audit of Breast Cancer in Older Patients	Y	Y	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	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 Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Audit of Care at the End of Life	Y	Y	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	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 Bariatric Surgery Registry	Y	Y	To accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include weight loss, co-morbidity and improvement of quality of life
National Cardiac Arrest Audit	Y	Y	Audit of in-hospital cardiac arrests in the UK and Ireland
National Cardiac Audit Programme - National Congenital Heart Disease	N	N	
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Y	Y	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 - National Adult Cardiac Surgery Audit	N	N	
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	Y	Y	As above
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	As above
National Cardiac Audit Programme - National Heart Failure Audit	Y	Y	As above
National Child Mortality Database	Y	Y	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 Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Clinical Audit of Psychosis	N	N	
National Early Inflammatory Arthritis Audit	Y	Y	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	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales
National Joint Registry	Y	Y	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	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	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	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 Obesity Audit	N	N	
National Ophthalmology Database Audit	Y	Y	Project includes large-scale audit for both cataract surgery and age related macular degeneration
National Paediatric Diabetes Audit	Y	Y	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	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal unit
National Prostate Cancer Audit	Y	Y	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Vascular Registry	Y	Y	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	
Perioperative Quality Improvement Programme	Y	Y	The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery
Prescribing Observatory for Mental Health Audit Programme: Improving the quality of valproate prescribing in adult mental health services	N	N	
Prescribing Observatory for Mental Health Audit Programme: The use of melatonin	N	N	
Renal Audits: National Acute Kidney Injury Audit	N	N	
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	N	N	
Respiratory Audits – Adult Respiratory Support Audit	Y	Y	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 – Smoking Cessation Audit- Maternity and Mental Health Services	N	N	Mental Health Trusts only for the Mental Health element - Project not currently running
Sentinel Stroke National Audit Programme	Y	Y	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 (SHOT): UK National haemovigilance scheme	Y	Y	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
Society for Acute Medicine Benchmarking Audit	Y	Y	A national benchmark audit of acute medical care. Provides a comparison for each participating unit with the national average (or 'benchmark')
Trauma Audit & Research Network	Y	Y	Analyses data of trauma care to improve emergency care management and systems
UK Cystic Fibrosis Registry	Y	Y	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
UK Parkinson's Audit	Y	Y	Audit investigates the quality and experience of care for people living with the condition in the UK

Learning from National Audits

The reports of 29 national clinical audits were reviewed by University Hospitals Dorset NHS Foundation Trust in 2022/23 and, as examples, the Trust intends to take the following actions to improve the quality of healthcare provided as a result:

- Society for Acute Medicine Benchmark Audit (SAMBA) - Implementation of handover web computer system at RBH for improved visibility and triage of take list.

- National Sentinel Stroke Audit Programme (SSNAP) - Transformation Action Groups were set up in SDEC and Inpatient Beds. Process mapping of Event at Front Door lead to a number of improvement actions including pre-alert phone implemented for calls direct to outreach team from paramedics.

- National Cardiac Audit Programme (NCAP) Heart Failure Audit – action taken to increase heart failure rehabilitation referrals via in-reach heart failure nurse.

- RCEM National Quality Improvement Project: Fractured Neck of Femur – Implementations of a new oramorph patient group direction (PGD) for analgesia. Training for the nursing staff on how to use the PGD to administer analgesia to patients in moderate to severe pain.

- NACAP Chronic Obstructive Pulmonary Disease (COPD) - Secondary Care Audit: Trust has employed a Smoking Cessation Team as part of the Addiction Services Team.

- MBRRACE UK Perinatal Mortality Surveillance Report - To re-introduce face-to-face antenatal booking appointments across the whole service to ensure improved compliance with Carbon Monoxide monitoring in the first trimester

Learning from Local Audits

The reports of 192 local clinical audits were reviewed by the Trust in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Vitamin B12 Screening of Type 2 Diabetes Patients on Metformin - Posters displayed in clinic room explaining the need to check B12 levels.
- Oral Maxillofacial (OMF) Department (Medical) Trust-wide Record Keeping Audit - Long term plan for operation notes to be moved to an electronic format.
- Children's Services Department (Nursing & Medical) Trust-wide Record Keeping Audit - Ensure iGrow access for doctors and nurses in ward settings.
- Improving the Quality of Care in the Outpatient Follow-up of Patients with Pulmonary Embolism after 3 months in PE Clinic - Both Bournemouth and Poole echocardiography now use the same software to report echocardiograms, this software includes optional drop-down menus which allow the reporter to state whether there is a low probability, intermediate probability or high probability of pulmonary hypertension on the echocardiogram.
- Local Audit of Transforming MND Care - To develop and start using a "My Clear Chest Plan" for all patients under the MND service where supportive respiratory interventions have been identified as being appropriate. This will be placed in the patients' home and updated as necessary.
- Hydroxychloroquine Retinopathy Monitoring in Dermatology Patients – An updated monitoring algorithm was made visible in all dermatology clinic rooms and in all systemics folders.
- Documentation of X-ray Report by Neonatal Team – Column added in the daily summary for checking the x-ray reporting each day. To be completed during each consultant round.
- Clinical Audit on Management of Immune Mediated Colitis - Business case for an immunotherapy toxicity team submitted which would help capture all relevant investigations for these patients.
- Assessment & Management of Low Back Pain and Sciatica in Spinal Triage & Treat Clinic - Introduction of documented evidence regarding information provided by using a patient information sheet ('Summary of Consultation').
- Re-audit of Completion of ADHD Documentation and Medication Prescribing - Development of an agreed paragraph to include on clinic letters advising on behavioural measures as part of a comprehensive treatment plan.
- Are the Hospital Guidelines Being Followed for Placental Histology – Implementation of a clear pathway for uploading and reviewing the results by the team, the lab now has a system in place to upload the results to EPR.
- Reporting of Nasogastric Tube (NGT) Position on Chest X-rays - Introduce coding onto Soliton to allow better management of the studies. New code for chest x-rays for NGT placement has been agreed across UHD through ICE.
- Emergency Management of Cauda Equina Syndrome - MRI is now available until 10pm, with emergency MRI available after this time.
- Communications Audit - Updated information, specific to departments, made available on the ‘Updates by Clinical Area’ section of the ‘Investing in our Hospitals’ intranet page on a regular basis.
- Audit of Legacy Treatment Escalation Plans on Electronic Patient Records - Roll out of UHD Treatment Escalation Plan completed.

- Radiation Doses from a Mobile Chest X-ray at RBH - Changed the pre-set ‘average’ exposure factors to be the same on both mobile machines. Image quality as well as dose to be considered when deciding which of the machines should be altered.

