University Hospitals Dorset
NHS Foundation Trust

Annual Quality Account 2023/2024

Contents

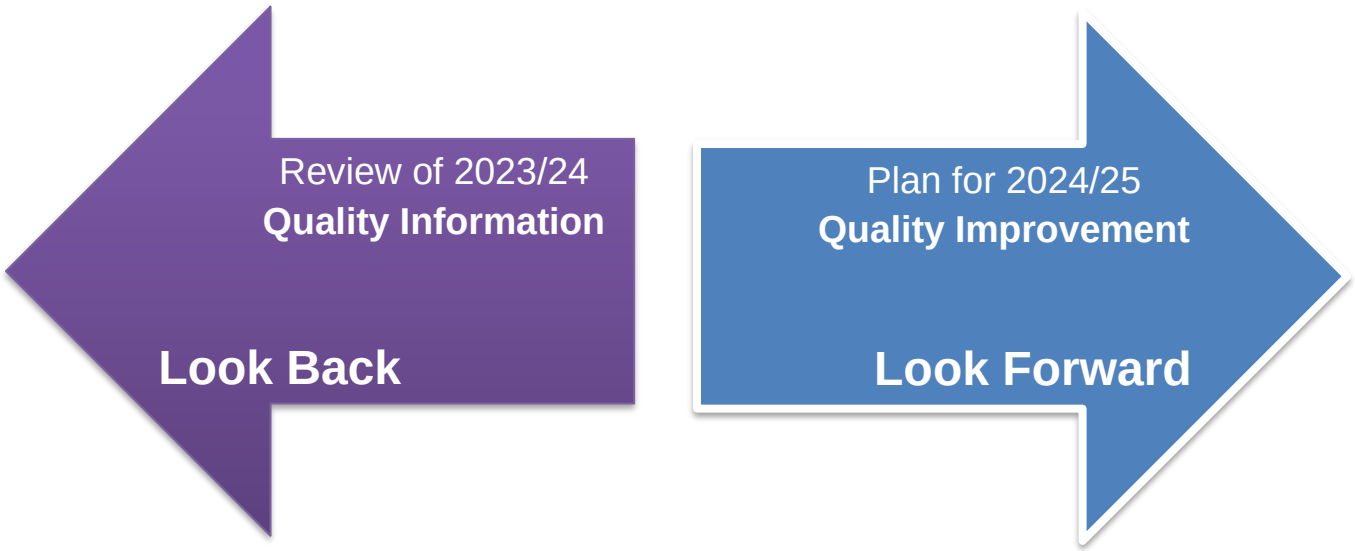
What is a quality account?

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 2023/24; and

2. set out our quality priorities and objectives for 2024/25.



To begin with, we will give details of how we performed in 2023/24 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.

We will also set out our quality priorities and objectives for 20024/25 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 of Directors, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the trust. We also encourage frontline staff to use quality accounts 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 2023/24 quality priorities and our quality priorities for 2024/25*
	Reviewing progress of the quality improvements in 2023/24 and choosing the new priorities for 2024/25
	Statements of assurance from the Board
Part 3	*Other information*

Part 1 Statement on quality from the Chief Executive

This Quality Report is the third published by University Hospitals Dorset NHS Foundation Trust.

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 also includes details of inspections by our regulators, the Care Quality Commission (CQC), during 2023/24 and the actions we have taken to improve patient safety and patient experience as a result of feedback received.

High quality care is at the heart of everything we do at UHD and maintaining and improving the quality of the care we provide remains the top priority for our trust.

Our staff work incredibly hard across our hospitals and the vast majority of the care we deliver is very good. We have seen improved safety culture scores in local and national staff surveys, and have appointed a patient safety partner this year. Through our newly named 'UHD Safety Crew', we have also invited the whole trust, no matter what their role, to be part of the safety conversation.

However, we know safety incidents occur and it is very important for us to have systems and process in place to ensure we learn from and improve where harm has, or might have, occurred.

This year we introduced our Patient Safety Incident Response Plan, aligned to the Patient Safety Incident Response Framework. Nationally, this is a fundamental cultural safety change in the way we think, report and investigate incidents. Where previous frameworks have formally described when and how to investigate a serious incident, PSIRF focuses on learning and improving local priorities for patient safety. With that in mind, our focus over the next 12 months will include looking at improving patient safety by reducing in hospital falls, pressure ulcers and venous thromboembolism. We are delighted to have been chosen as a pilot site for implementing Marthas Rule and will undertake this project as part of wider work on supporting the care and management of deteriorating patient. We have also set some important priorities for maternity care.

We have also implemented the Learn from Patient Safety Events (LFPSE) service this year, incorporating it into our current LERN forms. This national NHS service has a key focus on learning, which is underpinned by our values – 'listening to understand' and 'always improving'.

Developing a culture where people feel safe to talk is central to all our safety work. We have made a commitment to work in partnership with our patients and colleagues and hope to build on these strong foundations to further develop and embed safety systems and learning. By doing this, we aim to reduce patient safety incidents and patient harm, and to support staff to report concerns. We are all part of the safety conversation.

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:

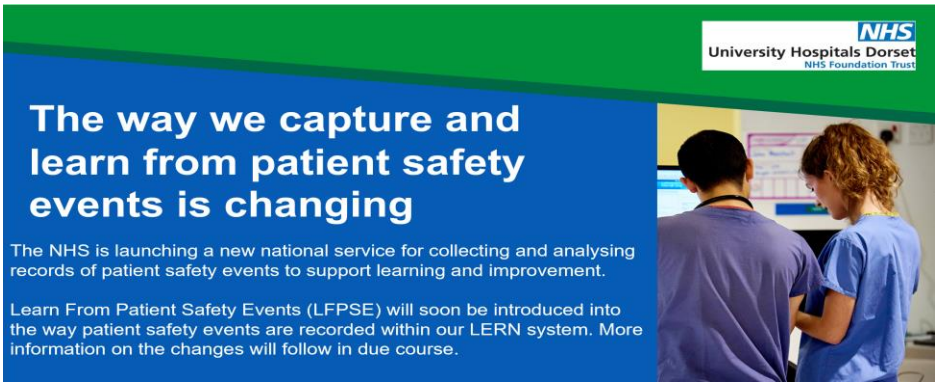
- *data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit programme of work each year*
- *data is collected by a large number of teams across the Trust alongside their main responsibilities, which 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.

Siobhan Harrington
Chief Executive

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

Performance against quality priorities set out in the Trust Quality Strategy for 23/24

Priority for 2023/4	Progress made in 2023/24
Transition from the National Reporting and Learning System and STEIS to the new National Learn from Patient Safety Events (LFPSE) service.	The Trust successfully moved over to LFPSE in November 2023. To support the transition: • Over 40 training and briefing sessions were held with teams before the change. • Regular screen saver and core brief messages were used to inform staff of the planned changes  • Presentations to the Clinical Governance Group, Care Group and Directorate governance meetings, team meetings and huddles. • Regular articles in the Core Brief and communications to support transition and positive messaging. • Workshops were held with staff to develop the new LFPSE compatible form. • LERN forms were streamlined to support ease of reporting for staff accidents and non LFPSE incidents. • Guidance on reporting key patient safety events such as falls and pressure ulcers was cascaded to frontline teams via briefings, newsletters, emails and meetings. Helpful videos were produced as user guides.

Spotlight on LERN - reporting for pressure ulcers

Pressure ulcers can be reported on either a 'patient safety' incident form or 'other' safety incidents form, depending on where the pressure ulcer was acquired.

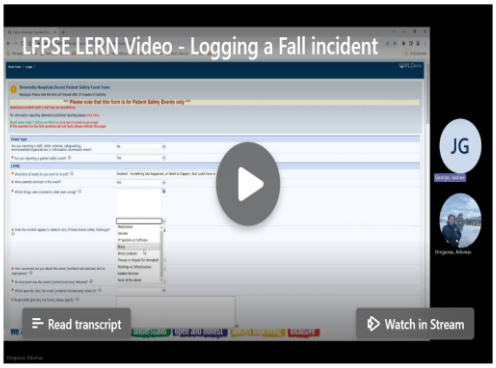
To help you decide which LERN form should be completed for a pressure ulcer, we have designed a decision tree which can be found here.

The patient safety team has also made an improvement to the drop-down choices in both forms to clarify the differences between 'present on admission' and 'acquired in the trust'. Under the sections '**how was the patient affected'** and '**who was affected by this incident',** the 'incident type tier two' selections are now:

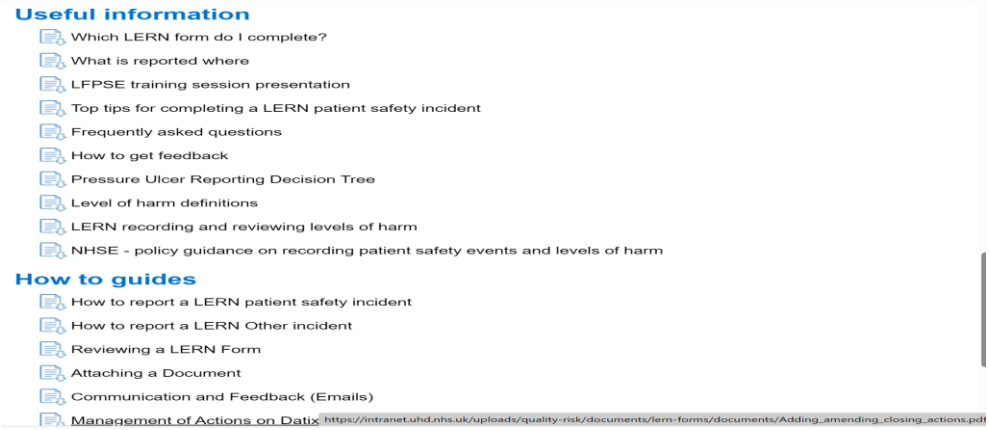
- present on admission to the trust
- not present on admission to the trust
- unknown whether present on admission to the trust

Both LERN forms are available here. For further information, please email qualityriskteam@uhd.nhs.uk

LFPSE LERN walkthrough – logging a fall incident

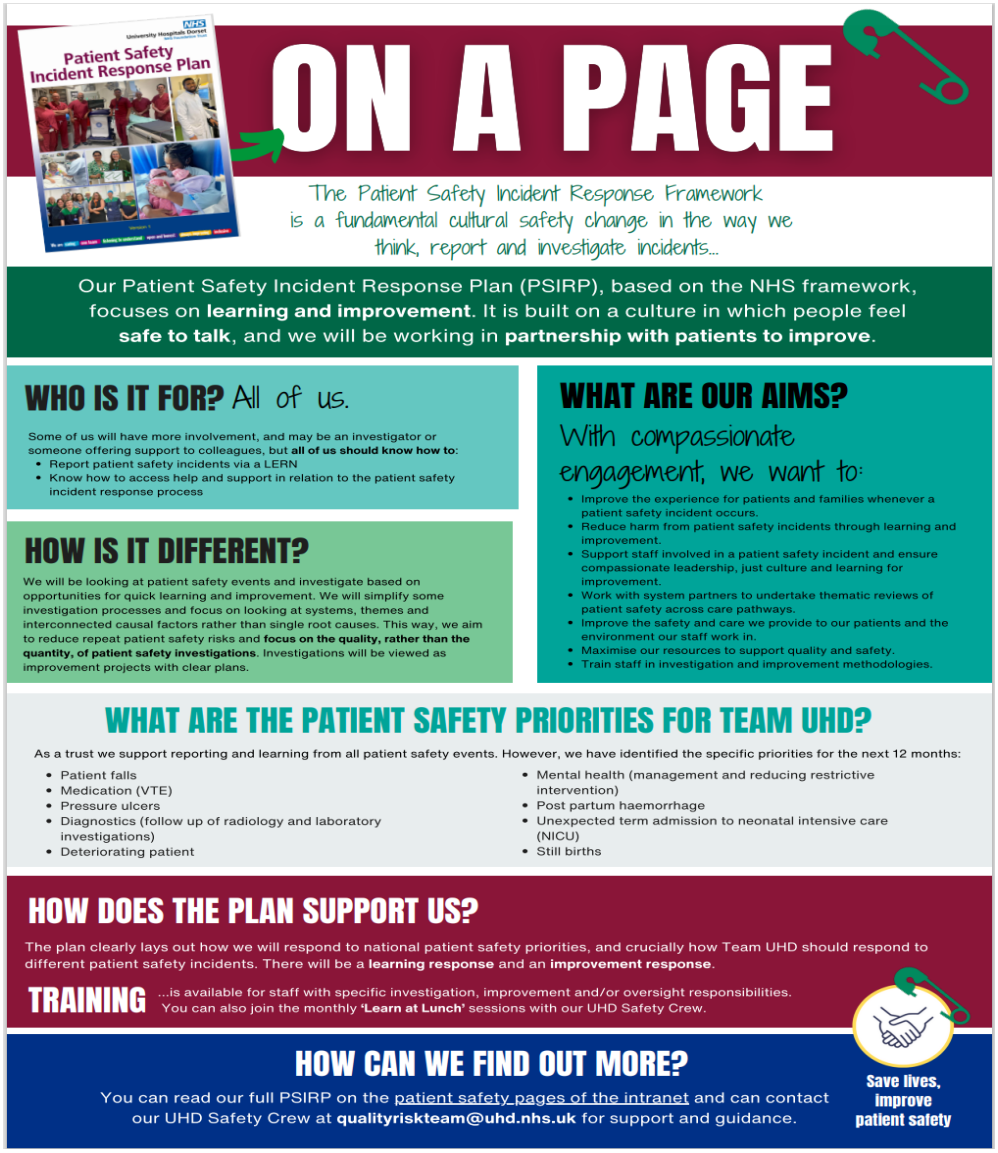


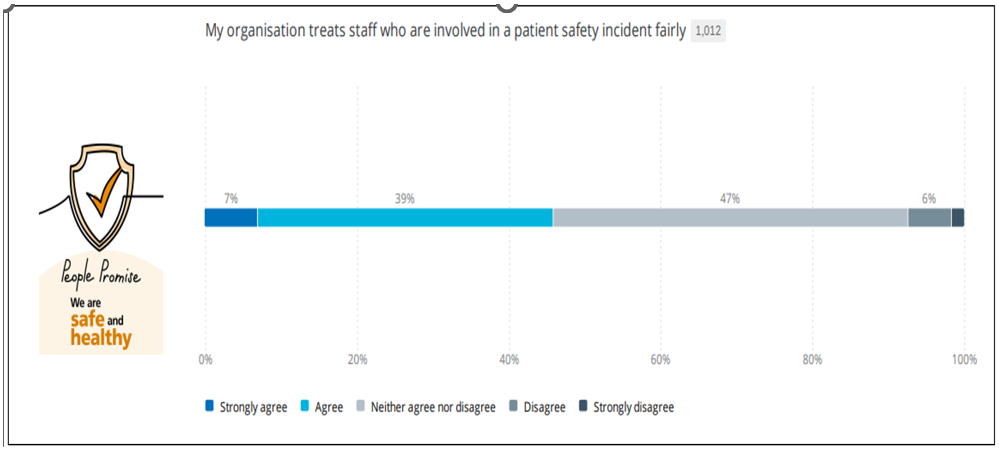
- The Intranet front page and patient safety pages were updated with guidance on reporting.

