University Hospitals Dorset
NHS Foundation Trust

Annual Quality Account 2024/2025

Contents

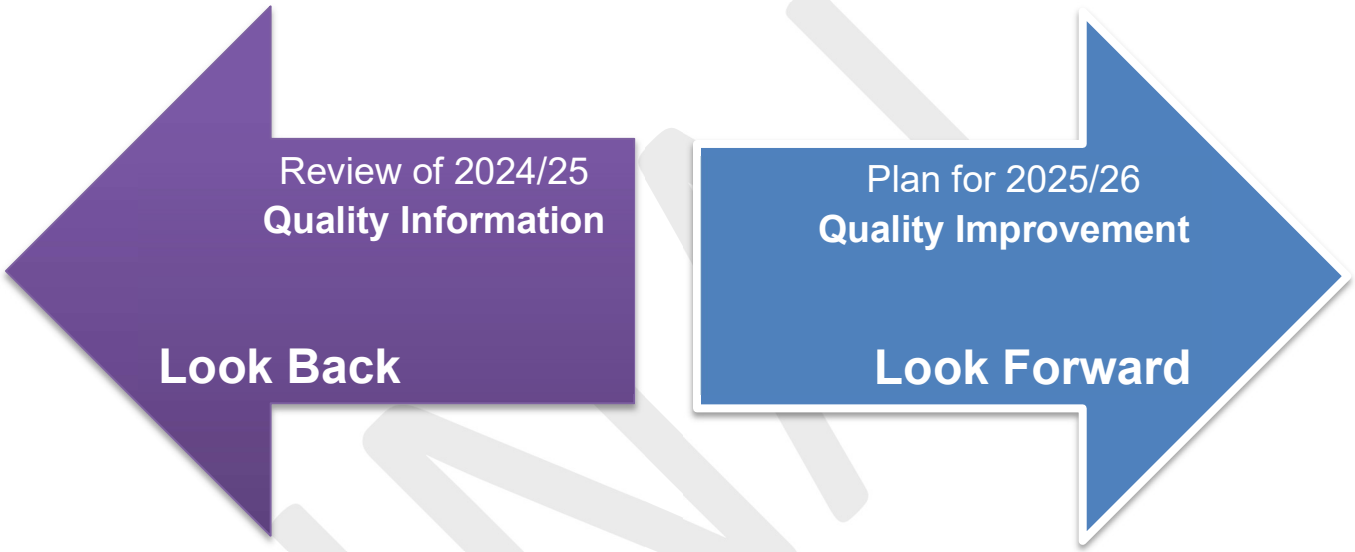
What is a quality account?

As part of the drive across the NHS to be open and honest about the quality of services provided to the public, from 2009, 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 2024/25; and

2. set out our quality priorities and objectives for 2025/26.



To begin with, we will give details of how we performed in 2024/25 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 2025/26 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 2024/25 quality priorities and our quality priorities for 2025/26*
	Reviewing progress of the quality improvements in 2024/25 and choosing the new priorities for 2025/26
	Statements of assurance from the Board
Part 3	*Other information*

Part 1 Statement on quality from the Chief Executive

Welcome to our Quality Account 2024/25. High quality care is at the heart of everything we do at UHD. Our long-term vision is to be rated the safest Trust in the country and to be seen by our staff as an outstanding organisation for effectiveness.

To do that, we need to develop a culture where people feel safe to talk and this is central to all our safety work. This starts with our 10,000 colleagues, our eyes and ears across our Trust, and we encourage all to report any concerns so we can learn from these and improve.

We have also made a commitment to work in partnership with our patients 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.

One of our five strategic themes is quality outcomes and safety, aimed at saving lives and patient safety. Our Quality Account outlines some of the main quality governance and patient safety projects that have been progressed this year and celebrates the engagement of our colleagues to continually improve patient and staff safety, patient experience and clinical outcomes.

Colleagues work incredibly hard across our hospitals and the vast majority of the care we deliver is very good. Our rollout of Patient First is encouraging them to develop their own improvement plans locally and to check on the progress of these regularly across their teams.

We have seen improved safety culture scores in UHD and national staff surveys, and have appointed four patient safety partners this year. Through our 'UHD Safety Crew', we have also invited the whole trust, no matter what their role, to be part of the safety conversation.

This year we developed 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. Our focus has included looking at improving patient safety by reducing in hospital falls, pressure ulcers and venous thromboembolism.