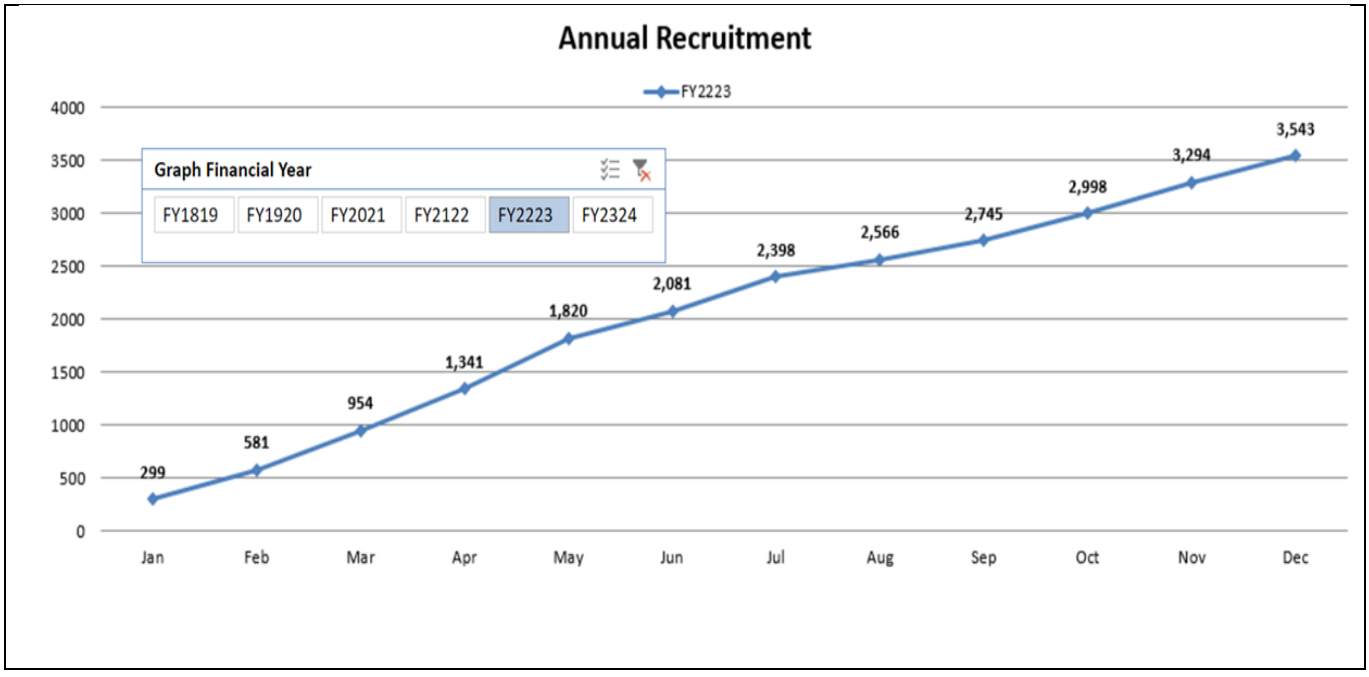
Meet Craig, our clinical audit and effectiveness manager

“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:

Recruitment at UHD is recovering post the pandemic. Recruitment at UHD was 3,543 in the financial year, with an additional 198 participants recruited at Bournemouth as part of the Wessex Partnership collaboration. The Wessex Partnership collaboration offers research opportunities to residents in the local area and has a strong commercial pipeline of studies planned.



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

The Trust's income in 2022/23 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.

CQC Inspection of Medicine and Surgery

The CQC undertook an unannounced focused inspection of on the 28th and 29th September 2022. The CQC did not look at all key lines of enquiry and limited their review to a small number of areas where concerns had been raised in older peoples services and surgery. The CQC rated Poole Hospital's Surgical Services as Requires improvement. The Inspectors' assessment of the hospital's Medical Care services did not lead to a rating being issued. The service remains rated good. The CQC rated Poole Hospital as "Requires improvement" overall. It was previously rated good.

No rating was issued for the Royal Bournemouth Hospital. The hospital remains rated good overall. Similarly, the inspectors' assessment of the hospital's medical care and its surgery did not lead to new ratings being issued. Both remain rated good.

The inspection did not lead to trust-wide ratings being issued.

In medical care at the Royal Bournemouth Hospital and Poole Hospital, inspectors found:

- There were not always have enough staff to keep people safe.
- Staff did not always complete and update risk assessments, and records were not always stored securely.
- Medicine storage was not always safe.
- People did not always receive enough food and drink.
- Some people who were medically fit for discharge stayed in the service longer than they needed to, due to a lack of community and social care packages in the region.
- Staff morale was low but still focussed on the needs of patients receiving care.

However:

- Staff knew how to protect people from abuse, and managed safety well.
- Infection risk was controlled well.
- Staff mostly identified and quickly acted for people at risk of deterioration.
- Staff assessed and monitored people regularly to see if they were in pain, and they mostly administered pain relief in a timely way.
- Staff supported people unable to communicate using suitable assessment tools, and they gave additional pain relief when needed.
- Staff collaborated well to benefit people.
- Staff treated people with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues it faced.
- The service had an open culture where people, their families and staff could raise concerns without fear.

In surgery at the Royal Bournemouth Hospital and Poole Hospital, inspectors found:

- There were not always have enough staff to care for people and keep them
- Care was not always planned to meet local people's needs.
- At Poole Hospital, people on a fractured neck of femur pathway did not always receive treatment within recommended timescales.
- People remained in Poole Hospital's surgery service when they were fit for discharge, due to a lack of community and social care packages in the region.

However:

- Staff assessed risks to people, acted on them and mostly kept good care records.
- Staff treated people with compassion and kindness, respecting their privacy and dignity.
- Staff were focused on the needs of people receiving care.

The CQC recognised that the trust were aware of a number of these issues and noted that in a number of areas organisational and system wide actions were in place to mitigate risk. The Trust has developed a detailed action plan to address the issues highlighted in the report. The Quality Committee will ensure oversight of effectiveness of the actions identified.

CQC reviews will remain an important part of the quality approach at UHD and we will continue to use these to understand where further improvements to our services can be made.

CQC Inspection of Maternity Services

The CQC inspected Maternity services at Poole Hospital in November 2022 as part of a national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country to held understand what is working well to support learning and improvement at local and national level. The CQC aim to publish a national report on the overall findings of the programme in 2023/24.

The inspection at Poole Hospital was a short notice announced focussed inspection looking at Safe and Well led key questions.

The inspection report was published on the 10 March 2023. The CQC rated Poole Hospital Maternity service inadequate. The service was previously rated good (January 2020).

In Poole Hospitals maternity services, the report noted that inspectors found:

- There were not always enough staff to keep women safe.
- Systems and processes for managing risk were not always effective, especially in maternity triage.

- Maintenance of the environment especially regarding the emergency call bell systems, were not adequate to maintain peoples safety. The CQC acknowledged that at the time of the inspection the trust was implementing a new call bell system and confirmed it had addressed this issue.
- Managers did not always investigate incidents thoroughly or in a timely manner.
- The maternity leadership team was new and did not always have enough capacity or experience.

However:

- Staff understood how to protect women and children from abuse.
- The environment was visibly clean.
- Staff managed medicines safely.
- Staff felt respected, supported and valued. They were focussed on the needs of women receiving care.
- The service had an open culture where women, their families and staff could raise concerns without fear.

Following the inspection, the CQC served the Trust a formal Warning Notice under Section 29A of the Health and Social Care Act 2008. The Warning Notice notified the Trust that significant improvements were required in maternity services in relation to safety processes for staff accessing help in an emergency. The Trust has identified a detailed action plan to address the issues raised in the CQC report. The Quality Committee will ensure oversight of effectiveness of the actions identified.

"I know how hard our staff are working, often under pressure, so it is disappointing to receive the judgements. However, we know that these reports are reflective of the challenges across the trust as we are not currently providing consistent standards of care.

"I do believe though that the themes within the reports are fixable. We have already put improvements in place and addressed some of the issues raised. We recognise though that there is more to do and will ensure we take the actions needed.

"I was very pleased that the CQC reports also highlighted some best practice across our hospitals, including the caring nature of our colleagues, with the CQC stating that patients told them our staff treated them well, with compassion and kindness."

"In light of the CQC's advice we now need to make sure we have everything in place to improve processes, management and leadership across the trust that have been impacted by the disruption of our merger, the pandemic and industrial action. With the wonderful colleagues I have across UHD I know we can do this. We look forward to welcoming the CQC back to our hospitals to show them the changes we are making."

Siobhan Harrington, chief executive

"We recognise that we need to have clearer and more effective ways of making improvements and learning from ourselves and others. Working with our trust Board and receiving insights from our Council of Governors, we will continue to strengthen governance – how we work as an organisation - and risk management. We have a strong ambition to make UHD the best place for both our staff and our patients and these reports will help us in this work."

Rob Whiteman, chair of UHD

6. Data Quality

The University Hospitals Dorset NHS Foundation Trust submitted records during 2022/23 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 99.8% for admitted patient care; 99.9% for outpatient care; and 99.2% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 99.7% for admitted patient care: 99.9% for outpatient care; and 93.9% for accident and emergency care. (Taken from the National M12 22-23 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

The results for UHD are all better or equal to the national average.