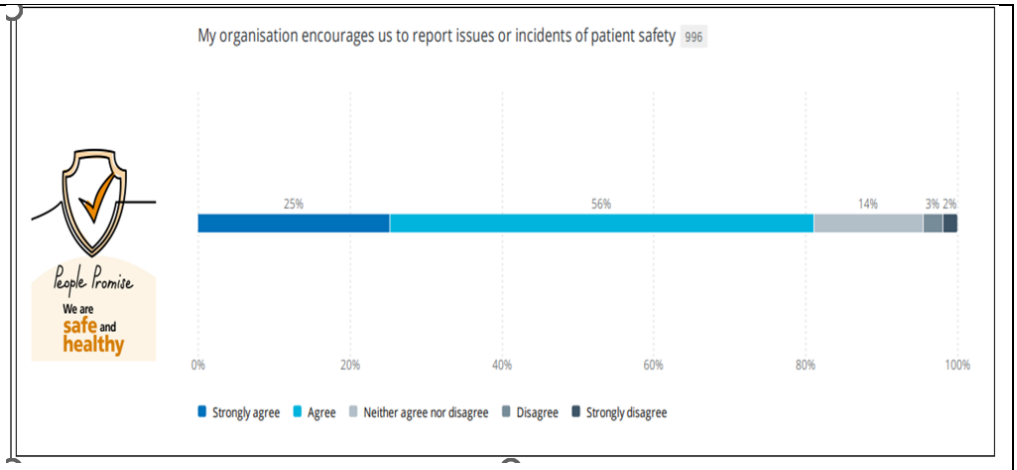


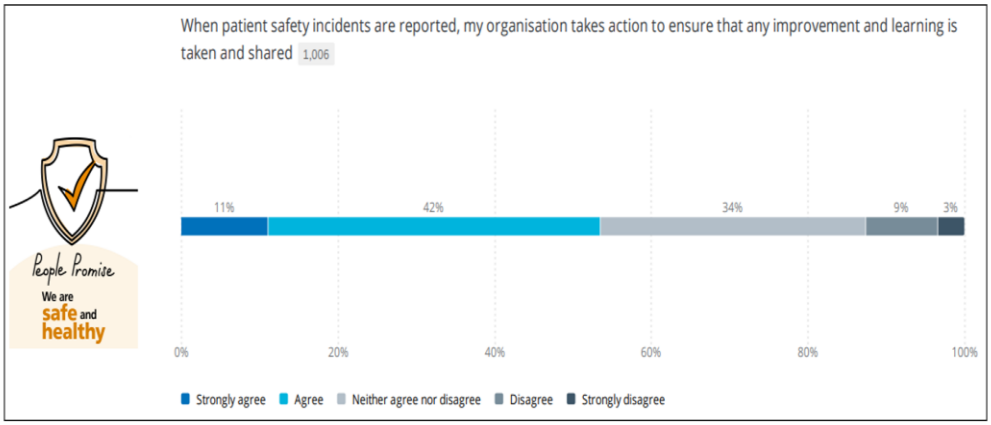
- Prompts were added to the Datix LERN reporting system to direct staff to the correct form and avoid incorrect completion.

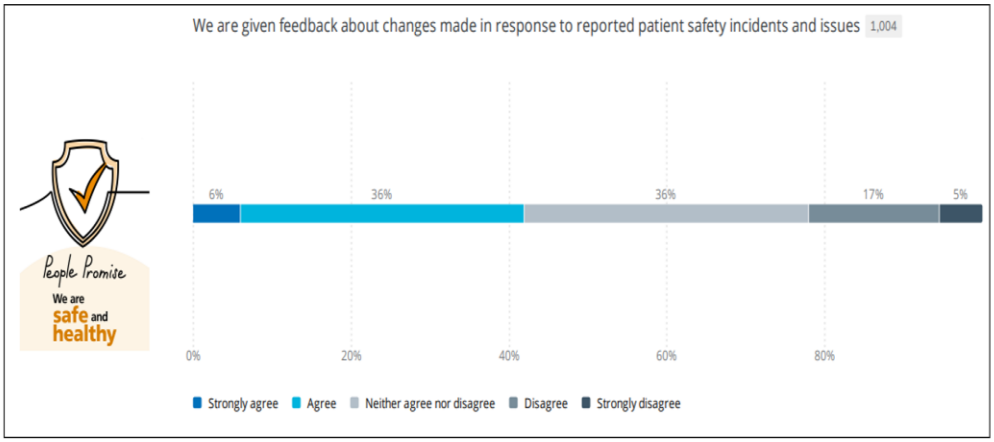
All this work resulted in a successful transition with no reduction in patient safety event reporting seen since the introduction in November 2023.

Implement the new Patient Safety Incident Response Framework (PSIRF)	The Trust developed a Patient Safety Incident Response Plan (PSIRP) in November 2023 in line with national timescales. The Patient Safety Incident Response Framework (PSIRF) is a fundamental cultural safety change in the way we think, report and investigate incidents. Our Patient Safety Incident Response Plan, based on the NHS framework, focuses on learning and improvement. It is built on a culture in which people feel safe to talk, and we will be working in partnership with patients to improve. Details of the patient safety priorities set out in the plan are provided in the Patient Safety section of the Quality Account. A summary "Plan on a Page" is provided below: 

Improve safety culture	A main objective for 2023/24 was to look at safety culture within the organisation and establish new frameworks for measuring and developing our improvement journey as part of Patient First. We set about reviewing safety culture in four ways: **Measuring improvement through the National Staff Survey**. More details are provided later in the report, but the good news is that safety culture scores improved significantly in the 2023 survey versus the previous year. The results were also better than the national average. For question 25a "Care of patients is my organisations top priority" the Trust scored 76.20% which was above the national average score of 74.83%. It was also an increase from the 2022 survey result of 72.9%. **Developing our own safety culture questions to the NHS People Pulse survey.** We included the following questions in our People Pulse Survey in Quarter 4 of 2023/24: • My organisation treats staff who are involved in a patient safety incident fairly • My organisation encourages us to report issues or incidents of patient safety • When patient safety incidents are reported, my organisation takes action to ensure that any improvement and learning is taken and shared • We are given feedback about changes made in response to reported patient safety incidents and issues The results were as follows: 







Supporting Culture Champions conversations – The BIG UHD Conversation

In March 2024, we asked our Culture Champion team to go out and about and talk to staff about safety culture. They asked staff six questions:

1. My organisation treats staff who are involved in an error, near miss or incident fairly - Agree/Disagree. 77% of staff who responded agreed. Comments included "*When I made a mistake I felt supported and it was a learning opportunity rather than a punitive exercise*".

	2. My organisation encourages us to report errors, near misses or incidents - Agree/Disagree. 100% of staff who responded agreed. Comments included *"In the past year there has been increased awareness and campaign around reporting incidents, so people are aware of how to report, why and when and the importance of reporting".* 3. When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again - Agree/Disagree. 77% of staff who responded agreed. Comments included *"If there has been an error we have received training around the topic", "Every time a Datix is submitted it is acknowledged by the seniors and tried to change practice", "an IV drug error was made last year and was discussed as a whole team".* 4. We are given feedback about changes made in response to reported errors, near misses and incidents - Agree/Disagree. 65% of staff who responded agreed. Examples included team meetings, noticeboards, team briefings and individual feedback. 5. I would feel secure raising concerns about unsafe clinical practice - Agree/Disagree. 92% of staff who responded agreed. Comments included "*I am happy to raise concerns with anyone, this may be through just talking or giving a nudge in the right direction. We are all here for the patient, and their safety is the most important thing."* 6. I am confident that my organisation would address my concern - Agree/Disagree. 62% of staff who responded agreed. Comments included "*Depends on the situation, concerns raised on the ward are addressed and escalated".* Further work with the UHD change/culture champions will be undertaken in 2024/25. **Implementation of a UHD version of the Manchester Patient Safety Framework - UHD PSaF** Measuring and improving safety culture within teams and across the trust is a key component of our Patient First strategy and Patient First objectives.

	 We have adapted some of the language used in the original 2006 Manchester Patient Safety Framework tool to create a bespoke UHD Patient Safety Assessment Culture Toolkit. The UHD PSaF Tool links to the UHD Trust values and Patient First objectives and will support staff to think about the strengths and weaknesses of the patient safety culture in their teams and consider what a more mature safety culture might look like. Teams will then use patient first improvement methodology to look at areas for improvement and to share good practice. We have started to test the new tool with a few pilot areas and aim to roll out wider across the Trust over the next 12 months. We are really excited about this project and have been approached by NHS England to share initial learning as part of a national case study.
Improve patient safety education and training	We have enhanced staff training and awareness about patient safety and patient safety learning in several ways during 2023/24: **National Patient Safety Syllabus Level 1** We made this training mandatory for all staff as part of essential core skills training. The training was adopted on the 1 March 2024 and by the end of the month 46% of staff had completed the on-line module. We are aiming for 100% uptake during 2024/25. **Patient Safety Incident Investigation Training** In February and March 2024, we commissioned two four-day patient safety investigation training courses for key staff (clinical and non-clinical). 30 staff successfully completed the course. This gives us an excellent platform and resource to support implementation of the new Patient Safety Incident Response Framework. Further training sessions will be provided during 2024/25. **Patient Safety Team News and Learn at Lunch** We have used Core Brief and other forums to promote the Patient Safety leads across UHD.

We have also introduced monthly Learn at Lunch sessions to discuss key topics. The sessions were launched in February 2024 and have been well attended with great engagement and feedback from staff.

Our UHD Safety Crew are hosting a series of monthly sessions this year on safety issues. The interactive sessions are suitable for all of Team UHD, as we are all part of the Safety Crew. You can use them for personal CPD points too. We hope to see you there #UHDSafetyCrew

Tuesday 6 February 2024

Learn at lunch with the Patient Safety Crew

Join us at 12.15pm tomorrow, **Wednesday 7 February,** for the first 'Learn at lunch' session hosted by our Patient Safety Crew.

The team will be presenting a series of monthly sessions this year on safety issues, with the first one focusing on **'What is patient safety and how can we measure it'**. It will be hosted on Teams by Dr Sean Weaver, our medical director for safety and quality.

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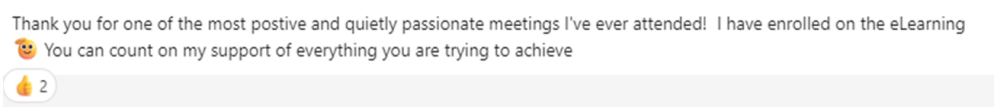

A full programme of Learn at Lunch sessions have been planned for 2024/25 with topics including:

- Safety Language – an A to Z
- How Human Factors is Essential to Patient Safety
- Clinical Simulation for Patient Safety
- Quality Statements – how they support safety and quality

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<td>Respond to national patient safety alerts</td>
<td>We have responded to all National Patient Safety Alerts in 2023/24 and achieved all relevant action plans and timescales.

Regular reports on actions related to published alerts are provided to the Medical Devices Group, Clinical Governance Group, Trust Management Group and Quality Committee.</td>
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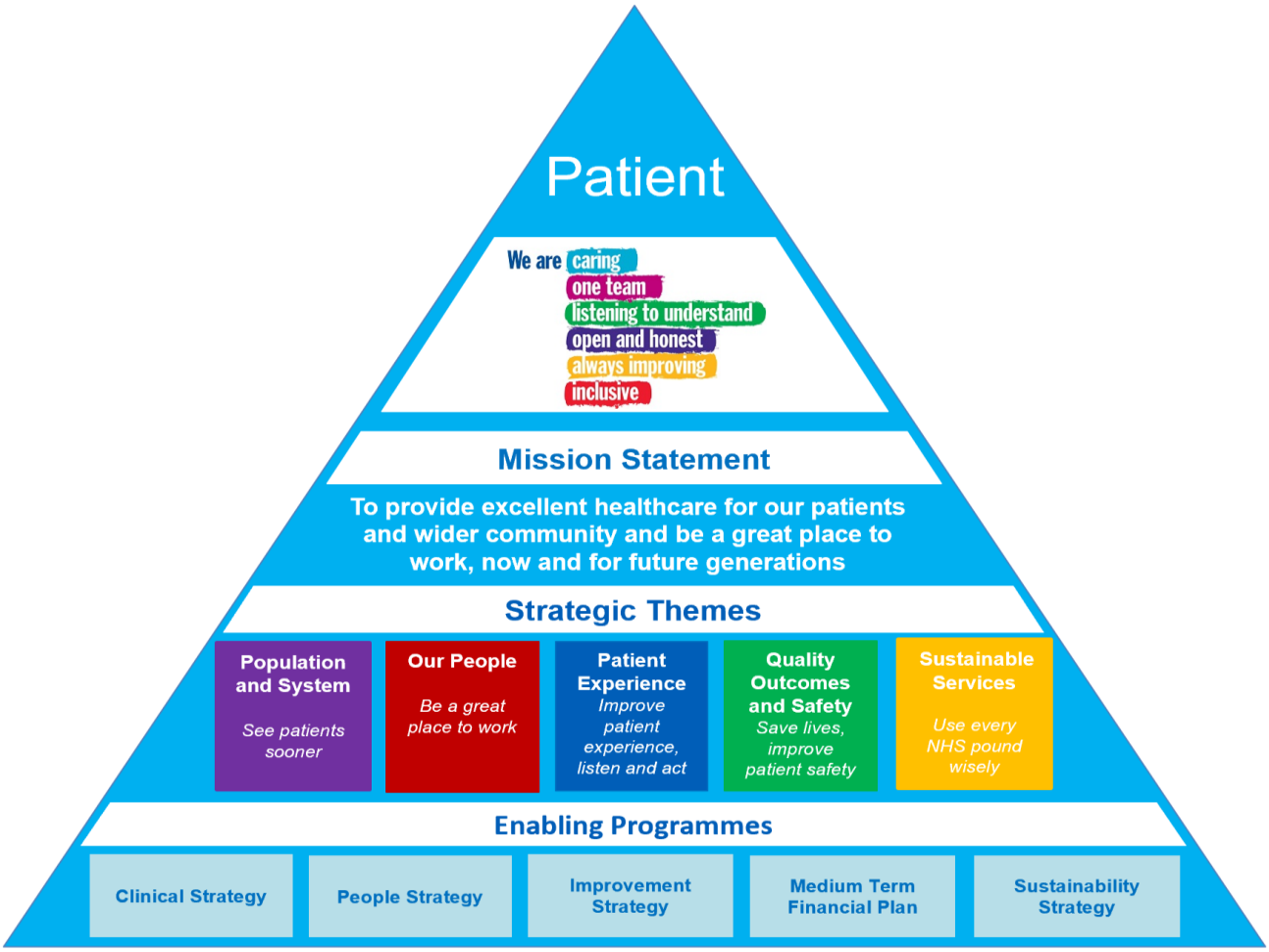
	During 2023/24 the Trust processes for responding to National Patient Safety Alerts was audited by NHS Dorset. The audit concluded '*This has been a positive audit; substantial assurance was obtained in response to your Patient Safety Alerts'.*
Prioritise patient safety improvement	In 2023/24 we introduced Patient First as our UHD Improvement Strategy. Patient First is a systematic approach to improvement led delivery of quality that will help build upon UHD strong foundations and what works well within the organisation. It will refresh our culture of excellence and further develop *the way we do things around here*. At its heart is an acknowledgement that when staff thrive, our patients experience sustained improvements in the quality and experience of their care. Our Patient First Improvement Strategy adopts the following principles:  The principles have helped shape our quality and safety objectives for 2023/24 and 2024/25.
The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system.	Patient Safety Partners are an essential part of the UHD Patient Engagement strategy. We have appointed Patient Partners to support a wide range of activities across the Trust including patient safety and patient experience. We look forward to developing the role of the PSP further in 2024/25 and working with them to support compassionate engagement as part of our Patient Safety Incident Response Plan.
Develop and implement a UHD Clinical Audit plan for 23/24.	A Clinical Audit plan for 2023/24 was approved by the Audit Committee and Trust Management Group in May 2024. Details of improvements made following the completion of national and local clinical audits are provided in the statements of assurance section of the report.