As part of work as a pilot site for implementing Marthas Rule we have also looked at supporting the care and management of deteriorating patient and listening to patients and their families in this process. We also set and achieved some important safety and quality priorities for maternity care.

We have also embedded the Learn from Patient Safety Events (LFPSE) service this year, incorporating it into our current Learning Event Report Notification (LERN) processes. We are pleased that this transition did not lead to a decrease in reporting and has, in fact, enhanced reporting in key areas of patient and staff safety.

We always promote a strong focus on learning, underpinned by our values – 'listening to understand' and 'always improving'. I am encouraged by our progress this has made to realise our long-term vision that is featured through our Quality Account. I thank all my colleagues for their commitment to improve and to learn and thank our partners and patients for all their support. 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:

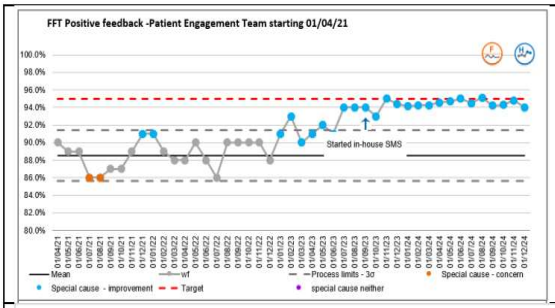
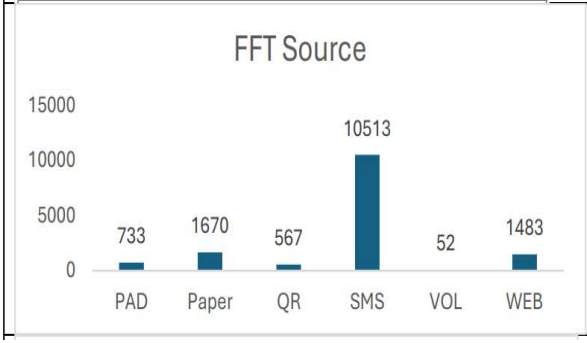
- *data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit programme of work each year*
- *data is collected by a large number of teams across the Trust alongside their main responsibilities, which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