Data management is largely handled by the Trust's Business Intelligence Department, Quality and Risk Management Department and the Clinical Audit Department, all of which are subject to internal and external quality checking and control. Aspects of these have been regularly checked and validated throughout the year as part of routine governance processes.

The Trust has a Data Quality Management Group which is responsible for ensuring robust mechanisms are in place for maintaining and improving the quality of data within the Trust and for monitoring compliance against national and local standards. The Data Quality Management Group is a formally constituted subgroup of Trust's Operational Performance Group and as such will receive the minutes / key actions of the Data Quality Management Group meetings.

The group is responsible for monitoring the quality of data used by the Trust, formulating a programme of work to improve data quality across UHD and approving action plans to address

poor data quality issues. This is achieved by raising awareness of data quality standards, monitoring compliance against National DQ Indicators and benchmarking against peers.

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 England by 30th June each year.

The following section provides details of the 22/23 DSPT submission at the end of May 2023.

The Data Security and Protection Toolkit (DSPT) is a self-assessment audit completed by every NHS Trust annually and submitted to NHS England by 30th June; 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 2022/23, 113 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.

By the end of June 2023, it is expected that the Trust will be able to declare compliance with 103 of the 113 mandatory assertions. Areas requiring further work include the proactive audit of user account permissions and removal of unnecessary permissions on IT systems, having 95% of all staff completing IG training within the year, risk assessment and removal of unsupported software/hardware to the level specified within the DSPT, and connected medical devices.

As a result, the Trust is not expected to be able to submit a fully compliant assessment, but instead will complete action plan which will be submitted to NHS England with a view to its DSPT status for 2022/23 being set to "Approaching Standards". Work will then continue in the coming months to attain the necessary compliance.

In 2023/24, 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 improvements made to the Trust's Information Asset Register during the year will facilitate this, 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 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 root cause analysis investigation process is undertaken.

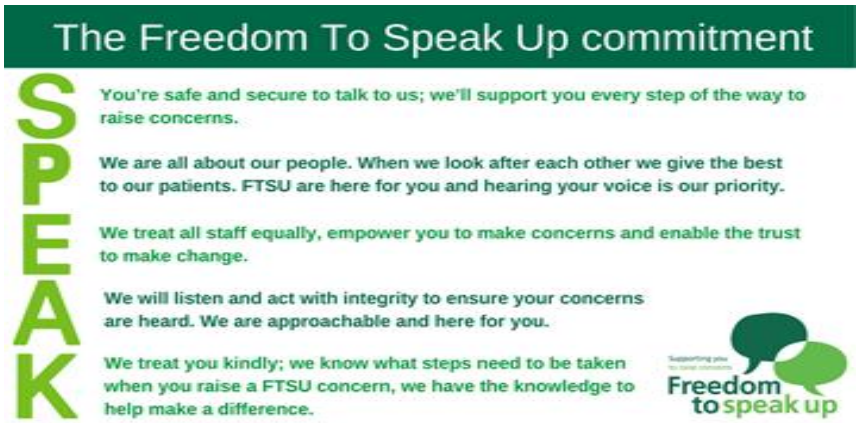
The Trust has a Medical Examiner process for all inpatient deaths. Part of the Medical Examiner process includes completion of an initial case note screen by a senior clinician. The aim of the screening process is to highlight any cases that require an urgent case note review or root cause analysis investigation.

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. Any learning points from the Group are disseminated through Directorate Mortality and Clinical Governance meetings.

A new electronic learning from deaths system was introduced across UHD in December 2022 in order to standardise the process for mortality reviews. Prior to implementation multiple different IT systems were in use and this meant that there was an inability to provide accurate data on the number and gradings of deaths reviewed across UHD. Once roll out is completed and the new process fully embedded, it is hoped that this data will be available for Quarter 1 23/24.

Themes for action and learning from mortality reviews and investigations have linked to the development of quality priority and quality improvement initiatives for 2023/24.

9. Freedom to Speak Up



Speaking up benefits everyone. Building a more open culture in which leadership encourages learning and improvement, leads to safer care and improved patient experience. At UHD, we have many routes that staff can use to speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff whom use it.

As previously mentioned in 2023/24 UHD will commence its exciting Patient first programme. Patient First will help us all by improving the way we work. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. Speaking up is integral to this work and we look forward to supporting this moving forward.

Key Progress during 2022/23

Speaking up – Our Senior Leaders

Every year our board take time to reflect and publicly commit to the Sir Robert Francis principles of speaking up, alongside a declaration of their behaviours. This commitment was made in September and is a visual statement, reminding us that the board commit to speaking up and to developing a culture of safety. The declaration of behaviours sets out how the board will role model this and sets the tone of the culture for UHD.

A board development session is planned for 2023 to take time to assess where we are in terms of speaking up, where we need to be and how our senior leaders can support it.

Speaking up Month – October 2022

Speak Up Month is a chance to raise awareness of speaking up and the work which is going on to make speaking up business as usual. This October the theme was "Freedom to Speak Up for Everyone" with each week having a specific focus including safety, civility, inclusion and for everyone. Throughout the month we promoted the importance of speaking up through written articles, visual flags, post it notes, pens and literature, videos from our executives and staff who have used the service and worked alongside our staff networks jointly walking our clinical and non-clinical areas with our award winning decorative roaming trolley. Nearly 20,000 social media hits occurred from this work.

FTSU Networks – "Looking in and out"

Our networks are key to our success in sharing the speaking up message but also as a support for each-other. We have several networks which continue to grow and mature.

UHD FTSU Network**:** Our FTSU network meets monthly and discusses our observations and recent guidance. It allows us to quality assure the work we are doing and more recently focus on updating and reviewing the model going forward. We have planned a programme of work for 2023 including some personal development in September.

South-west regional Network**:** The National Guardians Office (NGO) recognises the need to develop and engage within formal regional networks. UHD has been co-chair for this network since 2020 and chairs quarterly regional meetings, six weekly check ins and mentoring for new guardians. This network is excellent for support and sharing good practice.

Dorset FTSU Network**:** UHD set up and chairs this network since September 2018. The vision of this group was agreed to share best practice and act as mentors for difficult cases. The membership has since expanded and now has representation across CCG, private healthcare, ambulance service, acute trusts and our regional lead for NGO. The focus of these meetings has consequently changed to supporting speaking up across our multi-agency systems in Dorset.

Speaking up Policy (June 2022)

NHS England published an updated national Freedom to Speak Up policy to be adopted by all Trusts by January 2024. The policy provides a minimum standard with space to add local information. It is designed to help organisations deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.

This Policy has been assured by People and Culture Committee in February 2023 and is anticipated to be approved and in place by May 23.

Freedom to Speak Up training programme

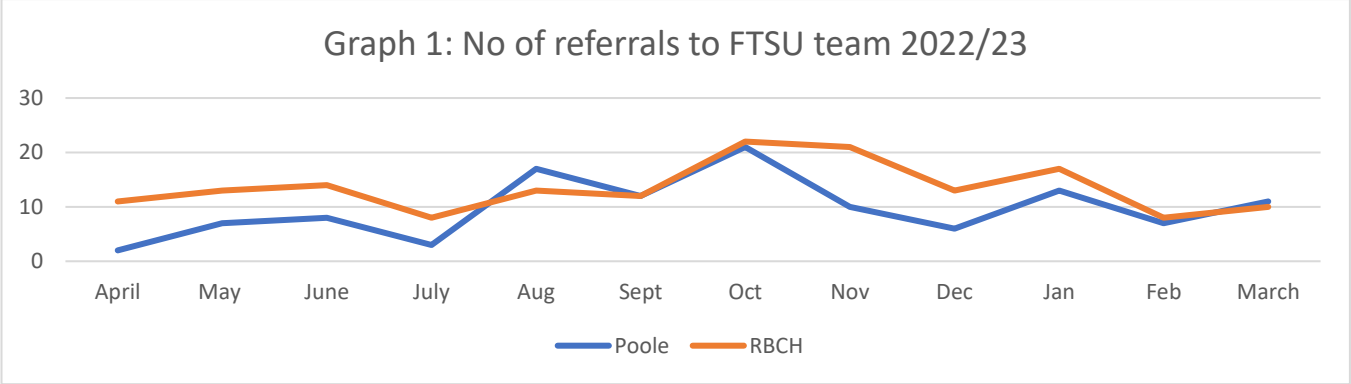
'Speak Up, Listen Up, Follow Up', is an e-learning package, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best. A focused communications campaign is planned for spring 2023 and the module will be included into core induction programmes such as Trust induction, preceptorship, medical and international educated programmes.