Our quality priorities for 2024/25

Our quality priorities for 2024/25 are part of a wider strategy that focuses on improvement and better supporting staff to put our patients at the forefront of everything we do.

Our 'Patient First' journey will be over the next three to five years and starts with setting our ambition high and recognising our current realities. 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 2024/25 trust objectives are based upon the five strategic themes:

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

For Quality our overarching objective is:

QUALITY OUTCOMES AND SAFETY	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios - SMR) and patient safety (Patient Safety Incidents - PSIs)

For Patient Experience it is:

PATIENT EXPERIENCE	All patients at UHD receive quality care, which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change

Specific breakthrough objectives for the next 12 – 18 months are:

Patient Experience

- **A 5% improvement in employees who see patient care as top priority for UHD**
- **To increase the Friends and Family Test (FFT) and Have Your Say (HYS) Feedback rates by 30%**

Quality Outcomes and Safety

- **HSMR less than 100**
- **Improve Staff Survey questions by 5%**
- **Implement UHD SaF**

To help us get there we have established eight organisational wide and/or complex projects. They all need to deliver within one to two years to enable us to deliver our strategy. They are, each in their own right, a 'blockbuster' programme with their own governance and projects. All are overseen by the Trust Management Group (TMG) the most senior operational group in the Trust.

The corporate project **Building a UHD Safety Culture in 2024/25** will include:

- Development of a new patient safety strategy for UHD which focuses on using the experiences of staff and patients to identify opportunities for learning and improvement.

- Development of transitional plans, guidance and tools to support the implementation plan for the new Patient Safety Incident Response Framework (PSIRF)

- Further work to develop and embed compassionate engagement. We want to:
    - Improve the experience for patients and families whenever a patient safety incident occurs.
    - Support compassionate leadership and embed the language and principles of a Restorative Just Culture.
    - Work with system partners to undertake thematic reviews of patient safety across care pathways.
    - Train staff in investigation skills, report writing, communication and compassionate engagement skills and improvement methodologies.
    - Support staff involved in a patient safety incident and create safe spaces for open and honest reporting and learning.

- Focused work on our Patient Safety Incident Response Plan priorities for the next 12-18 months. As set out in the Plan, we will focus in particular on:
    - Patient falls
    - Medication safety
    - Hospital Acquired Pressure ulcers
    - Diagnostics processes, specifically the follow up of Radiology and laboratory investigations
    - Deteriorating patient management, including implementation of Marthas Rule
    - Mental health (management and reducing restrictive interventions)
    - Post-partum haemorrhage
    - Unexpected term admission to neonatal intensive care (NICU)
    - Still births

    We will be looking for themes and interconnected causal factors. This way, we aim to reduce repeat patient safety risks and focus on the quality, rather than the quantity, of patient safety investigations. Investigations will be viewed as improvement projects with clear plans. We will develop additional feedback mechanisms to share learning and improvement across the Trust and within the wider community.

- Engaging with patients, carers, relatives and Patient Safety Partners in our improvement and learning responses to patient safety incidents and we will provide.

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 2023/24 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 2023/24 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2023/24.

2. Participation in clinical audit

During 2023/24, there were 53 national clinical audits and 4 national confidential enquiries which covered relevant health services that University Hospitals Dorset NHS Foundation Trust provides. During that period, University Hospitals Dorset NHS Foundation Trust participated in 95% of national clinical audits and 75% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that University Hospitals Dorset NHS Foundation Trust participated in, and for which data collection was completed during 2023/24 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits for Inclusion in Quality Report 2023/24	Eligible	Participated in 2023/24	% of cases submitted	Purpose of audit
Adult Respiratory Support Audit	Y	Y	100%	The aim for this audit was to capture data on patients outside critical care that have required respiratory monitoring or intervention, with a view to better understanding variations in clinical practice and outcome.
BAUS Nephrostomy Audit	Y	Y	100%	The audit will collect data on the management and outcomes of patients undergoing primary insertion of nephrostomy for an infected, obstructed, kidney in the emergency setting and identify variation in the nephrostomy pathway and its effect on the patient outcome.
Breast and Cosmetic Implant Registry	Y	Y	100%*	The registry collects data on all types of breast implant and explant (removal) surgery. This includes revisions and reconstructions, such as temporary tissue expanders.
British Hernia Society Registry	N	N	The audit is still in its pilot stage	
Case Mix Programme	Y	Y	100%*	The CMP is an audit of patient outcomes from adult general critical care units.
Cleft Registry and Audit Network Database	N	N		
Elective Surgery (National PROMs Programme)	Y	Y	95%*	Patient reported outcome measures (PROMs) surveys patients before and after surgery for the following planned procedures; 1) Hip replacement 2) Knee replacement

Emergency Medicine QIPs - Care of Older People	Y	N	For the 2022/23 round, the QIP audit information packs were published after the beginning of the data collection period. This meant there was not enough time to implement the new data points.	Identify current performance in Eds against nationally agreed clinical standards and show the results in comparison with other departments.
Emergency Medicine QIPs - Mental health self-harm	Y	N	As above	As above.
Epilepsy 12 - National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	173 cases were submitted for UHD, of which 26 had epilepsy (no % case ascertainment available)*	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	18%*	Measure against NICE technology assessments and guidance on osteoporosis and clinical standards for FLSs.
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Y	Y	100%	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals.
Falls and Fragility Fracture Audit Programme – National Hip Fracture Database	Y	Y	943 cases submitted, (no case ascertainment data in report) *	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.
Improving Quality in Crohn's and Colitis (IQICC)	Y	Y	Not available. Data uploaded until the IBD registry was closed in Jan 2024	The IBD Registry's Improving Quality in Crohn's and Colitis (IQICC) tool is an easy-to-use online data support tool to simplify collecting data for the new IBD clinical Key Performance Indicators (KPIs).

Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Y	Y	100%	Programme to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice.
Maternal and Newborn Infant Clinical Outcome Review Programme	Y	Y	100%	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies
Mental Health Clinical Outcome Review Programme	N	N		
National Adult Diabetes Audit - National Diabetes Footcare Audit	Y	Y	100%	Measures the effectiveness of diabetes care compared to NICE guidance.
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Y	Y	100%	As above.
National Adult Diabetes Audit - National Pregnancy in Diabetes Audit	Y	Y	100%	As above.
National Adult Diabetes Audit - National Diabetes Core Audit	Y	N	The trust is unable to upload data currently to the audit following decommissioning of Diabeta. IT are looking into an alternative solution	As above.
National Asthma and COPD Audit Programme – COPD Secondary Care	Y	Y	100% (749 cases)*	Aims to improve the quality of care, services and clinical outcomes for patients with asthma and chronic obstructive pulmonary disease (COPD).
National Asthma and COPD Audit Programme – Pulmonary rehabilitation	Y	Y	100%	As above.
National Asthma and COPD Audit Programme – Asthma adult in secondary care	Y	Y	100%	As above.

National Asthma and COPD Audit Programme – Children and Young People's Asthma Secondary Care	Y	Y	100%	As above.
National Audit of Cardiac Rehabilitation	Y	Y	100%*	Aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live
National Audit of Cardiovascular Disease Prevention	N	N		
National Audit of Care at the End of Life	Y	Y	100%*	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	100%	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	100%	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 Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Y	Y	100%	This audit will look at the care that patients are receiving for metastatic (secondary) breast cancer in England and Wales, in order to identify any shortfalls, and try to work out how to improve them.

National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Y	Y	100%	The audit aims to bring information all together for the first time, for a comprehensive analysis of all aspects of breast cancer care in England and Wales, whilst protecting patient anonymity.
National Cardiac Arrest Audit	Y	Y	100%*	Audit of in-hospital cardiac arrests in the UK and Ireland.
National Cardiac Audit Programme - National Adult Cardiac Surgery Audit	N	N		
National Cardiac Audit Programme - National Congenital Heart Disease	N	N		
National Cardiac Audit Programme - National Heart Failure Audit	Y	Y	100%	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 Audit of Cardiac Rhythm Management	Y	Y	100%*	As above.
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Y	Y	100%*	As above.
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	100%*	As above.
National Cardiac Audit Programme (NCAP): National Audit of Mitral Valve Leaflet Repairs (MVLR)	N	N		
National Cardiac Audit Programme (NCAP): The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N	N		

National Child Mortality Database	Y	Y	100%	The National Child Mortality Database (NCMD) records comprehensive, standardised information collected by local the Child Death Overview Panels (CDOPs) as part of the Child Death Review (CDR) process.
National Clinical Audit of Psychosis	N	N		
National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusion against NICE Quality Standard 138	Y	Y	100%	The objective of the programme is to provide evidence blood is being ordered and used appropriately, administered safely, to highlight where practice is deviating from guidelines to the possible detriment of patient care.
National Comparative Audit of Blood Transfusion: 2023 Bedside Transfusion Audit	Y	Y	100%	As above.
National Early Inflammatory Arthritis Audit	Y	Y	100%*	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	<50%	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales
National Gastrointestinal Cancer Audit Programme: National Bowel Cancer Audit	Y	Y	100%	A high-profile, collaborative, national clinical audit for bowel cancer, including colon and rectal cancer.

National Gastrointestinal Cancer Audit Programme: National Oesophago-gastric Cancer	Y	Y	100%	The audit evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.
National Joint Registry	Y	Y	100%	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety
National Lung Cancer Audit	Y	Y	100%	Measure lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best
National Maternity and Perinatal Audit	Y	Y	100%	Evaluates a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.
National Neonatal Audit Programme	Y	Y	100%	The NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high-quality care, and identify areas for quality improvement.
National Obesity Audit	N	N		
National Ophthalmology Database Audit: National Cataract Audit	Y	Y	TBC	Project includes large-scale audit for both cataract surgery and age-related macular degeneration
National Paediatric Diabetes Audit	Y	Y	235 cases submitted, no % case ascertainment in report*	Audit of the care processes received and outcomes achieved by all children and young people attending paediatric diabetes units.

National Prostate Cancer Audit	Y	Y	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes.
National Vascular Registry	Y	Y	100%*	Established in 2013 to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals.
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N	N		
Paediatric Intensive Care Audit Network (PICANet) - Level 2 HDU	Y	Y	100% - awaiting first report publication	PICANet is a web-based audit database that records and stores the details of the treatment of critically ill children in paediatric intensive care units
Perinatal Mortality Review Tool	Y	Y	100%*	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units.
Perioperative Quality Improvement Programme	Y	Y	100%*	The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery.
Prescribing Observatory for Mental Health: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N	N		
Prescribing Observatory for Mental Health Audit Programme: Monitoring of patients prescribed lithium	N	N		

Sentinel Stroke National Audit Programme	Y	Y	100%	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	100%*	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety.
Society for Acute Medicine Benchmarking Audit	Y	Y	100%	A national benchmark audit of acute medical care. Provides a comparison for each participating unit with the national average (or 'benchmark').
Trauma Audit & Research Network	Y	Y	Completed	Analyses data of trauma care to improve emergency care management and systems.
UK Cystic Fibrosis Registry – Paediatric service	Y	Y	100%*	Non-identifiable Registry data is used to improve the health of people with cystic fibrosis through research, to guide quality improvement at care centres and to monitor the safety of new drugs.
UK Renal Registry Chronic Kidney Disease Audit	N	N		
UK Renal Registry National Acute Kidney Injury Audit	N	N		

*based on submission for previously reported round

National Confidential Enquiries for Inclusion in Quality Report 2023/24	Eligible to Participate	Participated in 2023/24	% of required cases submitted
Testicular Torsion	Yes	No	Nil
End of Life Care	Yes	Identification spreadsheet in progress	Not required at this stage
Endometriosis	Yes	Organisational Questionnaire submitted	Not required at this stage
Juvenile Idiopathic Arthritis	Yes	Awaiting UHD Organisational Questionnaire sign off	Not required at this stage

Learning from National Audits

The reports of 35 national clinical audits were reviewed by University Hospitals Dorset NHS Foundation Trust in 2023/24 and, as examples, the Trust has taken or intends to take the following actions to improve the quality of healthcare provided as a result:

- Sentinel Stroke National Audit Programme (SSNAP) - To fully implement and embed pre-alert process for stroke admissions from the ambulance services – completed.

- National Neonatal Audit Programme (NNAP) – To improve 'Deferred cord clamping for babies less than 34 weeks'. Additional equipment purchased and the cord clamping rates are already up for the unit.

- Saving Babies' Lives Element 3 - Raising Awareness of Reduced Fetal Movements Audit – UHD Reduced Fetal movements Guideline updated to advise that ultrasound scan is to be performed by next working day when patient attends with recurrent reduced fetal movements – completed.

- National Paediatric Diabetes Audit (NPDA) – Increase provision of insulin pump therapy and real time continuous glucose monitoring with alarms, to match national average – in progress.

- National Early Inflammatory Arthritis Audit (NEIAA) – Plan for all consultant to see all the referred patients with possible early inflammatory arthritis within 3 weeks of referral – in progress.

Learning from Local Audits

The reports of 217 local clinical audits were reviewed by the Trust in 2023/24. A few examples of improvements taken as a result of completed audits include:

- Audit of the Management of Neutropenic Sepsis –Meeting held with ED and AMU Sisters to discuss audit results and agree problem-solving solutions to improve door to needle time.

- Audit of Personalised Care and Support Plans for Cancer Patients – Training needs supported for Cancer Support Workers including Motivational Interviewing and Health Coaching

- Audit of Completion of Proforma in Reporting Early Invasive Anal Carcinomas – The Team now use the Royal College of Pathology template for reporting local excision specimens for anal carcinomas to improve documentation standards.

- Re-audit SBARs in Maternity – New mandatory field added to the Badgernet IT system to support improved recording.

- Audit of Apgars Less Than 7 at 5 Minutes of Age – The audit identified there was the potential for calculation errors in the APGAR scores. Improvement actions and additional teaching sessions have been implemented and a significant improvement has occurred.

- Re-audit of Women with a BMI>35 kg/m2 who are offered Ultrasound Assessment of Growth from 32 Weeks' Gestation Onwards. As a result of the audit a serial scan regime for raised BMI was advertised in the antenatal care area to ensure the correct patients are being booked for the relevant ultrasound.