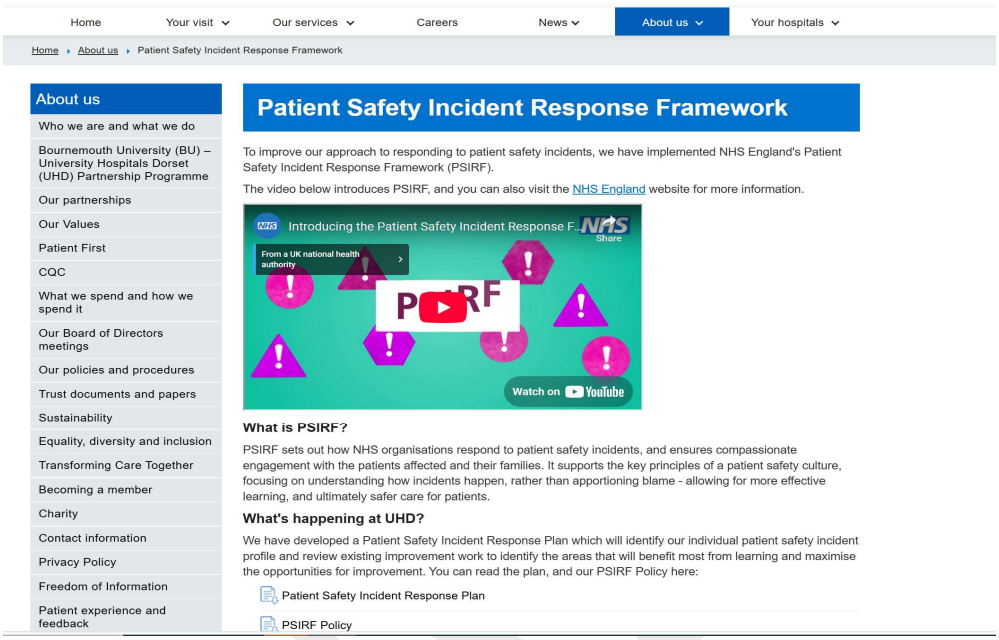
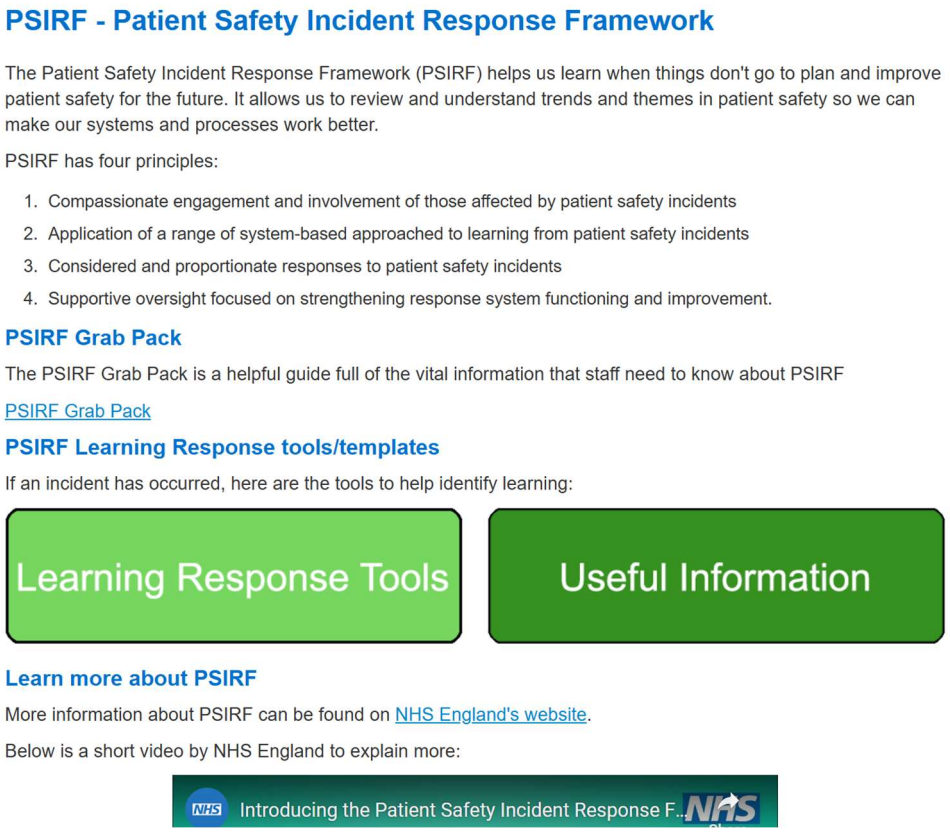
Siobhan Harrington
Chief Executive

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

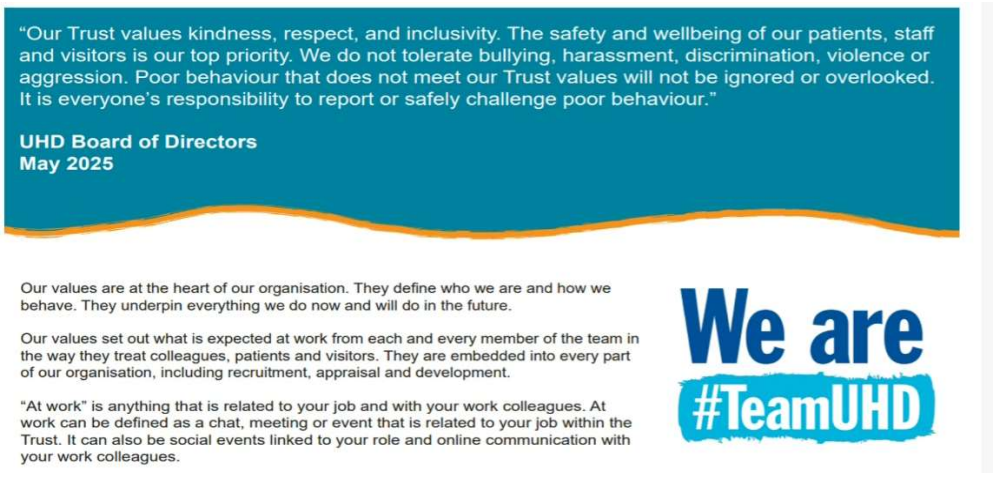
Performance against quality priorities set out in the Trust Quality Strategy for 24/25