Freedom to Speak Up Strategy at UHD

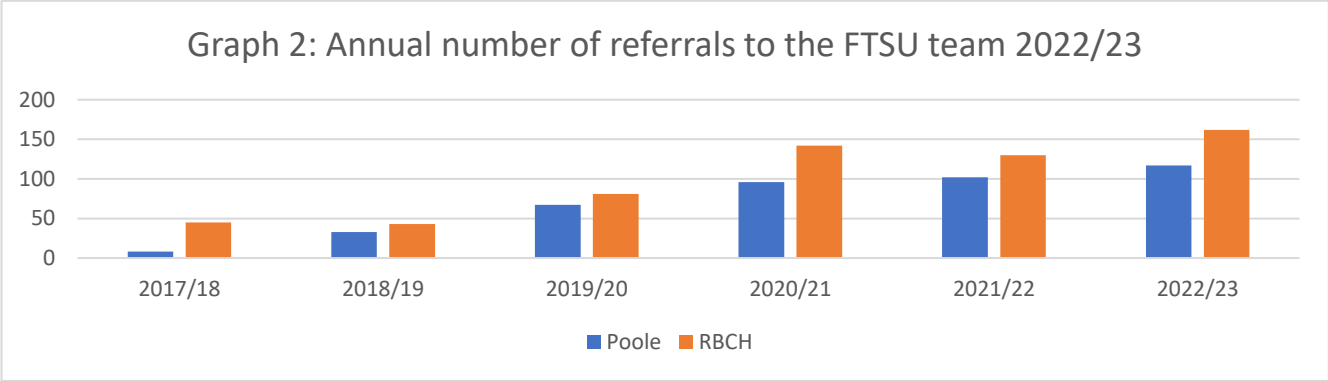
There is an expectation from National Guardian Office (NGO) that each Trust has a clear, robust and ambitious FTSU improvement strategy articulating our speaking up vision and goals. The strategy at UHD was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy with planned progress updates. The strategy was signed off by the senior team/board in January 2023 and will be part of a communications programme over the Spring to ensure successful delivery.

Case Referrals

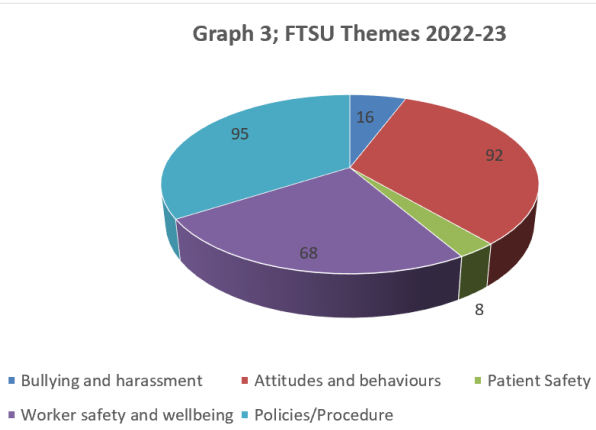
FTSU referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation. The graph below highlights the number of referrals received on a monthly basis to the FTSU team over 2022/23.



Graph 2 shows that the number of referrals to the FTSU team increased by 20% from 2021/22. Forty-two per cent of referrals come from staff at our Poole site and 58% from RBCH. Five per cent of referrals to the FTSU team were made anonymously which is the same as 2021/22 and continues to be lower than that seen nationally (10.4%; NGO annual report 2022).



Staff approach the FTSU team for a number of reasons. Graph 3 illustrates the greatest theme had an element of behaviours (108 staff; 39%); of which 15% of those (16 staff) were raised as bullying and harassment. This is followed by process and procedures (95 staff; 34%) and then worker safety and wellbeing (68 staff; 24%). Only 3% of referrals were related to patient safety and may reflect strong LERN reporting culture in capturing our patient safety issues.



Eighteen per cent of staff (50 staff) raised a concern from an ethnic minority background. All staff were signposted to our BAME networks who were also able to support and advise. The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our ethnic minority employee experience.

Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed into the culture at UHD. The following points are the learning and reflections of the FTSU team from referrals in 2022/23:

- Be mindful of how we speak/our tone to our colleagues or how we write emails can make our staff feel both un-important and undervalued.
- Invest time at the beginning of any re-structure or organisational change to explain the process and ensure their wellbeing is in the forefront of our minds with access to support if needed.
- Challenge the working patterns we offer.
- Improve clinical engagement and behaviours.
- Promote our leaders to attend Compassionate and Inclusive leadership programmes and People Management modules.
- Encourage our leaders to complete HEE/NGO Speak up, listen up and follow up modules on BEAT.
- Upskill our leaders on how to create psychological safe working environments to speaking up.
- Contribute, embrace and be involved in our Patient first programme. Patient First will help us all by improving the way we work. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. Speaking up is integral to this work and we look forward to supporting this moving forward.

We are #TeamUHD

University Hospitals Dorset's values aspire to having an open and honest culture. Speaking up has never been as important as it is today and yet our staff are telling us that we do not address concerns nor make people feel safe to raise them. Speaking up takes courage and therefore deserves the time to listen and address them. 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.

Reporting against core indicators

NHS foundation trusts are 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 January 22 – December 22 0.8916	1.000 1.000	1.1897 1.2186	0.7127 0.7117
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 HSCIC. 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% January 2022 – December 2022 41%	39% 40%	64% 65%	11% 12%
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 and 22/23 data for UHD is not available	No national data 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) April 2021 – March 2022 (i) = 14.0% (1095) (ii) = 13.1% (8630)	(i) = 12.5% (ii) = 13.0% 12.5% 12.0%	(i) = 64.4% (**) (ii) = 11.2% (**) 46.9% 142.0%**	(i) = 2.8% (**) (ii) = 1.1% 3.3% 2.1%

* 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	2022 Figures for UHD not currently available			

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% 2022 – 64.2%	66.9% 61.9%	89.5% 86.4%	43.6% 39.2%
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 2021/22 – 9.6 per 100,000 overnight bed days	15.79 16.46	80.65 53.62	0 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	National data not available	Not available	Not available

Part 3 – Other information

Review of quality performance in 2022/23

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 2022/23 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

Patient Safety Incidents

The following table provides details of the patient safety incidents reported during 2022/2023 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**
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)

2022/23	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
No Harm / Near Miss	**816**	**913**	**895**	**1005**	**994**	**881**	**978**	**970**	**957**	**1029**	**803**	**926**	**11167**
Minor	**449**	**395**	**396**	**456**	**401**	**413**	**490**	**395**	**469**	**449**	**455**	**435**	**5203**
Moderate	**8**	**9**	**5**	**9**	**8**	**8**	**9**	**9**	**2**	**16**	**12**	**6**	**101**
Severe	**0**	**3**	**3**	**8**	**7**	**4**	**4**	**1**	**8**	**5**	**8**	**2**	**48**
Total	**1273**	**1320**	**1299**	**1478**	**1410**	**1306**	**1481**	**1375**	**1436**	**1499**	**1278**	**1369**	**16524**

Table: Patient safety incidents reported during April 2022 to March 2023 and uploaded via the national reporting and learning system (NRLS) (as at 31/03/2023)

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.