- Re-Audit: Evaluation of Twins and Multiple Births Clinic (TAMBA). Raised awareness by the Sonography team to always have chronicity confirmed with a colleague.

- Re-audit Antenatal MEOWS (Modified Early Warning System in Obstetrics) Audit. A self-audit was introduced to all areas of maternity with a monthly review of individual areas and overall compliance.

- Reaudit of Endoscopy Procedure Room Turnaround Time – Turnaround time audit discussed in department meetings to inform Endoscopists and staff of potential morning delays causing delays to PM lists on a regular occasion - in progress.

- Traumatic Hemopneumothorax – Chest Wall Trauma Group in UHD was set up between OPS and Surgeons with radiology and acute pain lead from anesthetics with the aim to create a chest wall trauma pathway. This is to include a high index of suspicion for suspected trauma in older people, to consider CT chest in patients with chest wall trauma where there is a suspicion of rib fractures, haemothorax, reduced O2 sat, chronic lung conditions or anticoagulants. Frailty scoring will be considered as part of this.

- Bleeding Disorder Tags and Treatment Plans – New Critical Treatment Plan (CTP) developed to add to patients' records. For those patients under annual review with mild, moderate and severe bleeding disorders, this will be recorded on the top of every haematology clinic letter in the form of current medication, bleeding dose, head injury dose and tranexamic acid dose – in progress.

3. Participation in clinical research:

Recruitment at UHD is recovering post the pandemic. Recruitment at UHD was 4258 in the financial year, with an additional 97 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 2023/24 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. University Hospitals Dorset NHS Foundation Trust is yet to receive a rating by CQC for its services or hospital locations.

The CQC undertook short notice announced focused inspections to urgent and emergency care services (Emergency Departments at Poole Hospital and Royal Bournemouth Hospital) as well as Outpatients at Poole Hospital and the Outpatients Assessment Clinic at Dorset Health Village on 27 and 28 June 2023. The CQC focused on the key questions of well-led, safe and responsive for these services as well as caring for urgent and emergency services at both hospitals. As it was a focused inspection, no ratings were produced.

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

- Not everyone could access services in a timely and clinically safe way, with some remaining in the departments for much longer than necessary.
- Inspectors saw some people who needed to remain in the emergency department because there were no porters available to transfer them to a ward causing a blockage. This blockage meant new people waiting to come into the department for treatment were delayed. This caused lengthy delays for ambulance crews waiting to handover people to the hospitals meaning other people in the community were waiting longer for care and treatment from the emergency services.
- The layout of the departments meant staff could not see everyone in the waiting area, making it difficult to spot if people's health was deteriorating. There were some mitigations put in place, such as a live camera feed for reception staff, but it was not monitored consistently.
- There was not always a dedicated space for young people and their families, meaning children were not always protected or removed from seeing and hearing adults using services, some with complex needs.
- Neither reception was fully accessible or suitable for wheelchair users. Inspectors observed wheelchair users attempting to stand to be seen and heard by reception staff which was unsafe.
- People's records were not always consistently completed in full or easily accessible, but a new record system had just been installed and as being rolled out.
- There was enough suitably trained staff to care for people safely, most of the time but staff skill mix and experience wasn't always optimally balanced.

Positively inspectors did find that:

- Staff and managers worked hard to prioritise people in terms of clinical need well, and there was a clear understanding of everyone's needs and reasons for delays.
- There was exceptional teamwork across all staff groups, which was highly valued by all staff.
- Staff received training specific for their role on how to recognise and report abuse. They could give examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act.
- 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 outpatient services at Poole Hospital and the Outpatients Assessment Clinic, inspectors found:

- There was enough suitably qualified staff to care for people safely.
- People could not always access the service when they needed it and had long waits for treatment putting their health at risk of deteriorating.
- Services used multiple information systems as well as paper records for triage and booking of appointments which meant there was a reliance on staff to ensure tracking of appointments.

Inspectors found the following at all services:

- Managers monitored the effectiveness of services and made sure staff were competent.
- There was an open and honest culture where people could raise concerns.
- Staff were supported and trained in key skills and understood how to protect people from abuse, acting where necessary.
- Safety incidents were well managed, and lessons were learnt and shared to prevent them from happening again.
- Staff felt respected, valued, and proud to work in the organisation.
- It was easy for people to give feedback.
- Staff were kind, compassionate and caring.

The Trust has developed detailed action plans to address the issues highlighted in the reports. The Trust Management Group ensure actions are progressed and completed and assurance is provided to the Quality Committee on a monthly basis.

Current CQC Ratings

Poole Hospital remains rated 'Requires Improvement and Royal Bournemouth Hospital remains rated 'Good' overall.

Rating : Poole site
CQC Inspection September 2022 : report published 8 March 2023

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Medical care (including older people's care)	Requires improvement →← Mar 2023	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Surgery	Requires improvement →← Mar 2023	Requires improvement ↓ Mar 2023	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Mar 2023
Critical care	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Maternity	Inadequate ↓ Mar 2023	Good Jan 2020	Outstanding Jan 2020	Outstanding Jan 2020	Inadequate ↓↓ Mar 2023	Inadequate ↓↓ Mar 2023
Services for children and young people	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
End of life care	Good →← Jan 2020	Good →← Jan 2020	Outstanding ↑ Jan 2018	Good →← Jan 2020	Good ↑ Jan 2020	Good →← Jan 2020
Outpatients	Good May 2016	N/A	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Overall	Requires improvement →← Mar 2023	Good →← Mar 2023	Outstanding ↑ Jan 2020	Good →← Jan 2020	Requires improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023

***Rating :* Bournemouth site**
CQC Inspection September 2022 : report published 8 March 2023

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018
Medical care (including older people's care)	Requires improvement ↓ Mar 2023	Good →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018
Surgery	Requires improvement ↓ Mar 2023	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Critical care	Good Mar 2016	Good Mar 2016	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016
Maternity	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018
Services for children and young people	Good Feb 2016	Good Feb 2016	Outstanding Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Outpatients	Good Feb 2016	N/A	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Overall	Requires improvement ↓ Mar 2023	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018

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. In addition, during 2024/25 we will ensure:

- Completion of a baseline self-assessment against the new Care Quality Commission (CQC) Quality Statements for Well led
- Provision of briefing sessions to staff to raise awareness about the new CQC single assessment framework.
- Ensuring staff are aware of the new Quality Statements, evidence sources and assessment methodology that will be used for future inspections.
- Provision of resource materials to help teams discuss the new CQC methodology and help teams prepare for the new style inspections.
- Ensure ongoing monitoring of CQC action plans following inspections to address the issues highlighted in previous reports. The Trust Management Group and Quality Committee will ensure oversight of effectiveness of the actions identified.
- Horizon scan reports published by external bodies such as the CQC, NHS England and Health Services Safety Investigations Body, to learn from others and aim for continuous improvement. External reports and reviews on our services, and the services of others, are 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.
- Develop and implement quality assurance, peer review and ward accreditation processes to support assurance against Quality Statements

6. Data Quality

The University Hospitals Dorset NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS number was 99.9% for admitted patient care; 100% 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 100% for admitted patient care: 100% for outpatient care; and 99.8% for accident and emergency care. (Taken from the National M12 23-24 SUS DQ report)

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

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

7. Data Security and Protection Toolkit attainment levels

All NHS trusts are required to complete an annual information governance assessment via the Data Security and Protection Toolkit (DSPT). This replaced the Information Governance Toolkit from April 2018 onwards. The self-assessment must be submitted to NHS England by 30 June each year.

The following section provides details of the 23/24 DSPT submission at the end of May 2024.

The Data Security and Protection Toolkit (DSPT) is a self-assessment audit completed by every NHS Trust annually and submitted to NHS England; the purpose being to assure an organisation's Information Governance practices through the provision of evidence around numerous assertions which change slightly each year.

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

During 2023/24, the Trusts aim is to achieve compliance with all of the mandatory assertions by the end of June 2024. To date, the Trust has yet to complete its assessment for 2023/24, however it is expected that the submission will be fully compliant by this date.

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.

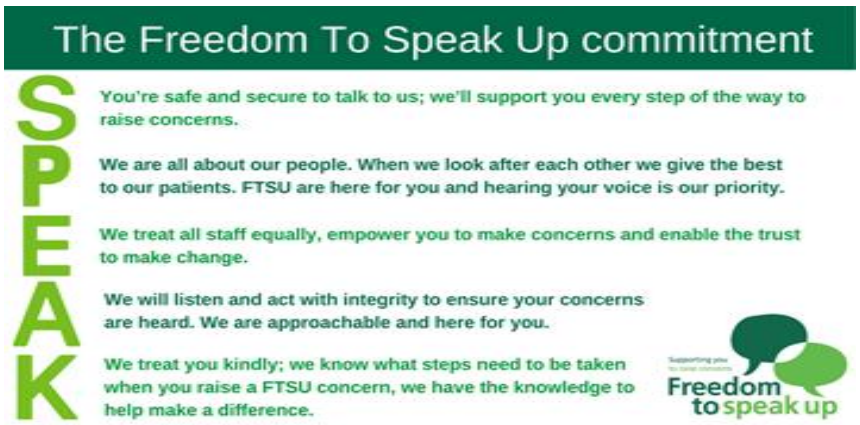
Once any death is categorised as grade 2 or 3, a LERN Form is completed and a patient safety incident investigation is undertaken to identify learning and actions for improvement.

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 patient safety investigation.

The Trust has a multi-disciplinary Mortality Surveillance Group (MSG), chaired by the Medical Director for Quality, 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.

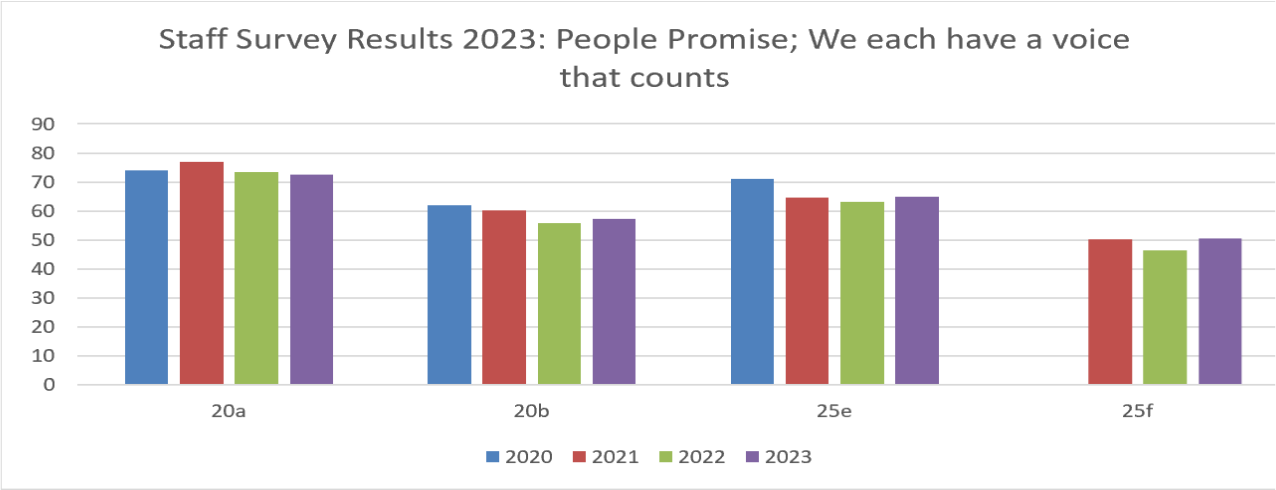
Themes for action and learning from mortality reviews and investigations have linked to the development of patient safety incident response plan priorities and patient first quality improvement initiatives for 2024/25.

9. Freedom to Speak Up



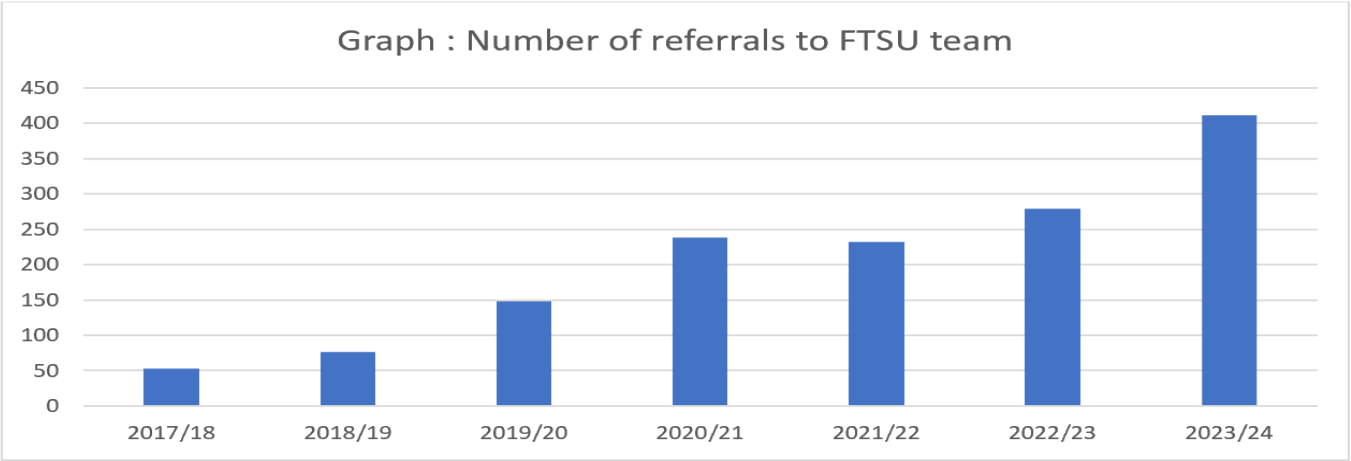
'Speaking up' benefits everyone. Building a more open culture in which leadership encourages learning and improvement, leads to safer care and improved patient experience. At UHD, we have many routes that staff can use to speak up including our line managers, occupational health, staff governors, using 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 who use it.

Speaking up is entrenched within our objectives, strategy and improvement programme. This year, over 5600 staff shared their voice through the staff survey: 59% of UHD. This rich data tells us that over 50.63% staff feel our speaking up culture has improved from 2021 when only 46.31% felt the same. This is nearly a 10% increase from the previous 12 months and will contribute to our safety culture breakthrough objective for quality outcomes and safety.