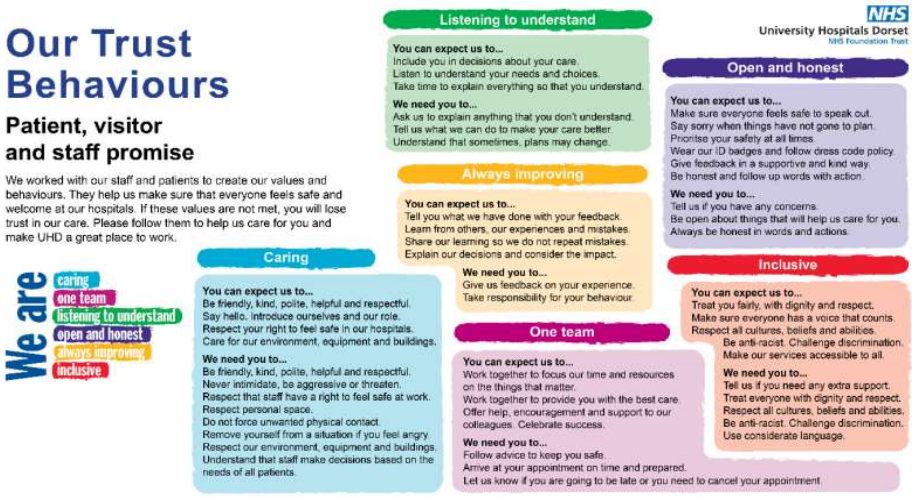
Priority for 2024/5	Progress made in 2024/25
Patient Experience – Achieve a 5% improvement in employees who see patient care as top priority for UHD.	For question 25a of the National Staff Survey 2024 the Trust scored 76.4% for "Care of patients is my organisations top priority". This was above the national average score of 75.1% and a slight increase from the 2023 score of 76.3%. We aim to make further improvement this year.
Patient Experience - Increase the Friends and Family Test (FFT) and Have Your Say (HYS) Feedback rates by 30%	UHD in house SMS text messaging service has been introduced to enable the Trust to increase the number of received responses. The FFT positive score has remained high since January 2024 with the percentage positive scores near to target. UHD SMS text messaging service has meant a higher volume of feedback is being received, reaching more services. PATIENT EXPERIENCE REPORT  FFT Positivity remains consistently around the 94% region with a slight decrease this quarter, which may also be linked to the festive period  SMS remains the best medium for attaining patient feedback with many areas' requesting a return to paper forms to aid their patients who are less digitally inclined For more information see section 3 of the Quality Account Report.
Quality Outcomes and Safety – Maintain a HSMR less than 100.	The latest fully coded Hospital Standardised Mortality Ratio (HSMR) position is January 2025 at 96.9. This is below (better than) the national average of 100.

	We continue to remain well below the national average in our Summary Hospital-level Mortality Indicator (SHMI) and it is the lowest of any acute trust in the Southwest.
Quality Outcomes and Safety - Improve Staff Survey questions by 5% and Implement UHD SaF	**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 again in the 2024 survey versus the previous year. We did not reach our target of 5% but the results were also better than the previous year and better than the national average. **Implementing 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 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 then use patient first improvement methodology to look at areas for improvement and to share good practice. We initially piloted the tool with our early adopter wards for Patient First, we also asked our Board of Directors to complete the tool and used the results to support discussion at a Board development session on patient safety and risk management. We have now started a wider roll across our three Care Groups.
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	We are currently finalising our UHD Quality and Safety Strategy for 2025/26. Consultation will include sharing the draft strategy with our patient safety partners and discussing at relevant forums including our Clinical Governance Group, Trust Management Board and Quality Committee. A new Trust Risk Management Strategy has been produced with additional focus on risk escalation and discussion on risks that breach, or may soon breach, risk appetite or risk tolerance.

Development of transitional plans, guidance and tools to support the implementation plan for the new Patient Safety Incident Response Framework (PSIRF)	The inaugural UHD PSIRF plan and policy are available on both the intranet and internet.  We have developed a PSIRF Toolkit and “Grab Pack” for Teams to use to support local discussion and learning from patient safety incidents. Guidance and learning response tools have also been uploaded to intranet. 