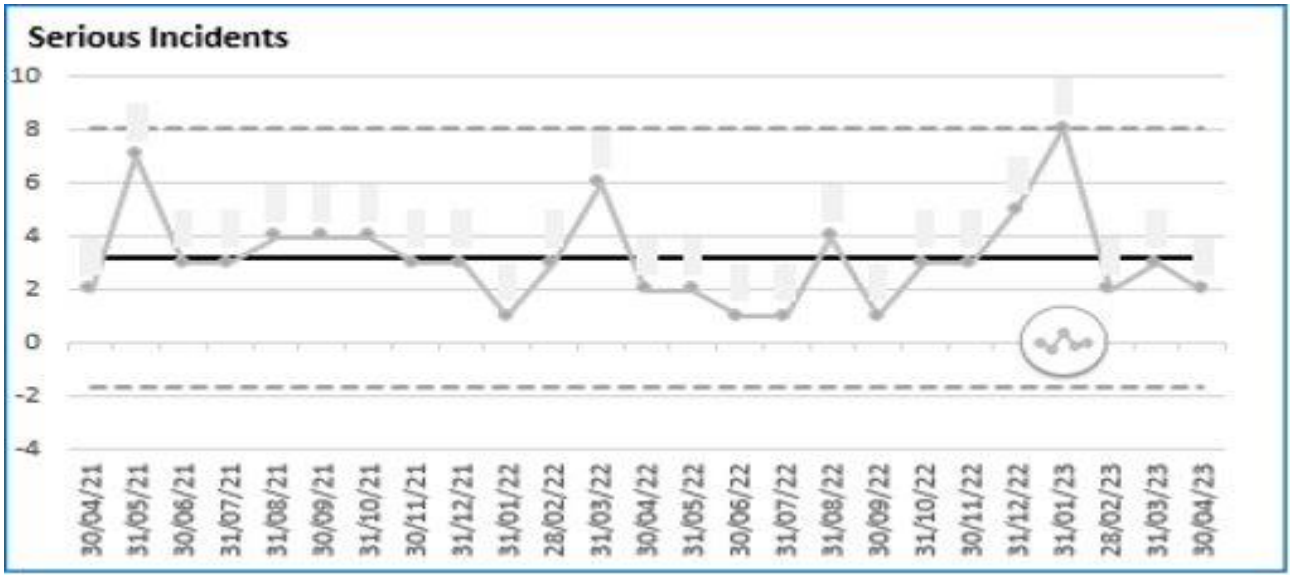
In 2022/2023 the Trust reported 35 serious incidents compared to 42 in 21/22

LERNS identified as External reports:

All External reports by date reported on STEIS and Care Group 22/23

UHD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	% to date
Surgical Care Group	0	2	1	0	1	0	0	2	0	1	0	2	9	26
Medical Care Group	2	0	0	0	2	1	2	1	4	6	2	1	21	60
Specialties Care Group	0	0	0	1	1	0	0	0	1	1	0	0	4	12
Corporate Directorates	0	0	0	0	0	0	1	0	0	0	0	0	1	2
Total	2	2	1	1	4	1	3	3	5	8	2	3	35	100

All External reports by date reported on STEIS (Month and year) (comparative 21/22 and 22/23)



Examples of Trust wide Learning Alerts shared across the Trust following serious incident investigations have included:

- Trust wide learning – sharing and storage of images taken in clinic
- Trust wide learning - Timely treatment of suspected Sepsis
- Trust wide learning - Review of Radiology results
- Trust wide learning - Specialty discharge from the ED Department
- Trust wide learning – Guidance to patients when prescribing
- Trust wide learning - Labelling pathology requests
- Trust wide learning - Amendment to consent forms following procedure
- Trust wide learning - Release of emergency equipment

- Trust wide learning - Acute Kidney Injury
- Trust wide learning - Access to Emergency Blood Transfusion
- Trust wide learning - Access to toilet cubicles in emergency
- Medicine Safety Notice - Security of Medicine Storage via Keypad Entry System
- Trust wide learning - Delayed prescription of antibiotics
- Trust wide learning - Interventional Radiology transfers
- Trust wide learning - NG/OG Tube placement

All safety alerts are discussed at the Trust Clinical Governance Group and shared in the monthly CGG Top 10 briefing. The Alerts are also made available to staff in the Quality and Risk pages of the Trust intranet.

Never Events

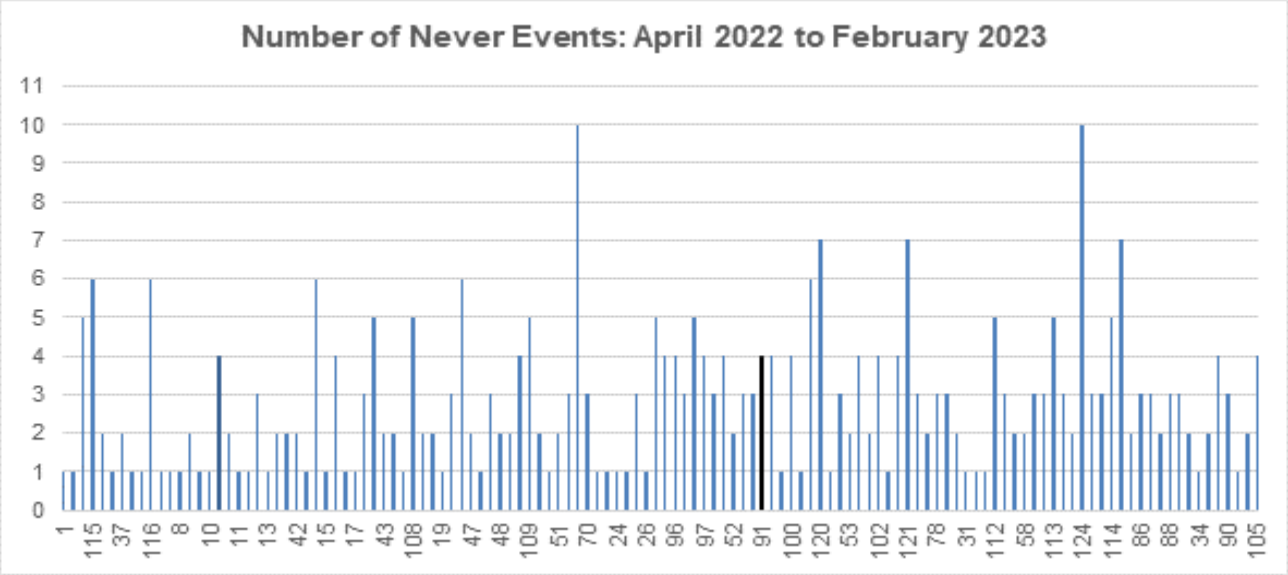
Never events are patient safety incidents that should be because there is national guidance in place requiring the use of strong systemic protective barriers.

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 2022 – 31 March 2023) the Trust reported 4 never events.

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

Nationally 356 Serious Incidents met the definition of a Never Event and had an incident date between 1 April 2022 and 28 February 2023; this number is subject to change as local investigations are completed.



*** the black line indicates UHD**

All never events are fully investigated and any learning shared across the Trust.

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 2022/23 NHS Dorset undertook an independent audit of the Trust arrangements for duty of candour. The Audit reported that the review provided moderate assurance that appropriate processes are in place and are being followed by staff.

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:

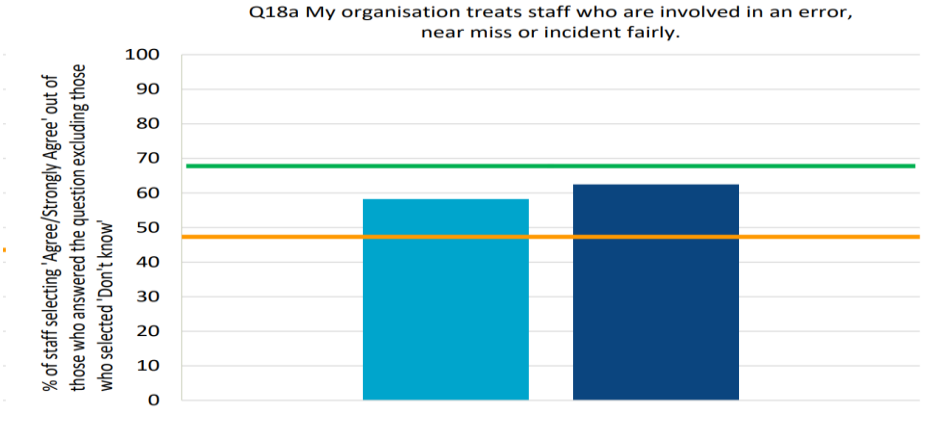
The national survey centre publishes full and summary reports of core survey responses appropriately benchmarked against national data for all trusts in England. The survey data is used in a variety of ways including:

- 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.