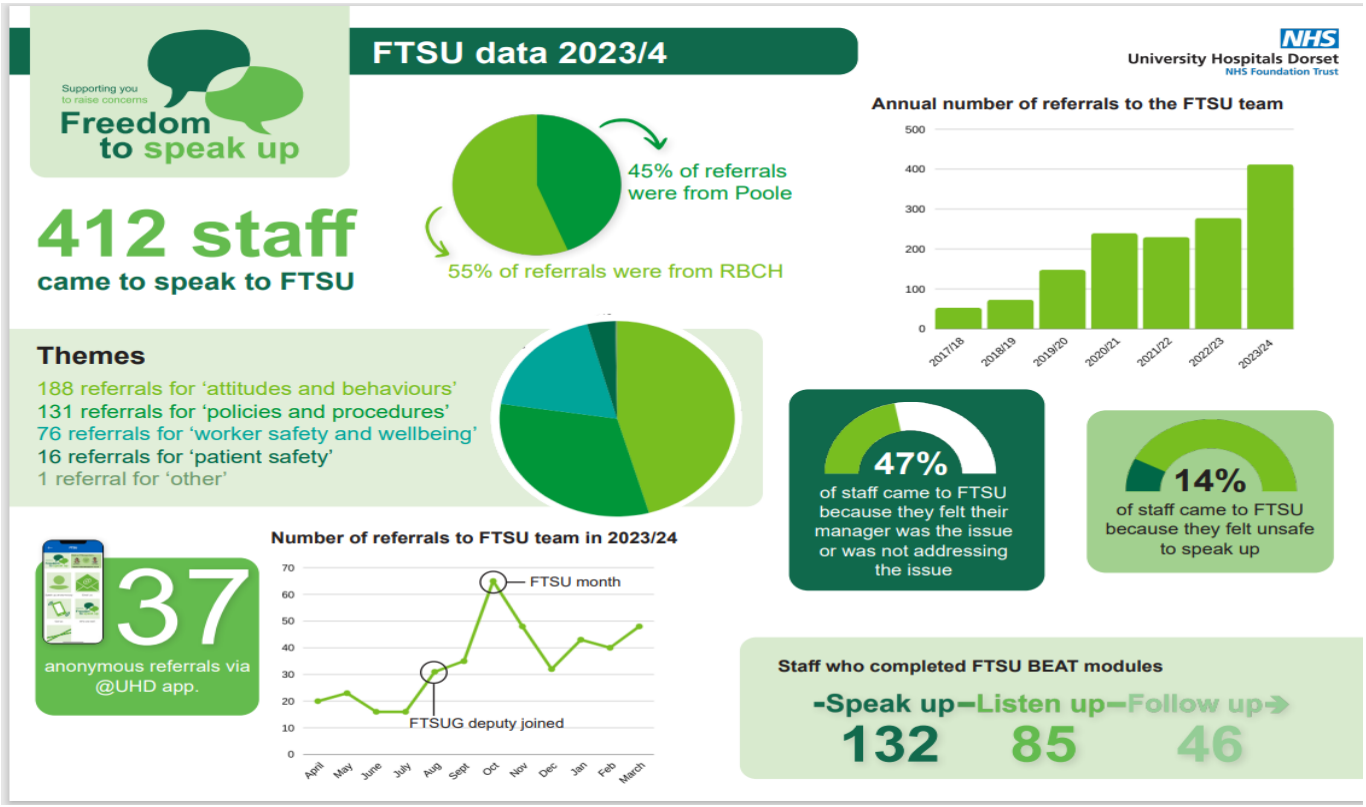
Q	Speaking up - clinical safety
20a	I would feel secure raising concerns about clinical practice
20b	I am confident that my organisation would address my concern
	Speaking up -raising concerns
25e	I feel safe to speak up about anything that concerns me in this organisation
25f	If I spoke up about something that concerned me, I am confident my organisation would address my Concern

412 staff raised concern with the FTSU team during 2023/4. This is an increase of 48% on previous 12 months.



The largest themes raised by staff is issues relating to behaviours and attitudes (188 staff; 46%) followed by process and procedures (131 staff; 32%) and then worker safety and wellbeing (76 staff; 18%).

Staff use the F2SU route more for workplace and relational issues than patient safety. Learning includes the need to develop a respective and civil workplace based on psychological safety principles. Work is underway with the development of behavioural frameworks, leadership behaviours, information/tools on our intranet and our patient first improvement programme.



The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. Our leaders, need to play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture at UHD. Indeed, it is the experience of how our managers listen and act to concerns that we are often judged. Consequently, we need to be curious as to why staff choose not to go to their line manager. Over the last 12 months, 47% of staff who come to the FTSU team say that they cannot go to their line manager because either they are the issue or that they are not addressing it. We need to get better at this for us to be an embedded speaking up organisation. Our safety culture work and patient first improvement journey will support this and will allow a focus on leadership for safety, communication and team working.

The UHD Guardian of Safe Working Hours Annual Report (January – December 2023) was presented to the Board of Directors in May 2024.

We are #TeamUHD

Speaking up has never been as important as it is today and yet whilst improving, staff tell us that we do not address concerns nor make people feel safe to raise them. It is both futile and results in fear.

At UHD, it is everyone's business to encourage speaking up and to do this we need leaders to create psychologically safe working environments where every voice is heard, celebrated and action occurs.

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 2023 – December 2023 0.8682 January 22 – December 22 0.8916	1.000 1.000	1.2548 1.2186	0.7202 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 2023 – December 2023 32% January 2022 – December 2022 41%	42% 40%	67% 65%	16% 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	22/23 and 23/24 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 2022 – March 2023 (i) = 14.2% (1185) (ii) = 12.0% (7535) April 2021 – March 2022 (iii) = 14.0% (1090) (iv) = 13.1% (8565)	 12.0% 11.8% 12.5% 12.0%	 302.9%** 489.1%** 46.9% 142.0%**	 1.3% 0.8% 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	2023 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%	66.9%	89.5%	43.6%
		2022 – 64.2%	61.9%	86.4%	39.2%
		2023 – 67.3%	63.3%	88.8%	44.3%
The Trust considers that this data is as described for the following reason. The exercise is undertaken by an external organisation with adherence to strict national criteria and protocols.					
University Hospitals Dorset NHS Foundation Trust intend to take the following action to improve this percentage, and so the qualities of its services, by implementation of a detailed action plan. The results of the survey have been presented to the Workforce Committee (a sub-committee of the Board of Directors) and key actions agreed.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The rate per 100,000 bed days Of cases of C difficile infection reported within the trust during reporting period.	Public Health England (PHE)	2020/21 – 10.49 per 100,000 overnight bed days	15.79	80.65	0
		2021/22 – 9.6 per 100,000 overnight bed days	16.46	53.62	0
		2022/23 – 16.5 per 100,000 overnight bed days.	18.48	73.34	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 as part of the Integrated Performance Report.					
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.					

Part 3 – Other information

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 following section provides an overview of the performance in 2023/24 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.

SAFETY

Patient Safety Incident Response Framework and UHD Plan

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as “a foundation for change” and as such, it challenges us to think and respond differently when a patient safety incident occurs.

PSIRF is a fundamental cultural safety change in the way we think, report and investigate incidents. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement.

PSIRF and the responsibility for the entire process, including what to investigate and how, is down to our Trust as a whole. There are now no set timescales or external organisations to approve what we do. There are a set of principles that we need to work towards but outside of that, it is up to us to agree and approve what is the right direction for finding the learning from each Patient Safety incident and this will be done in several ways.

In the past if it was approved to investigate, often, we meant learning as understanding on what had happened but there is much more that can be detailed from an investigation.

The exciting change of implementing PSIRF is that we will focus on improving our approach to patient safety incidents and develop a culture in which people feel safe to talk.

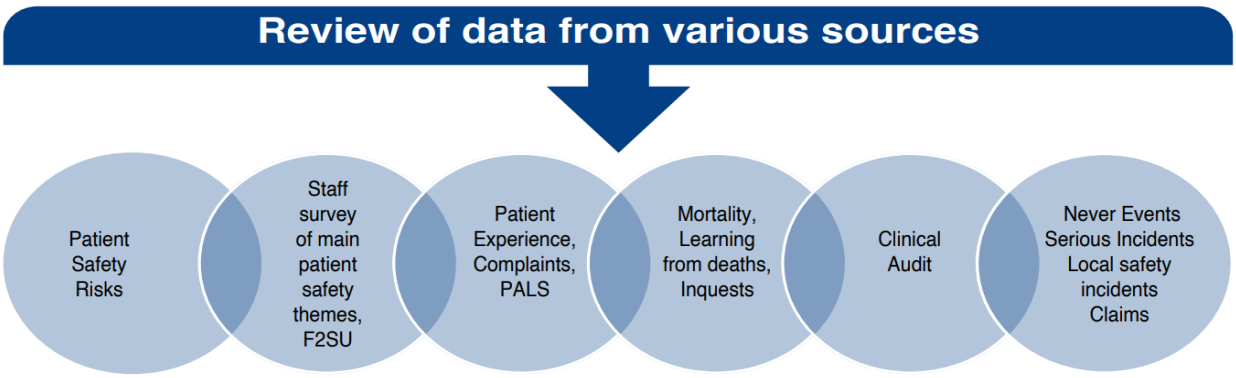
We will support our core ambition of working in partnership with patients to improve and it is important to recognise that if there are good reasons to carry out an investigation we will continue with the newly developed tools and thinking of PSIRF. With sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation.

Moving forward with compassionate engagement and moving forward with this journey to develop the safety science of psychological safety, behavioural and human factors that will continue to evolve our organisation and not only continue to learn but share that learning with patients and staff, stakeholders and the NHS as an organisation we are very excited.

PSIRF fits with our continuous improvement journey Patient First as follows:

Trust objective	Patient First theme	PSIRF objective
Improve patient experience, listen and act	Patient experience	Improve the experience for patients and families whenever a patient safety incident occurs.
Save lives, improve patient safety	Quality	Reduce harm from patient safety incidents through learning and improvement.
Be a great place to work	Our people	Support compassionate leadership, just culture and learning for improvement. Create a safe environment for staff to raise concerns and ensure staff receive feedback on action taken when they do. Improve our Staff Survey scores for safety culture.
Work as one team, fit for future changes	One team	Work with system partners to undertake thematic reviews of patient safety across care pathways.
See our patients sooner	Population and health system working	Improve the safety and care we provide to our patients.
Use every pound wisely	Sustainable services	Maximise our resources to support quality and safety.
Start our Patient First Journey	Patient First Programme	Train staff in improvement methodologies.

To identify our PSIRF Plan and patient safety priorities we looked at data from a various range of sources and stakeholders:



As a result of the analysis undertaken, we identified the following areas of patient safety priorities over the next 12-18 months:

PSIRP priority:
Improve the safety of the care we provide to our patients

Incident type	Speciality
Patient falls	Trust-wide
Medication (VTE)	Trust-wide
Pressure ulcers	Trust-wide
Diagnostics (follow up of radiology and laboratory investigations)	Trust-wide
Deteriorating patient	Trust-wide
Mental health (management and reducing restrictive intervention)	Trust-wide
Post partum haemorrhage	Maternity
Unexpected term admission to neonatal intensive care (NICU)	Maternity
Still births	Maternity

Our investigation and improvement response to each theme will be different (set out in detail in the plan) and will focus on maximising resources to seek early identification of learning outcomes and quality improvement.

We will be on a learning journey over the next 12-18 months as we implement our plans and processes under PSIRF. Part of this work involves establishing new quality dashboard reports using the new coding and categories of patient safety events under LFPSE and PSIRF.

Due to these national coding changes we are unable to provide any data comparisons to previous years, however the following tables provide some baseline information for 2023/24.

External reports (Serious Incidents) – Comparative themes year on year

The Trust reported 36 Serious Incidents in 2023/24 compared to 35 in 2022/23. The themes were similar in year although a slight increase in maternity incidents was noted. This was as a result in changes in mandatory reporting requirements and definitions in year.

Serious Incident Category (National Definitions)	22/23	Frequency/ month	23/24 to end March	Frequency/ month	Comparative frequency yr on yr to date
Maternity/Obstetric incident meeting SI criteria: baby only	1	0.1	6	0.5	⇧
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	12	1	10	0.8	⇧
Slips/trips/falls meeting SI criteria	3	0.25	2	0.2	ò
Medication incident meeting SI criteria	2	0.2	2	0.2	
Maternity/Obstetric incident meeting SI criteria: mother only	0	0	2	0.2	⇧
Sub-optimal care of the deteriorating patient meeting SI criteria	5	0.4	4	0.3	ò
Treatment delay meeting SI criteria	4	0.3	3	0.25	ò
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	0.1	0	0	ò
Pressure ulcer meeting SI criteria	2	0.2	1	0.1	ò
Surgical/invasive procedure incident meeting SI criteria	3	0.25	5	0.4	⇧
Pending review (EPR Outage)	1	0.1	0	0	ò
Blood Product/transfusion incident meeting SI Criteria	1	0.1	0	0	ò
HCAI/Infection control incident meeting SI criteria	0	0	1	0.1	⇧
Total	**35**	2.9	**36**	3.05	⇧

Patient Safety Incidents reported by PSIRF theme in March 2024

We have amending our LERN database to be able to record the PISRF Themes for each reported patient safety incident.

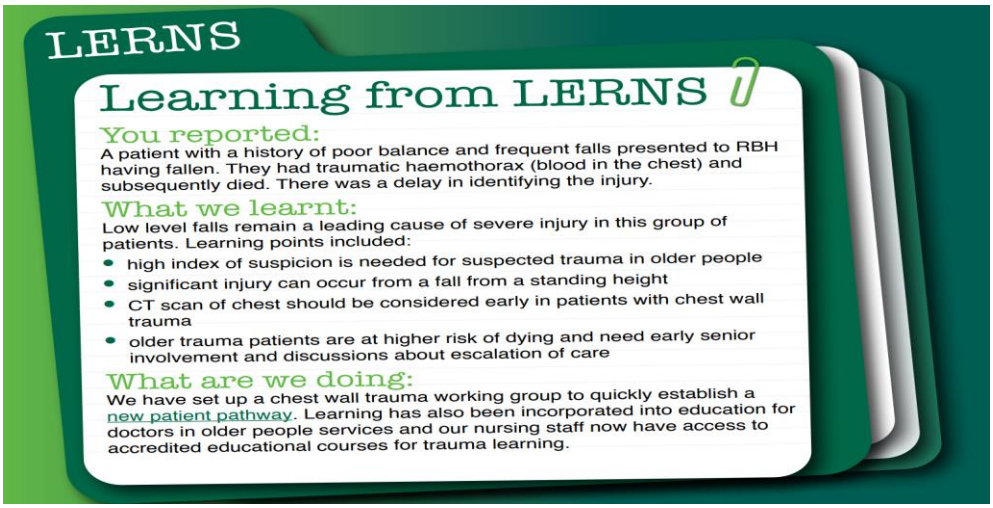
The following table shows the first quarter of data collection (1 January 2024 – 31 March 2024).

PSIRF Theme	January 2024	February 2024	Mar 2024
Deteriorating patient	51	45	46
Diagnostic- radiology/laboratory	89	70	60
Falls	189	181	188
Medication	122	134	149
Mental health	31	18	13
Other	363	283	340
Postpartum haemorrhage	13	15	10
Pressure ulcers	254	159	153
Stillbirth	0	0	0
Unexpected term admission to NICU	24	16	18
VTE	3	2	6

The patient safety theme is chosen at the time of reporting and can be updated by the 'reviewer' of the LERN. It is possible for a 'reviewer' to add a theme to an 'Other' safety event form which explains why the total is higher than the number of patient safety events reported.