	 Starting from quarter 3 (October-December 2024), a new audit process was introduced to look at patient safety incidents reported to the national Learning from Patient Safety Events (LFPSE) system. Under the audit all events with the harm level of moderate or above (for either physical or psychological harm) will be reviewed to consider: • Was the incident recorded on the correct form? • Had the incident been triaged? • Had an appropriate learning response been uploaded to the LERN record? • Had the learning/actions fields been completed? • Did the level of harm match the outcome of the review? • Had statutory Duty of Candour (DoC) been undertaken and was there evidence attached? • Had statutory DoC been recorded correctly for the duty of candour compliance report? This new quarterly audit will enable UHD to confidently identify whether moderate harm incidents or above are reducing, that the PSIRF triage process is embedded and a variety of learning responses are being used, that staff are receiving feedback when they report an incident and that duty of candour is effectively documented
Develop and embed compassionate engagement.	Research and experience show us the values of engaging fully with families and carers when things don't go to plan. Our UHD aim is that staff, patients, families and carers will be involved in the learning response right from the very beginning by gaining an understanding of the needs of all involved and working to reduce the risk of compounded harm. In all cases, the apologies will be meaningful, the guidance and clarity will be provided ensuring all involved are heard, the approach is collaborative and open, subjectivity is accepted, and equity is strived for.

	Duty of candour will be completed at the beginning and the family and carers will be supported to contribute to the learning response by sharing their experience and any concerns in order to frame the review. The cornerstones of the engagement with all will be: • Apologies will be meaningful. • Approach will be individualised. • Timing will be sensitive. • Those affected will be treated with respect and compassion. • Guidance and clarity are provided. • Those affected are heard. • The approach is collaborative and open. • Subjectivity is accepted. • Strive for equity. To support staff to meet these expectations; guidance, support and training is provided. Success will be monitored via audits and patient feedback surveys. Our patient safety partners will support us in this work. In addition, following extensive stakeholder engagement, a UHD Behaviour charter statement has been developed alongside supporting documents to represent our Trust values and meet the needs of patients, staff, visitors, and the wider community UHD serves. The statement provides the foundation for an explicit message from the Board about behavioural expectations for anyone who attends UHD whether for work, education, or care. The statement will be used on formal documents, patient letters and information leaflets, the internet, intranet and wider Trust communications. Standardising behavioural expectations can contribute to our Trust vision of being a great place to work. 

	Supporting documentation has also been produced: 
Train staff in investigation skills, report writing, communication and compassionate engagement skills and improvement methodologies	We have enhanced staff training and awareness about patient safety and patient safety learning in several ways during 2024/25: **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 the number of staff completing the training has steadily increased month on month. We initially set a target of 90% for all staff groups in 2024/25 and achieved an overall compliance of 93.0%. We are aiming for 95% uptake during 2025/26. The number of staff having undertaken their training is steadily increasing. **Patient Safety Incident Investigation Training** We have rolled out a series of training sessions in year including: • PSII Investigation skills • PSII Report writing. • PSIRF learning responses.

Break Level 1	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Add Prof Scientific and Technic	67.4%	78.8%	82.4%	88.6%	91.7%	93.4%	93.6%	93.5%	94.4%	93.9%
Additional Clinical Services	79.0%	85.0%	87.7%	90.1%	91.6%	93.2%	93.4%	94.3%	94.5%	94.9%
Administrative and Clerical	79.5%	84.3%	87.5%	89.1%	90.7%	92.8%	93.2%	93.9%	94.1%	94.5%
Allied Health Professionals	77.1%	83.5%	86.6%	89.1%	91.8%	93.4%	93.0%	94.0%	94.6%	95.2%
Estates and Ancillary	68.5%	73.6%	76.8%	80.0%	82.6%	84.8%	84.8%	88.3%	89.7%	89.5%
Healthcare Scientists	68.0%	72.4%	77.3%	80.8%	82.5%	84.8%	86.9%	87.9%	89.9%	90.4%
Medical and Dental	57.3%	62.8%	66.9%	69.9%	75.1%	78.9%	80.2%	81.2%	83.0%	83.6%
Nursing and Midwifery Registered	79.3%	84.1%	87.8%	89.4%	91.0%	92.5%	93.3%	94.1%	94.7%	95.2%
Students	0.0%	0.0%	0.0%	0.0%	0.0%	91.7%	91.3%	92.0%	93.0%	94.0%
Total	**75.2%**	**80.6%**	**84.2%**	**86.2%**	**88.4%**	**90.4%**	**90.9%**	**91.9%**	**92.7%**	**93.0%**

- PSIRF A3 principles
- After Action Review facilitation and participation
- Duty of Candour and compassionate engagement
- LERN reporting and reviewing.
- Using Datix dashboards
- Using Ward to Board Quality dashboards

In addition, our Associate Medical Director for Clinical Governance, Dr Kamy Thavanaesan and our Associate Director Quality Governance and Risk, Jo Sims have both completed the national patient safety specialist course as part of the initial national cohort 1. Only 450 specialists across the country have completed the course which covers the NHSE Patient safety syllabus training levels 3 and 4.