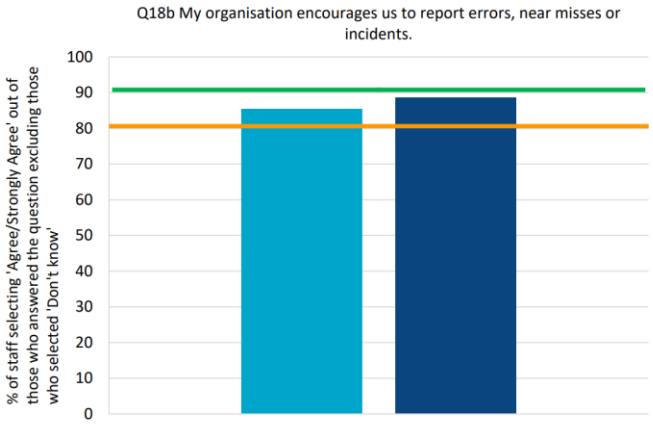
Within the Trust we analyse our data at team, subject and Trust level in order to understand:

- 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 2022 survey results were announced at the end of March 23. The results for safety culture, whilst slightly lower than 2021 were still significantly better than the sector average in a number of areas.



	2022
Your org	62.5%
Best	67.8%
Average	58.2%
Worst	47.3%
Responses	3253



	2022
Your org	88.6%
Best	90.8%
Average	85.5%
Worst	80.6%
Responses	4009

	2022
Your org	67.0%
Best	75.9%
Average	67.0%
Worst	52.7%
Responses	3680

Question		2021 Score	Significance	2022 Score	Significance	Sector Score
18a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	-	N/A	62.5%	Significantly Better	58.6%
18b.	My organisation encourages us to report errors, near misses or incidents.	-	N/A	88.6%	Significantly Better	85.2%
18c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	-	N/A	67.1%	Not Significant	67.4%
18d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	-	N/A	57.4%	Not Significant	59.0%

Schwartz rounds

Schwartz Rounds provide a structured forum where staff, clinical and non-clinical, come together to discuss the emotional and social aspects of working in healthcare. The purpose of Schwartz Rounds is to offer a safe, reflective space for staff to share stories with their peers about their work and its impact on them.

At UHD, Schwartz Rounds are open to all staff employed at UHD including our students and junior doctors. Schwartz Rounds follow a structured format. They start with refreshments to allow staff time to rest and network. The Schwartz round then starts with three or four presentations within the chosen title from staff, after which, the discussion is open to all. The one-hour sessions are led by our team of trained facilitators and all thoughts and views shared during the session are treated as confidential.

Attendance is associated with a statistically significant improvement in staff psychological wellbeing. Evidence shows that staff who attend Schwartz Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care.

Schwartz rounds are led by a Clinical Lead alongside which a steering committee sits which includes administrative support, trained Schwartz Round facilitators and communication support. The team represent what conversations are happening in the Trust and help set up, facilitate and promote the work of Schwartz Rounds as part of our health and wellbeing offering at UHD.

Schwartz rounds are licenced by Point of Care Foundation and provide structured training and mentor support.

Schwartz rounds 2022-23

The team in 2022 underwent a re-fresh and re-branding with the support of our Point of Care Foundation mentor. The steering committee set out an exciting 18 month programme.

Our communications and branding team have been integral to this refresh and integration of UHD teams.

Table 1 shows the number of rounds that have been set up since its refresh in June 2022.

Date	Title	Attend	Rate (good+)
July 22	*A picture tells 1000 words*	12	100%
Aug 22	*Small acts of kindness*	32	100%
Dec 22	*Working under pressure in the NHS*	29	91%
Jan 23	*When I am trying my best but it is still not enough*	24	100%
March 23	*Dealing with unexpected loss*	60	100%

All rounds are evaluated. Feedback includes:

- Very powerful stories; we are not frightened to talk about topics that are really difficult
- The panellists are amazing and made me realise that I am not the only one that thinks like this
- Today's Round will help me work better with my colleagues.
- The group discussion was helpful to me
- What a lovely session. Thank You
- Very valuable to see how the team work from all comes together
- Everyone was so positive - One big team
- The amazing power of compassion, empathy and team work.
- Emotional and uplifting stories. Thoroughly enjoyed it
- Made me feel connected and that I was not on my own

Schwartz rounds for 2023

- The programme has been set up for 2023 with 4 main rounds and up to 8 mini pop up rounds
- The membership of the steering committee will be reviewed annually to ensure they represent our workforce but also that they are able to contribute to the programme
- To review our team of facilitators and focus on increasing the number based at Poole site
- To succession plan for the clinical lead and administrative support tenure in March 2024
- To increase the attendance of our senior team and executives and support this wellbeing offering. To explore increasing clinical engagement attendance to rounds but also steering committee.

CLINICAL EFFECTIVENESS

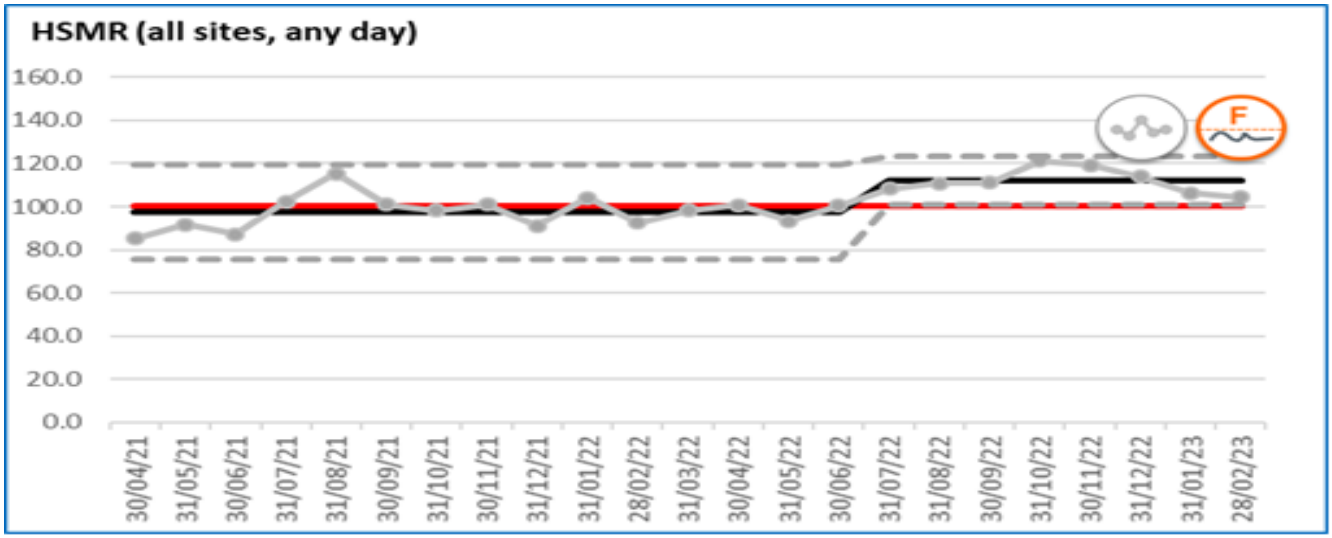
Reducing Mortality

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 reported Standardised Mortality Ration (SMR) position for the Trust:

HSMR March 22 to February 23 (UHD) SHMI February 22 to January 23

Indicator	Site	Value	Range
HSMR	UHD	104.5	As expected
SMHI	UHD	89.6	As expected



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. The Trust also appointed a new clinical lead for mortality in April 2023. This is an opportunity to review the governance around mortality and learning from deaths.