Learning from patient safety investigations is shared in a number of different ways including:

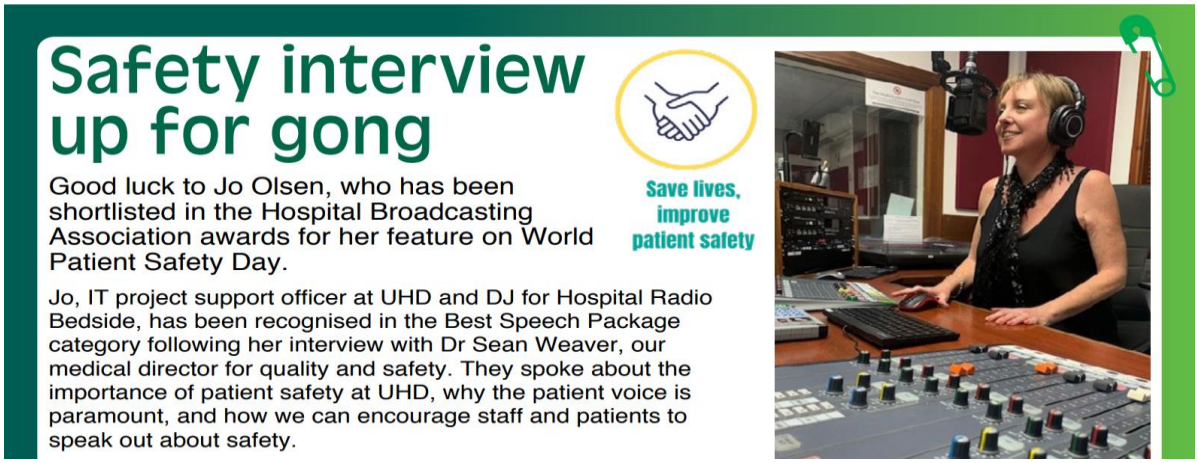
- Individual feedback (the LERN system provides an automatic response back to the reporter)
- Safety huddles
- Team, Care Group and Corporate newsletters
- Clinical governance, Quality and Risk meetings at various levels across the organisation
- The monthly Clinical Governance Group "Top 10" briefing
- SBAR Patient Safety Alerts
- Core brief articles



- Training sessions, ½ audit days, presentations and other learning forums

World Patient Safety Day

To raise awareness about patient safety, and support World Patient Safety Day, our Medical Director for Quality and Safety was interviewed live on air and broadcast across hospital radio. The hour-long session was very popular and was shortlisted for a national award.



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 2023 – 31 March 2024) the Trust reported 3 never events, this compares to 4 in 2022/23. According to NHS England published data, 345 Never events were reported by Acute Trusts in the period 1 April 23 – 29 February 24)

In all cases detailed investigations have been conducted and actions for improvement and learning implemented. Learning has also been shared across the system at the ICB Patient Safety Group.

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.

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

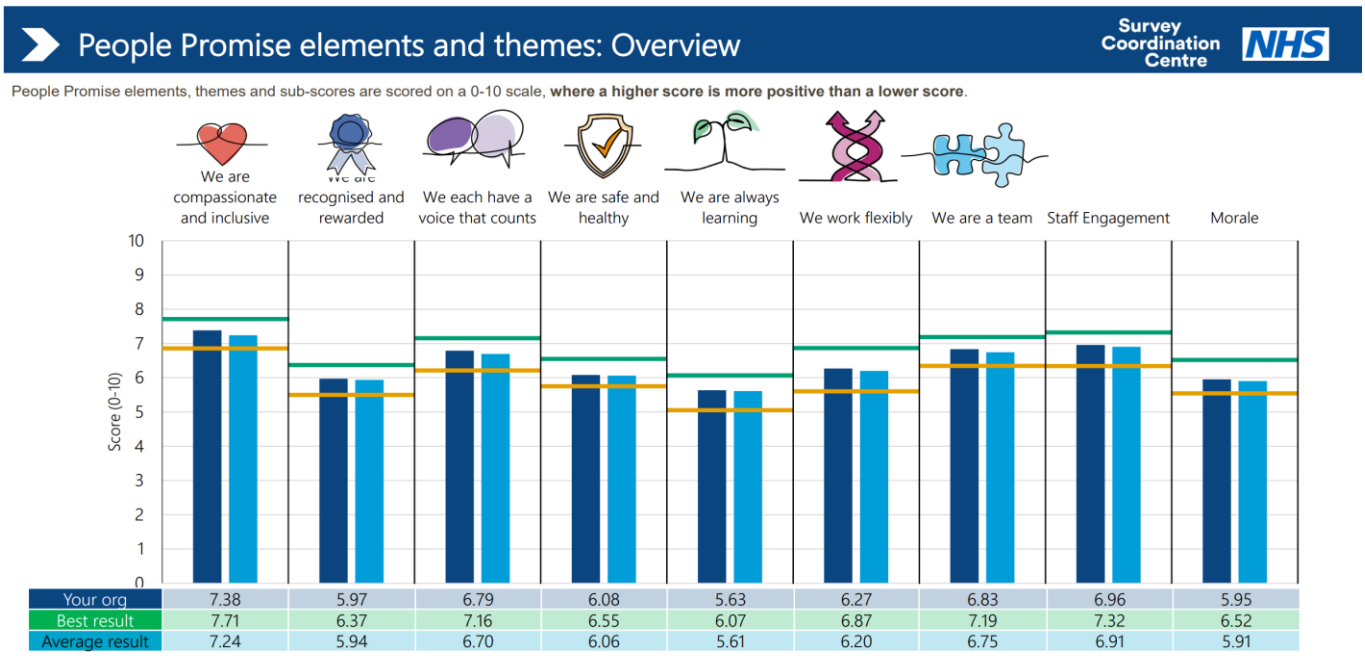
Within the Trust we analyse our data at team, subject and Trust level in order to understand:

- How we can celebrate and share good practice.
- How we can channel resources to best support our teams.
- Areas and issues for particular attention.

The 2023 survey results were announced at the end of March 2024. The results show that **in the majority of areas we have improved since last year**, although we still have more to do to achieve our aim of making UHD the best place to work. Two specific highlights are:

- In 2022 72.9% of you said that care of patients is a top priority at UHD.
  In 2023 that has risen to 76.2%.
- In 2022 56.2% of you said you would recommend UHD as a place to work.
  In 2023 that has risen to 63.4%.

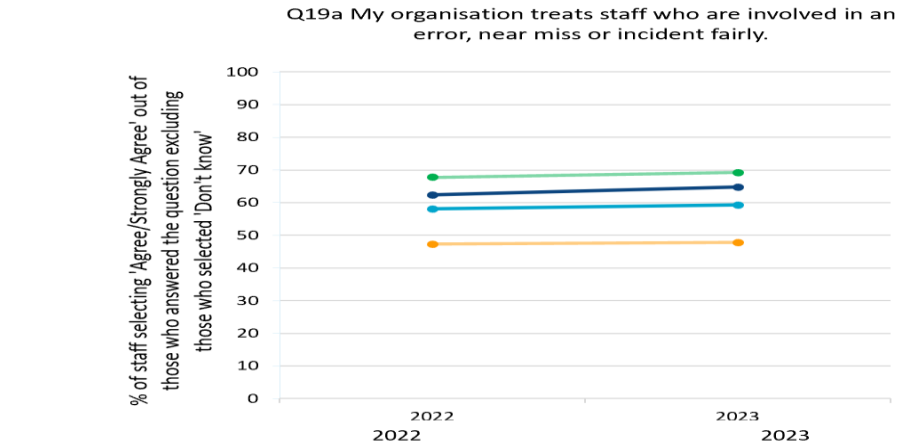
An overview of our People Promise scores is shown below:



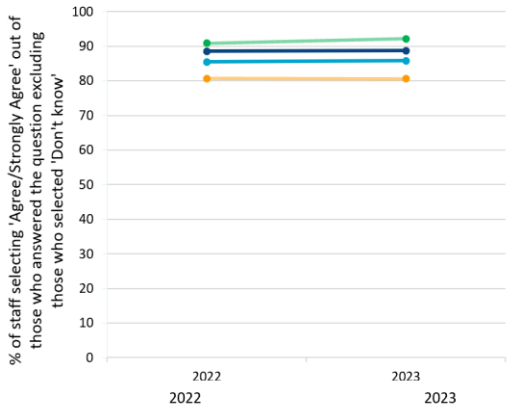
NHS Staff Survey – 2023 Results for Safety Culture

A number of the questions in the National Staff Survey are specifically relevant to safety culture.

We were really pleased to note that the survey scores for 2023 showed improvement in relation to staff feeling safe to raise concerns and report patient safety events.

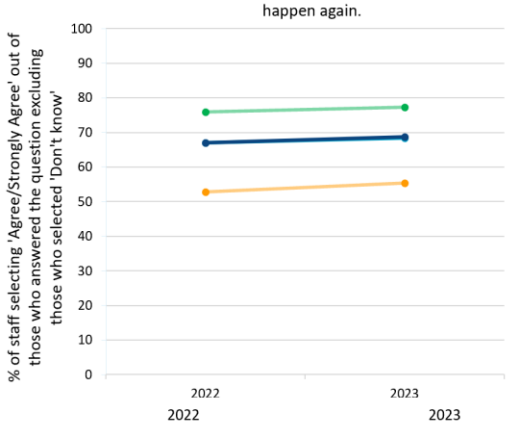
Question (Q)	2022		2023		Movement	Comparison to national results (average) 2023
	Q ref	% score	Q ref	% score		
My organisation treats staff who are involved in an error, near miss or incident fairly	18a	62.4	19a	64.71%	↑ up	Better (59.36%)
						
	2022	2023				
Your org	62.43%	64.71%				
Best result	67.74%	69.31%				
Average result	58.15%	59.36%				
My organisation encourages us to report errors, near misses or incidents	18b	88.6	19b	88.76%	↑ up	Better (85.79%)
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	18c	66.9	19c	68.79%	↑ up	Better 68.30%
We are given feedback about changes made in response to reported errors, near misses and incidents	18d	57.2	19d	59.70%	↑ up	Slightly lower (60.53%)

Q19b My organisation encourages us to report errors, near misses or incidents.



	2022	2023
Your org	88.65%	88.76%
Best result	90.82%	92.17%
Average result	85.51%	85.79%

Q19c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



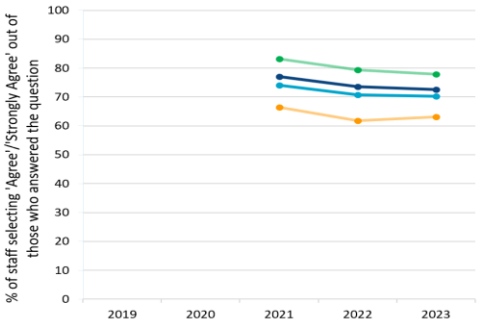
	2022	2023
Your org	67.01%	68.79%
Best result	75.89%	77.22%
Average result	67.04%	68.30%

I would feel secure raising concerns about unsafe clinical practice	19a	73.5	20a	72.65%	↓ down	Better (70.24%)
I am confident that my organisation would address my concern	19b	55.7	20b	57.25%	↑ up	Better (55.90%)

People Promise elements and theme results – We each have a voice that counts: Raising concerns

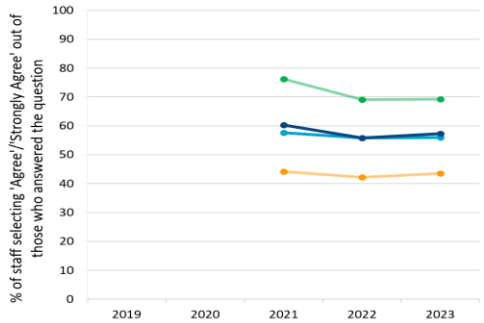
Survey Coordination Centre NHS

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2019	2020	2021	2022	2023
Your org	-	-	76.97%	73.57%	72.65%
Best result	-	-	83.19%	79.44%	77.96%
Average result	-	-	74.07%	70.82%	70.24%
Worst result	-	-	66.44%	61.78%	63.19%
Responses	-	-	3333	4119	5570

Q20b I am confident that my organisation would address my concern.



	2019	2020	2021	2022	2023
Your org	-	-	60.26%	55.79%	57.25%
Best result	-	-	76.17%	69.05%	69.29%
Average result	-	-	57.69%	55.75%	55.90%
Worst result	-	-	44.13%	42.27%	43.62%
Responses	-	-	3318	4106	5561

University Hospitals Dorset NHS Foundation Trust Benchmark report

Care of patients/service users is my organisation's top priority	23a	72.9	25a	76.20%	↑ up	Better (74.83%)

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 2023-24

The team in 2023/4 underwent a re-fresh and re-branding with the support of our Communications Team. The steering committee set out an exciting 12-month programme.

The following table shows the number of rounds that have been set up since its refresh in 2023/24:

Date (2023/4)	Type of Round	Title of Round	Number of Staff Attending	Rate (good+)
26th April	Mini (Cardiology)	*When communication makes a difference*	31	100%
18th May	Mini (theatres; RBH site)	*A day that turned into the unexpected*	34	100%
28th June	Full (Poole)	*The world feels in turmoil*	31	100%
13th September	Full (RBH)	*Do you know the real me? A time when I felt different*	20	100%
18th October	Full (RBH)	*A time when I spoke up*	20	100%

17th November	Mini (theatres; Poole)	*A day that turned into the unexpected*	52	100%
8th December	Full (Poole)	*a time when a team helped me through*	21	100%
19th January	Mini (Stroke)	*When change is constant*	15	100%
14th February	Mini (Maternity)	*Does Change, change us*	14	100%
6th March	Full (XCH)	*You cannot pour from an empty cup*	43	100%

All rounds are evaluated. Feedback included:

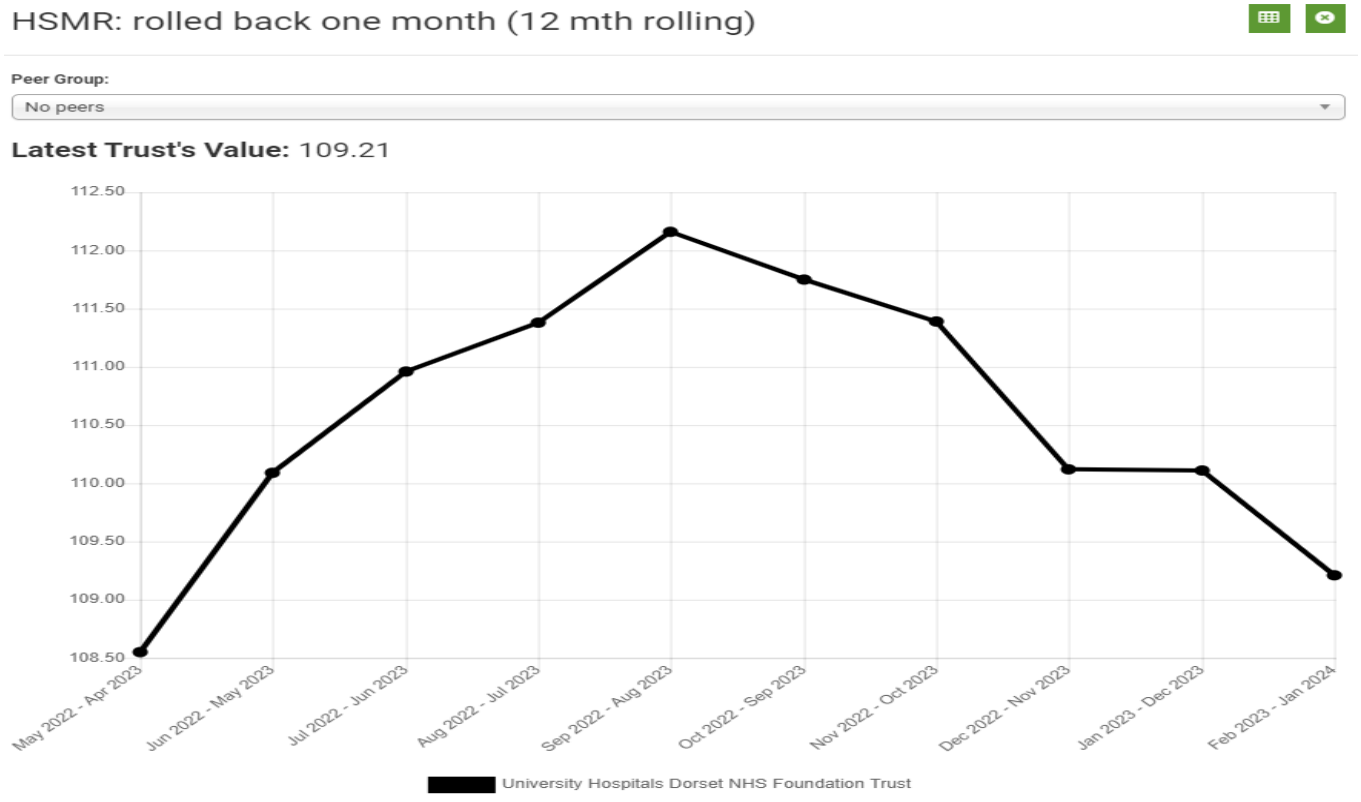
- *Was nice to feel a weight off my shoulders, to be able to talk and listen to similar experiences*. *It was great for my Mental Health*
- *Really nice to have the opportunity to take time out to talk and think about feelings, which we do not usually have time to do.*
- *Brave and bold to discuss this topic. Very helpful to verbalise these issues and raise awareness for them*
- *Fantastic way to express our feelings towards our work life.*
- *It has opened my eyes to how people are and their experiences; because people smile that does not mean they are always happy*
- *Excellent topic. Gets the thought process thinking and allows me to see the real people I work with. Well done to all that was involved.*
- *Absolutely fantastic; thank you for all the efforts that have gone into publicising and arranging this.*
- *It gave me the opportunity to air my burdens and it helped me get relief.*

CLINICAL EFFECTIVENESS

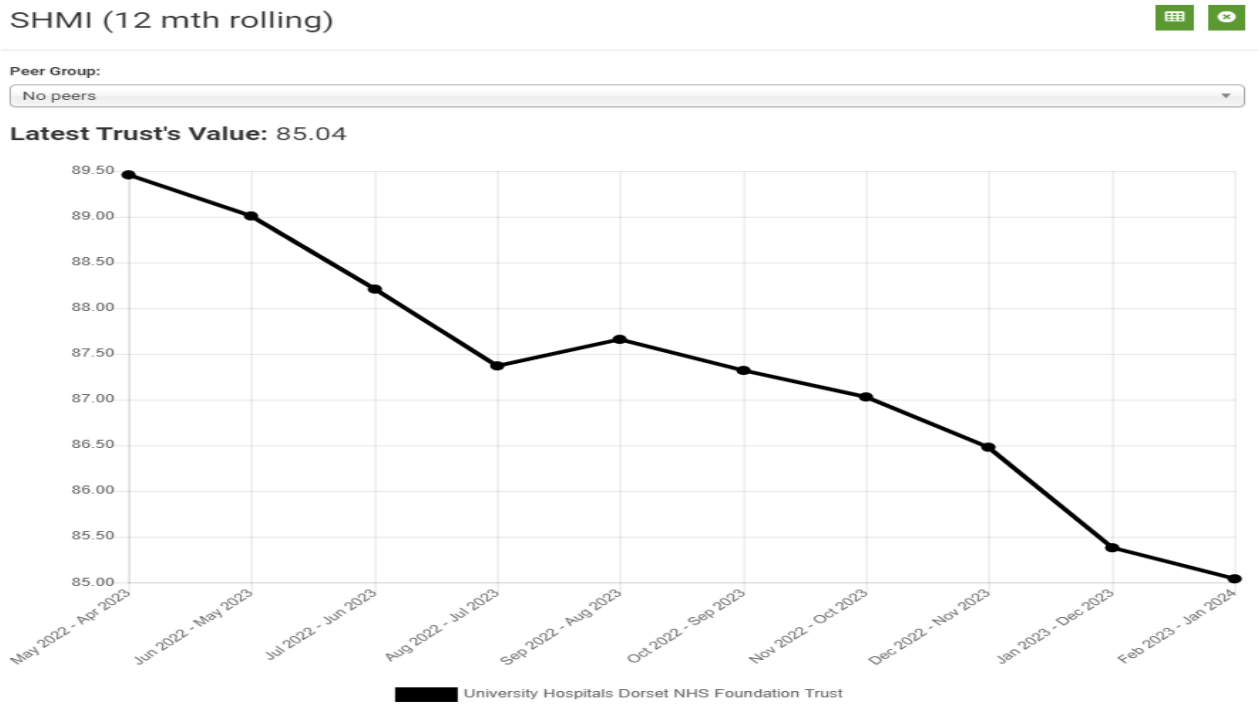
Reducing Mortality

Hospital mortality is normally assessed using two measures. The first is the hospital standardised mortality ratio or HSMR. This is averaged out and compared with all trusts in the country and the average mortality is set at 100. This is a measure based on people who die whilst hospital and is influenced by a number of factors such as the age of the person, the condition being treated and the nature of the care they received. It is a goal of the Trust for the HSMR to be better than average and therefore be below 100.

During 2023/24, there has been a steady downward trend which is positive however further improvement remains a priority for the Trust.



The second of measure is the standardised hospital mortality index or SHMI. This takes into account people who die within 30 days of being discharged from hospital. SHMI is calculated by NHS Digital and the SHMI for the Trust is very low (which is good). The average is set at 1 and for UHD it is 0.85 and consistently dropping.



The difference between these 2 figures highlights that measuring mortality is complex and different ways of measuring can have in different results.

It is important that we learn from the care we provide, and we work closely with the Medical Examiner Service who review all deaths in the trust. Because of the way HSMR is calculated it is also crucial that we record and code the nature of the care we provide accurately. Our clinical coders play a vital role in supporting this work.

As previously noted, we have a formal learning from deaths process in the Trust. Historically it has been at goal to review the care of every person who dies in the trust. We are moving to a more focused approach to maximise learning and make best used of the time involved. There are strict criteria set by NHS England about cases we must review, we have also set our own priorities linked to PSIRF. We will also review all cases where either the Medical Examiner or the family raise concerns. By doing this in a focused and more timely way we hope to be able to act on any learning more quickly and keep all our mortality measures low.

As we move forward as a large trust, we are supporting the specialties and care groups to review, understand and learn from their mortality at the local level. We have developed new dashboards and mortality reporting processes in year and aim to continue this work in the year ahead. The trust wide mortality steering group continues to have an overarching view and provide leadership on strategy and the best way forward to maximise learning and help support best patient care.

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

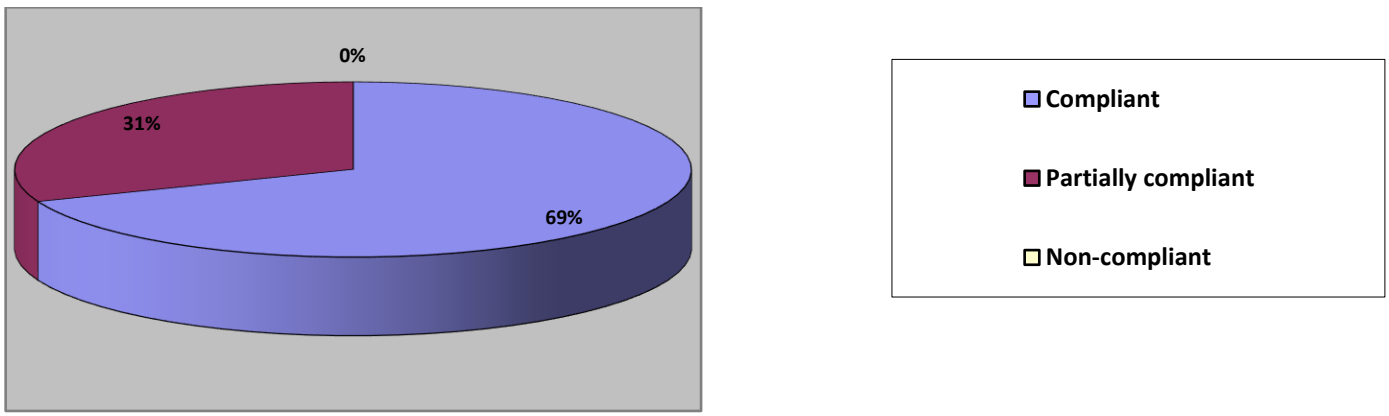
This section covers the NICE process at UHD including the NICE procedure. The report provides: an overview of guidance published by NICE; the status of all new guidance published in 2023/24; developments undertaken in 2023/24; developments planned for 2024/25.

The final reportable position on current NICE Guidance for UHD (**published** from 1 April 2023 to 31 March 2024) for the financial year at Q4 2023/24 is as follows:

Care Group	Compliant	Partially Compliant	Non-Compliant	Not applicable	Grand Total
Medical	4	3	0	9	16
Surgical	3	1	0	14	18
WCCSS	2	0	0	17	19
Operations	0	0	0	0	0
Corporate	0	0	0	4	4
Grand Total	**9**	**4**	**0**	**44**	**57***

*This figure does not include Technology Appraisals (TAs), Health Technology Evaluations (if they have been disseminated for information only), guidance awaiting review of compliance or **updates to guidance** that was previously published.

Of those that were rated as applicable to UHD as per the table above (published from 1 April 2023 to 31 March 2024), the compliance status is recorded as follows:

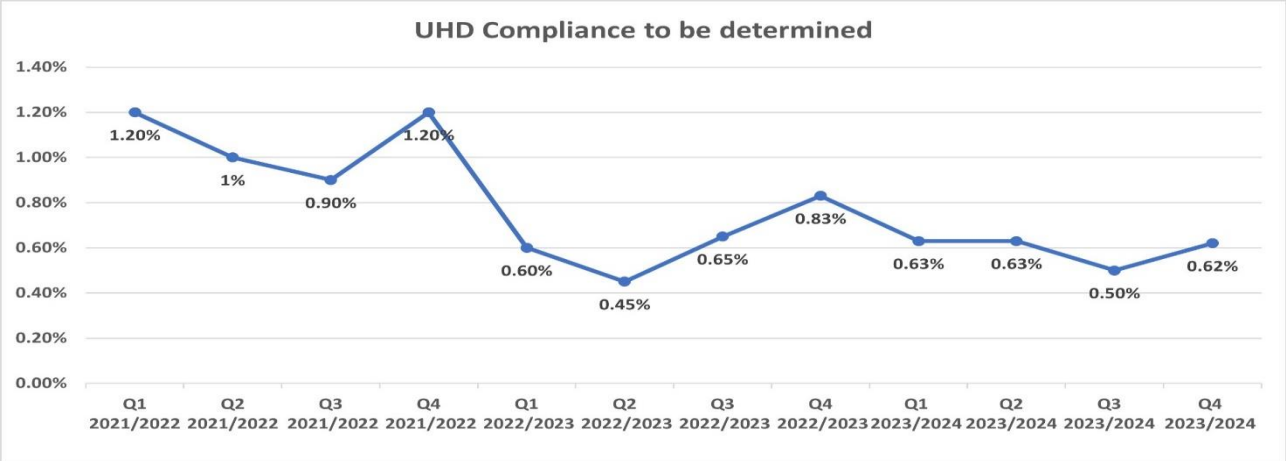


Where there was a rating of partially compliant for UHD (newly published from 1 April 2023 to 31 March 2024), the reasons for partial compliance and corresponding action plans are listed in the table below:

Partially compliant NICE				
Guidance	**Title**	**Specialty**	**Overview of the situation for elements of non-compliance:**	**Action Plans**
NG 236	Stroke rehabilitation in adults	Stroke	1.1.2 Partial compliance - Podiatry and audiology not accessible for inpatients. Only accessible in community (Dorset wide). 1.2.16 Partial compliance regarding needs based rehabiliation 1.11.7 Partial compliance for physical stimulation standard due to due to lack of all equipment options and capacity to provide at suggested intensity.	Work is in process to align therapy provision to accommodate this standard. There is ongoing work to increase therapy intensity through other methods such as the delivery of group work.
IPG 761	Endoscopic ultrasound-guided biliary drainage for biliary obstruction	Gastroenterology	Partially compliant - EUS guided drainage procedures used in some cases, usually when alternative procedures have failed	Regular clinical discussion at User group
QS210	Acute respiratory infection in over 16s: initial assessment and management including virtual wards (hospital at home)	Respiratory Medicine	Respiratory virtual ward is not fully up and running currently.	A lot of work is going into developing a virtual ward, but there have been several barriers that still need to be overcome, such as midline insertion, microbiologist input and staffing. Work in progress
NG233	Otitis media with effusion in under 12s	ENT	The guidance has changed from the previous iteration. ICB policy also relates to this diagnosis and now is inconsistent with the NICE guidance. The ICB policy is under review but this leaves the Trust in a challenging position in the interim as it either complies with NICE guidance or ICB policy.	Awating clarification from the ICB NHS Dorset.

Work to determine the level of compliance continues to be carried out within the clinical or corporate directorates and represents an on-going commitment to what is a growing NICE programme. NICE guidance can be and often is complex, taking time to scope and become compliant. It is noted that NICE now have a programme of updating previous NICE guidance which requires further review to clarify the level of compliance. It should be noted that in 2023/24 NICE updated/published 226 guidelines (including TAs).

Graph: Level of Compliance to be determined for UHD in percentage:



Examples of improvement following implementation of NICE Guidance include the following case studies:

NG18 Continuous glucose monitoring (CGM)

'NG18 Diabetes (type 1 and type 2) in children and young people: diagnosis and management' The Trust was previously not compliant with the recommendations around CGM. However, children and young people who meet the criteria are now able to access CGM as per this NICE guidance. This has the potential to improve diabetes management and to increase control over diet and social life for these young patients.

The Trust is now also compliant with QS209 statement 3:

'Adults with type 2 diabetes who have multiple daily insulin injections and a condition or disability that means they cannot use capillary blood glucose monitoring are offered continuous glucose monitoring (CGM) to support self-monitoring'

QS144 Care of dying adults in the last days of life

The Trust was previously only partially compliant with standard 3: 'Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.' UHD have now been marked as fully compliant with this quality standard due to the development of an electronic end of life care prescribing bundle which can be individualised according to the specific clinical picture. This has the potential to reduce drug and prescribing errors whilst improving symptom control and comfort at end of life.