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

This section 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 guidance published in 2022/23; developments undertaken in 2022/23; developments planned for 2023/24.

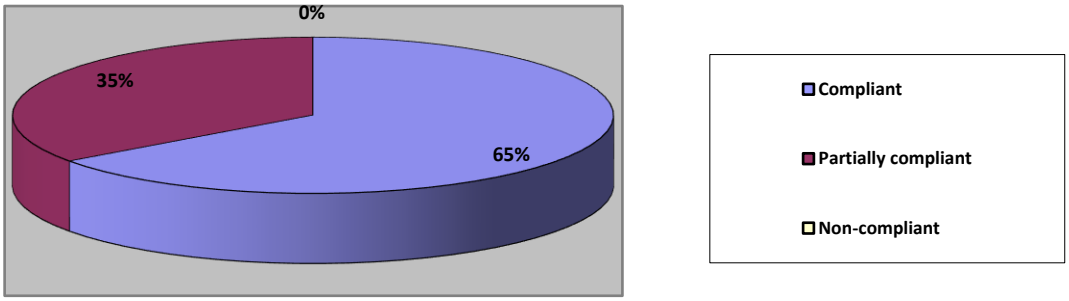
The final reportable position on current NICE Guidance for UHD (published from 1 April 2022 to 31 March 2023) for the financial year at Q4 2022/23 is as follows:

Care Group	Compliant	Partially Compliant	Non-Compliant	Not applicable	Grand Total
Medical	4	4	0	10	18
Surgical	3	0	0	15	18
Specialties	6	2	0	13	21
Operations	0	0	0	0	0
Corporate	0	1	0	4	5
Grand Total	**13**	**7**	**0**	**42**	**62***

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

Of those that were rated as applicable to UHD as per the table above (published from 1 April 2022 to 31 March 2023), the compliance status is recorded as follows:

Compliance status

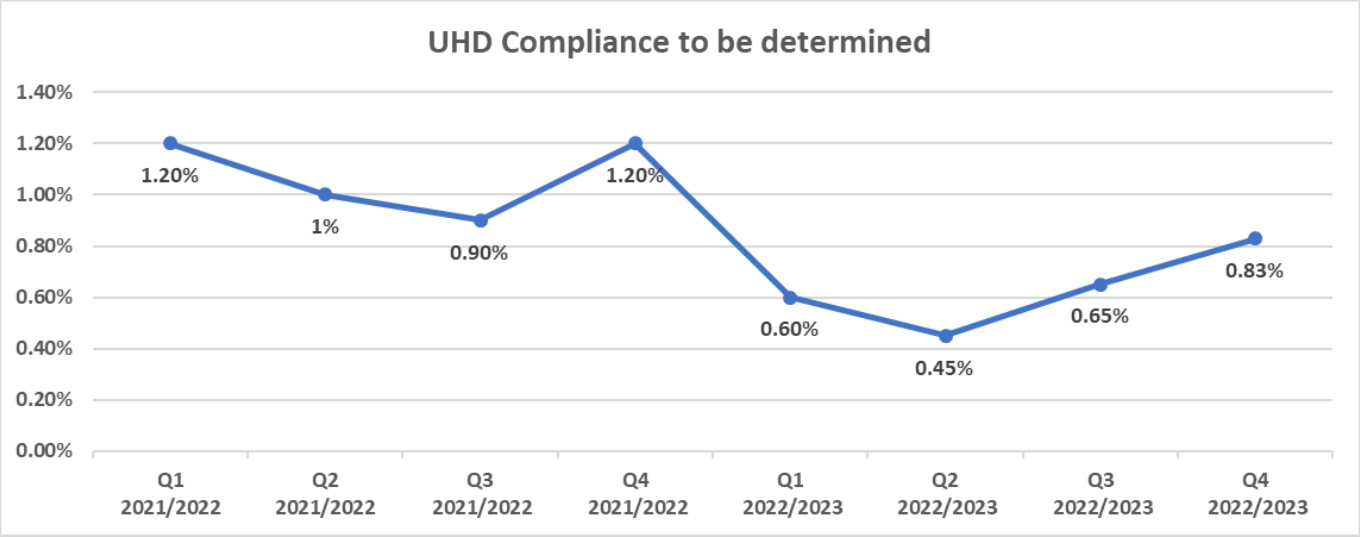


Of those that were rated as partially compliant for UHD (published from 1 April 2022 to 31 March 2023), the reasons for partial compliance are listed in the next table. Action plans are in place for each area of partial compliance. For example:

Guidance	Title	Specialty	Areas of partial compliance
NG 218	Vaccine uptake in the general population	Occupational Health/Maternity	Compliant for occupational health. Partially compliant for maternity Maternity are considering the appointment of a vaccine nurse later in the year, to vaccinate all service users with a regular service. In addition, from summer 2023 the Public Health Midwife will be able to focus on specific communities and demographics.
NG 217	Epilepsies in children, young people and adults	Neurology/ Paediatrics	Partially compliant due to epilepsy nurses' workload. Service to review need for additional admin support for epilepsy nurses. Continue to work with adult team to improve their capacity to take part in structured pathway for transition.
NG 220	Multiple sclerosis in adults: management	Neurology	Partial compliance. Due to the continual increase in patient numbers and complexity, the service is not always able to offer a full annual review to all NICE recommended patients.
NG 225	Self-harm: assessment, management and preventing recurrence	Acute Medicine	Partially compliant as awaiting IT support for electronic system update.
NG 229	Fetal monitoring in labour	Maternity	UHD follow 'Physiological interpretation of CTG' which is recognised nationally, rather than NICE interpretation. We are fully compliant with an equivalently recognised national CTG guideline.

At the 31/3/23, the number of guidance classed as “compliance to be determined” for UHD was 13 (for the previous financial year that number was 17). UHD have demonstrated effective processes of coordinating Trust responses to NICE guidance issued.

Level of Compliance to be determined for UHD in percentage:



Compliance is monitored quarterly via the Clinical Audit and Effectiveness Group.

Case studies of improvement following implementation of NICE Guidance

NG137 Twin and triplet pregnancy

In 2021 the Trust was partially compliant with this guidance but has now achieved full compliance following implementation of the NICE recommended care pathways. This includes the NICE recommendation that ‘antenatal clinical care for women with a twin or triplet pregnancy should be provided by a nominated multidisciplinary team.’ ‘This team should consist of a core team of named specialist obstetricians, specialist midwives and sonographers, all of whom have experience and knowledge of managing twin and triplet pregnancies’ . According to the Trust lead for this guidance, this means that the care pathway is evidenced based and has the potential to reduce twin stillbirths and perinatal morbidity.

QS38 Acute upper gastrointestinal bleeding

This QS recommends that ‘people admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable are given an endoscopy within 24 hours of admission’ . UHD are now fully compliant with this standard, as there are endoscopy slots available 7 days a week. When this guidance was last reviewed for RBCH, patients could only be offered endoscopy within 24 hours of admission, Monday to Friday. Therefore, this improved access to endoscopy can ‘help to avoid re-bleeding and can reduce the length of their hospital stay’, thus ensuring better outcomes for patients and saving Trust resources.

Development work and plans for the year ahead

The Clinical Audit Department has worked on streamlining NICE compliance recording on the newly merged NICE guidance database. This included seeking compliance updates from lead clinicians for guidance previously assessed as partially compliant and recording a status for UHD, rather than the old compliance status for RBCH/PH. This is an ongoing process.

Actions planned for 2023/24 include:

- To further work on maintaining the level of compliance to be determined at less than 10%.
- To carry on seeking compliance updates from lead clinicians for guidance previously assessed as partially compliant.