During 2023/24, the Clinical Audit Department has carried on working on streamlining NICE compliance recording on the 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 Bournemouth and Poole Hospitals. This is an ongoing process and will continue during 2024/25.

For 2024/2025 quarterly updates will continue to be given via the Quarterly Audit Report and the Quarterly NICE Report to the Clinical Audit and Effectiveness Group (CAEG), as well as via dissemination to Clinical Directors, Speciality Clinical Audit Leads and General Managers. This process ensures that all levels of non-compliance (partially, non-compliant) and guidance awaiting review are kept on the governance agenda.

PATIENT EXPERIENCE

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

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

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

The UHD Patient Experience and Engagement Strategy 2023-2025 sets out how the Trust will deliver the patient first objectives and guide how we will continue to meaningfully engage with patients during the continued transformation of our services.

As part of the Patient First journey, our patient experience **CARE** Priorities further expand on the trust priority of 'improving patient experience' by acting on feedback.

The **CARE** priorities for the organisation are as follows:

Continuous Feedback- increasing the opportunity for patients to give their views on their care and increase accessibility by using different methods to enable patients to tell us about their experiences.

Areas for Improvement- teams use this feedback to recognise and drive changes, ensuring any improvements that are made deliver the intended improvement.

Recognising People- ensuring all patients who use our services are heard, by actively seeking out their opinion through engagement with the community.

Excellent Partnerships- working with health, social and voluntary partners to understand the views of the public and work together to solve problems.

The **CARE** Priorities link to our trust values. The strategy describes what activities and measures will be taken to achieve these Priorities. During 2024-2025 it is expected that the **CARE** priorities, set out in the strategy will be realised in full, with the outcome being outstanding care for our patients.

Clear and transparent communication with the public about the transformation of our services has been vital and will continue into 2024/25, where plans for moving of services across UHD will be realised. The public and patients of the hospitals have been extensively involved in decision making through the Clinical Services Review engagement, but this was several years ago. Therefore, this next phase will include being informed of the changes and provided with educational materials and workshops to understand what the transformation will mean to them. Involvement includes co-designed workshops for the transformation of services e.g. stroke services. Similar involvement of our patients is planned into future transformation, which will include larger scale workshops and smaller group work for particular changes.

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	**2023/24**	**2022/23**	**2021/22**
	UHD	**UHD**	**UHD**
	800	984	491

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 usually 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	2023/24	2022/23	2021/22
	UHD	UHD	UHD
	5982	5530	5200

Subjects of complaints

Every complaint is assessed at the outset and the key themes extracted. The themes, (total of 1499 for the 800 complaints received) based on the DOH submission dataset can be seen in the table below; recorded by number and % of total.

Complaint Themes	2023/24	2022/23	2021/22
Clinical treatment	**505 (33.7%)**	664 (35%)	373 (44%)
Access to treatment	**64 (4.3%)**	94 (4.9%)	2 (0%)
Admission, discharge, transfers	**101 (6.7%)**	97 (5.1%)	37 (4%)
Delays & cancelled appointments	**38 (2.5%)**	153 (8%)	16 (2%)
Communication	**272 (18.1%)**	435 (22.9%)	1 (0%)
Consent	**7 (0.5%)**	27 (1.4%)	211 (25%)
End of life care	**14 (0.9%)**	21 (1.1%)	6 (0.5%)
Facilities	**6 (0.4%)**	0 (0%)	0 (0%)
Integrated care	**3 (0.2%)**	0 (0%)	7 (0.5%)
Patient care	**72 (4.8%)**	90 (4.7%)	0 (0%)
Mortuary	**2 (0.1%)**	0 (0%)	0 (0%)
Prescribing	**37 (2.5%)**	43 (2.2%)	0 (0%)
Privacy, dignity & wellbeing	**41 (2.7%)**	22 (1.1%)	81 (10%)
Staffing numbers	**1 (0.1%)**	9 (0.5%)	4 (0%)
Administration	**48 (3.2%)**	0 (0%)	39 (5%)
Values & Behaviours	**264 (17.6%)**	146 (7.7%)	39 (5%)
Waiting Times	**24 (1.6%)**	95 (5%)	32 (4%)

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.

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 are as follows:

You Said: Patient reported feeling uncomfortable moving around in only a hospital gown following day surgery
We Did: The Unit has ordered a supply of dressing gowns for patients who did not bring their own.

You Said: Patient attending for an ultrasound reported anxiety about procedure and not knowing what to expect
We Did: Radiology have reviewed and updated the patient information leaflet

You Said: Patient who attended for radiotherapy reported the experience was daunting and that they did not fully understand the process on the day
We Did: A new patient information screen is being installed in one of the waiting areas and radiotherapy are also increasing the number of staff on duty at reception so that they are able to spend more time supporting and providing explanations to patients.

You Said: Concerns raised by family of a patient regarding a lack of support from staff when their relative was nearing the end of their life
We Did: Staff on the ward have received advanced end of life training from the practice educator and there are now six end of life care champions on the ward who can in turn share learning with their colleagues to improve care in this area. .

You Said: Concerns raised by family that a patient's communication difficulties were not being taken into consideration by staff on the ward
We Did: Multi-professional education sessions are being arranged for the whole ward team to enable junior team members to develop their skills and understanding, and emphasising the need to regularly liaise with relatives, modifying care according to an individual patient's needs. Trust has launched Oliver McGowan training for all staff and will also continue to offer learning disability training as part of safeguarding training.

You Said: Patient attending for a radiology procedure raised concerns that there were too many trainees present in the room.
We Did: Moving forwards, radiology will restrict the number of trainees present in examination rooms to a maximum of 2, in order to restore a more relaxed atmosphere to the room.

You Said: Patient reported that their endoscopy procedure was cancelled on the day as the correct blood tests had not been carried out.
We Did: It was highlighted this occurred as a result of lack of knowledge on a staff members part. A training afternoon was therefore organised for the whole team to increase staff knowledge and prevent future similar occurrences.

You Said: A patient raised concerns regarding difficulties in contacting the maternity team after her son's birth in order to discuss her experience.
We Did: This has been raised with the labour ward matron and lead obstetrician to highlight the importance of women being provided with information on how to contact the Birth Afterthoughts Service. The Maternity Matters website is also being upgraded to make this easier to navigate and to make the Birth Afterthoughts contact information clearer.

You Said: Mother of a patient received a text message reminder about her daughter's ultrasound appointment, as her number was incorrectly listed under 'home telephone number'
We Did: Obstetric scans will be removed from the Doctor Doctor reminder system to avoid such confidentially breaches in the future. All obstetric ultrasound appointments can be viewed in the Badgernet app therefore text message reminders are not required.

You Said: Concerns raised by relatives that nurses did not have time to appropriately assist in feeding patients.
We Did: Food is now plated up on the ward, with patients able to choose their own portion sizes. Different plate colours have been introduced for patients who require assistance, enabling staff to identify who requires additional support. Volunteers have also been trained in patient feeding and are now in place across areas in the Trust.

You Said: Concerns raised about the limited drinks options available on the ward and the effect on patient's hydration.
We Did: A Hydration project was launched on the ward and the frequency of hydration rounds was increased. There is now also a more varied drink selection for patients.

Action plan for 2024/25

An internal audit of the Trust complaints procedures was undertaken in year and the results presented to the Audit Committee. The audit highlighted a number of areas for further improvement including:

- Setting a trajectory to improve response times
- Improve communications with complainants to explain about potential delays
- Creating a survey for users of the Patient Experience service to complete once the complaint process is completed
- Provide quarterly reports to the Quality Committee detailing information from the survey
- Review and update the Trusts complaint policy

A detailed action plan has been produced and the following actions have already been taken:

- PALS and Complaints team members are beginning to work across both areas with the intention to focus together on resolutions and improve communications
- A User survey has been implemented was completed
- Trust complaint policy has been reviewed and uploaded to intranet for all staff access

The improvement work around response times and communication will progress during the year ahead.

Performance against national priorities 2023/24

National Priority	2023/24 Actual	2023/24 Target	2021/22	2022/23
18 week referral to treatment waiting times – admitted (31/03/2024)	**46.0%**	92%	45.5%	49.8%
18 week referral to treatment waiting times – non admitted (31/03/2024)	**66.1%**	92%	65.1%	54.6%
18 week referral to treatment waiting times – patients on an incomplete pathway (31/03/2024)	**62.0%**	92%	61.0%	53.8%
Proportion of patients staying for over 12 hours in Emergency Departments	**7.0%**	<2%	1.85%	7.3%
62 Day General Standard (all cancers)	**68.9%**	85%	73.8%	67.8%
31 Day General Treatment Standard (all cancers)	**96.1%**	96%	97.0%	97.1%
28 Day General Faster Diagnosis Standard (FDS - all cancers)	**67.1%**	75%	70.9%	67.4%
Clostridium difficile year on year reduction	**103**	64	70	84
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	**Compliance certified**	Compliance certified	Compliance certified	Compliance certified
Maximum 6 week wait for diagnostic procedures (31/03/2024)	**89.3%**	>99%	84.1%	93.0%

Annex A – Feedback from Stakeholders

NHS Dorset

Quality Directorate
Vespasian House
Barrack Road
Dorchester
DT1 1TG

Thank you for asking NHS Dorset to review and comment on your Quality Account for 2023/24. Please find below the ICB statement for inclusion in the final document:

NHS Dorset welcomes the opportunity to provide this statement on University Hospital's Dorset Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of information we have received during the year as part of monitoring discussions during 2023/24. The trust has been focusing on improvements in patient safety during 2023/24. The ambitions have been met this year, but priorities will continue into 2024/25 with new ambitions set. There have been several CQC inspections in the last 12 months which have supported improvements, which is evident in this quality account. The drive for quality improvement and embedded learning internally and from others is central to the improvements that University Hospital's Dorset have put in place.

The 'Patient First Approach' continues into the priorities for 2024/25 with a focus on staff support, to drive putting our Dorset residents first. This clearly defines ongoing improvement based upon the 5 strategic themes highlighted, in Population Health and System working, Our People, Patient Experience, Quality (Outcome and Safety) and Sustainable Services. The ICB will continue to work with the Trust over the coming year to ensure all five quality priorities are supported as well as the reporting requirements of the NHS Contract. The ICB also remains committed to supporting the Trust in building upon collaborative working with all health and social care partners within the Dorset Integrated Care System.

Debbie Simmons
Chief Nursing Officer

UHD Governors

Council of Governors Quality Group feedback:

Excellent report. Congratulations to Joanne Sims and the team for compiling this report, which showcases the progress made over the last 12 months.

This is a very comprehensive and detailed report created within constrained criteria, so well done for bringing everything together in an understandable way.

Feedback from Governors:

A comprehensive account demonstrating rigour and impact.

Progress made by gaining greater team engagement and through successful interventions but dogged determination to address areas where more focus is required.

The patient first approach is showing itself to be a great vehicle, it's inspiring teams and providing clarity throughout the organisation.

It is increasingly encouraging to see evidence of progress considering the challenges faced by those working for the NHS and for UHD.

Immense pride in the work being completed.

Annex B

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

ED – Emergency Department

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

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. This has now been replaced by **LFPSE** – Learning from Patient Safety Events Service

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)

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.

PSIRF Patient Safety Incident Response Framework

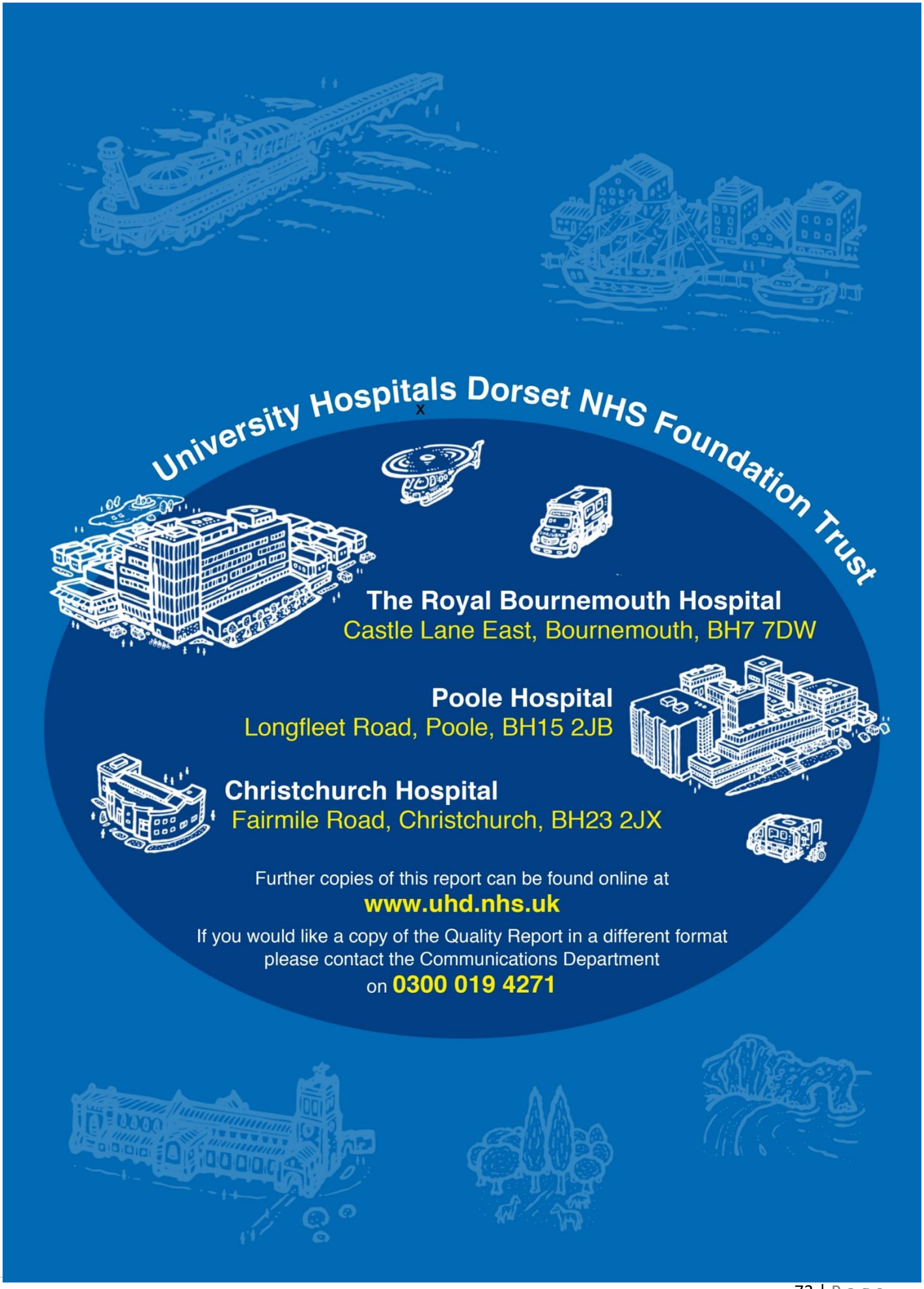
R&I – Research and Innovation

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

The NHS England Serious Incident Reporting Framework has now been replaced by PSIRF.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