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 can be seen below:

Formal complaints received	2022/23	2021/22	2020/21	2020/21	
			Q3 and 4	Q1 and 2	
	UHD	UHD	UHD	RBCH	PH
	984	491	447	169	75

The Trust has implemented an early resolution of complaints process, the data for these types of complaints was not included in the complaints figures previously however this is now part of the formal complaint process and reported as such. Early resolution is intended to provide a quicker response within 10 working days. 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	2022/23	2021/22	2020/21	2020/21	
			Q3 and 4	Q1 and 2	
	UHD	UHD	UHD	RBCH	PH
	5530	5200	2347	1072	741

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	2022/23		2021/22	2020/21		2020/21		
				Q3 and 4		Q1 and 2		
	UHD	Nat Ave	UHD	UHD	Nat Ave	RBCH	PH	Nat Ave
Upheld	18%	26.8%	14%	21%	24.6%	14%	20%	28%
Partially upheld	38%	37.5%	34%	29%	37%	33%	39%	35%
Not upheld	44%	35.7%	52%	50%	38.4%	53%	41%	37%

Subjects of complaints

Every complaint is assessed at the outset and the key themes extracted. The themes, (total of 1896 for the 984 complaints) based on the DOH 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

Complaint themes	2022/23	2021/22	2020/21 Q3 and 4	2019/20 Q1 and 2	
	UHD	UHD	UHD	RBCH	PH
Clinical treatment	664 (35%)	373 (44%)	138 (32%)	103 (38%)	61 (30%)
Access to treatment	94 (4.9%)	2 (0%)	23 (5%)	14 (5%)	1 (0.5%)
Admission, discharge, transfers	97 (5.1%)	37 (4%)	27 (6%)	13 (5%)	7 (4%)
Delays & cancelled appointment	153 (8%)	16 (2%)	12 (3%)	4 (2%)	3 (2%)
Communication	435 (22.9%)	1 (0%)	92 (21%)	41 (15%)	37 (18%)
Consent	27 (1.4%)	211 (25%)	1 (0%)	1 (0.5%)	1 (0.5%)
End of life care	21 (1.1%)	6 (0.5%)	3 (0.5%)	0 (0%)	2 (1%)
Facilities	0 (0%)	0 (0%)	3 (0.5%)	1 (0.5%)	5 (3%)
Integrated care	0 (0%)	7 (0.5%)	2 (0.5%)	0 (0%)	0 (0%)
Patient care	90 (4.7%)	0 (0%)	97 (23%)	86 (31%)	35 (17%)
Mortuary	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prescribing	43 (2.2%)	0 (0%)	3 (0.5%)	0 (0%)	8 (4%)
Privacy, dignity & wellbeing	22 (1.1%)	81 (10%)	3 (0.5%)	1 (0.5%)	5 (3%)
Restraint	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Staffing numbers	9 (0.5%)	4 (0%)	0 (0%)	0 (0%)	1 (0.5%)
Transport	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Administration	0 (0%)	39 (5%)	12 (3%)	0 (0%)	15 (8%)
Values & Behaviours	146 (7.7%)	39 (5%)	13 (3%)	1 (0.5%)	20 (10%)
Waiting Times	95 (5%)	32 (4%)	0 (0%)	3 (1%)	0 (0%)

The PALS concerns are themed using the same assessment used for formal complaints and are very similar percentages.

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

Patient information leaflets regarding post-surgery discharge care and given to patients on their discharge lacked detail and could be more clear.

We did

Surgical matron has reviewed the leaflets, and these have been updated, with clearer and more specific advice. The 'Information Following General Anaesthesia' leaflet has also been updated.

You said

Concerns raised regarding lack of updates from ward when father-in-law was an inpatient at Bournemouth Hospital.

We did

Complaint has been shared with staff anonymously for learning and staff training has been revisited with regard to communication.

You said

Concerns raised as mother of patient found a needle and syringe left in a cubicle in the Emergency Department, and the way in which it was handled.

We did

Staff members were identified, and additional training has been given regarding sharps safety and their disposal. Apologies given to patient and her mother.

You said

Feedback received regarding the lack of pillows available for patients in the Emergency Department.

We did

The Senior Matron for ED has ordered additional stock to ensure an adequate supply.

You said

Concerns raised regarding the Parkinson's service and the impacts of reduced staff in the service.

We did

Further administration staff have been recruited to support the team and changes have been made to ways of working in order to improve the service, including the uploading of all correspondence to the electronic patient record so these are immediately accessible for GPs.

You said

Concerns raised regarding the Labour Line and the difficulties in accessing staff.

We did

Labourline now has a call waiting system so that staff can see when they have missed calls and can call people back. More staff are also being recruited to the team with an aim to provide a continuous 24-hour labourline.

You said

Concerns raised regarding uneven steps by Longfleet Road entrance of Poole Hospital.

We did

Estates Department have conducted a Health & Safety Review and are considering the addition of further painted signage on the concrete to advise caution.

You said

Patient and his father were upset by the manner of the doctor when they saw him in clinic. They were also unhappy that they had not yet receive the results of a recent MRI.

We did

The feedback regarding communication was passed on to the locum doctor for reflection. Another consultant reviewed the MRI results and wrote to the patient and the GP with the findings. A further appointment with an alternative consultant was offered.

You said

Concerns were raised about patient's being discharged from hospital in gowns and nightclothes as they did not have suitable clothes with them during their admissions.

We did

In conjunction with our physiotherapy and occupational therapy teams, we are in the early stages of trialling a charity funded project. Patients will be provided with new clothing and shoes free of charge to help patients to be discharged in more appropriate clothing and footwear.

You said

A local GP raised concerns that there were delays in the pathway when trying to admit patients their patients to the Royal Bournemouth Hospital in emergency situations.

We did

There is now a dedicated Emergency Admissions Team which answers calls across the whole Trust and continuous work is undertaken to improve the service further. Feedback from GPs have already noted improvements and quicker responses.

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 2022/23 the PHSO advised of 13 cases that they were looking into. One of the cases opened by the PHSO has now been closed and not upheld. One case has resulted in a compensation payment of £750. The other cases are still with the PHSO being reviewed.

Performance against national priorities 2022/23

National Priority	2022/23 Actual	2022/23 Target	2021/22
18 week referral to treatment waiting times – admitted (31/03/2023)	49.8%	92%	**45.5%**
18 week referral to treatment waiting times – non admitted (31/03/2023)	54.6%	92%	**65.1%**
18 week referral to treatment waiting times – patients on an incomplete pathway (31/02/2023)	53.8%	92%	**61.0%**
Proportion of patients staying for over 12 hours in Emergency Departments	7.3%	<2%	**1.85%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	67.8%	85%	**73.8%**
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	82%	90%	**85.3%**
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	97.1%	96%	**97.0%**
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	89.5%	94%	**88.8%**
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti-cancer drug treatment	99.4%	98%	**99.6%**
Clostridium difficile year on year reduction	84	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 (31/03/2023)	93.0%	>99%	**84.1%**

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

- **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 (4).

- **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.

- **Highly Specialised Technologies Guidance (HST)** evaluations are recommendations on the use of new and existing highly specialised medicines and treatments.

- **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' (2).

- **Diagnostics Guidance (DG)** designed to help the NHS adopt efficient and cost-effective medical diagnostic technologies more rapidly and consistently (5).

- **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 (3).

- **Health Technology Evaluations (HTE)** are an 'early value assessment (EVA) approach to assess those technologies that are most needed and in demand. This approach allows rapid assessment of digital products, devices and diagnostics for clinical effectiveness and value for money. So, the NHS and patients can benefit from these promising technologies sooner (1).

- **Cancer Service Guidelines (CSG)** provide guidance focused on the way services are organised for the treatment of different types of cancer.

- **Clinical Guidelines (CG)** provide guidance on the appropriate treatment and care of people with specific diseases and conditions.

- **Public Health Guidance (PH)** provides guidance on the promotion of good health and the prevention of ill health.

- **Social Care Guidelines (SC)** provide recommendations on 'what works' in terms of both the effectiveness and cost-effectiveness of social care interventions and services.

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

- **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

PSIRF Patient Safety Incident Response Framework

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.

University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East, Bournemouth, BH7 7DW

Poole Hospital
Longfleet Road, Poole, BH15 2JB

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

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