Staff feedback is collated and feedback acted upon.

We used Core Brief and other forums to promote the Patient and Staff Safety across UHD.

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

Learn at lunch

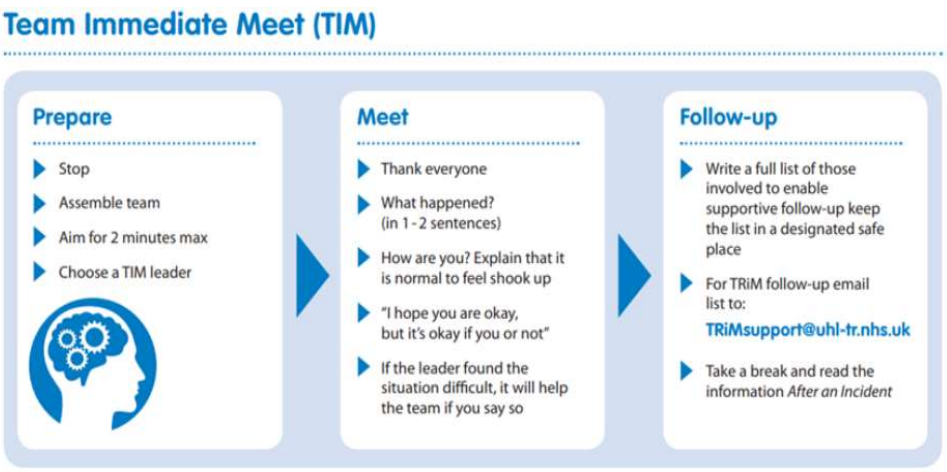
Our UHD Safety Crew are hosting a series of monthly sessions this year on safety issues. The interactive sessions are suitable for all of Team UHD, as we are all part of the Safety Crew. You can use them for personal CPD points too. We hope to see you there #UHDSafetyCrew.

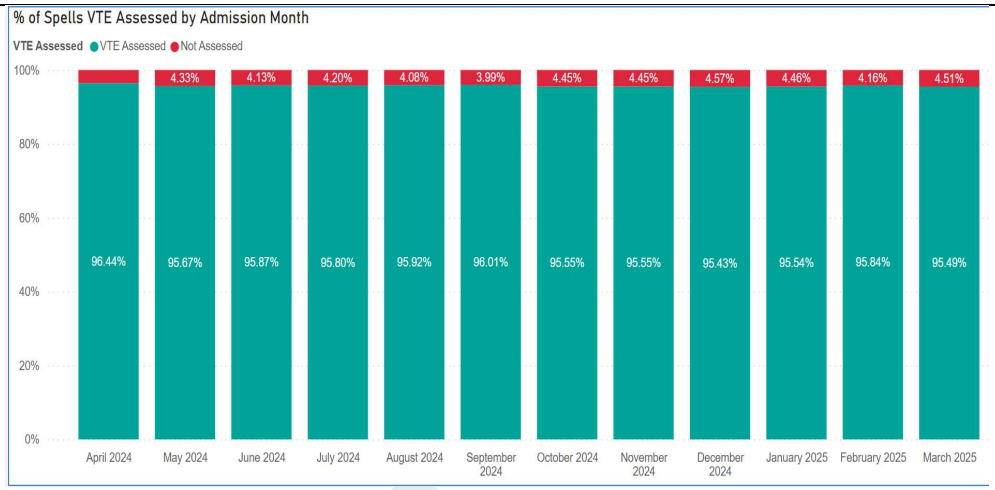
2025 dates	Topic	Time	Link
22 January	**Falls safety**	12.15pm	Catch up here
13 February	**Medicine safety**	12.15pm	Catch up here
13 March	**Quality governance and assurance**	12.15pm	Catch up here
25 April	**Security at UHD**	12.15pm	Join here
22 May	**PSIRF and falls**	12.15pm	Join here
June-Dec	**Topic TBC**		

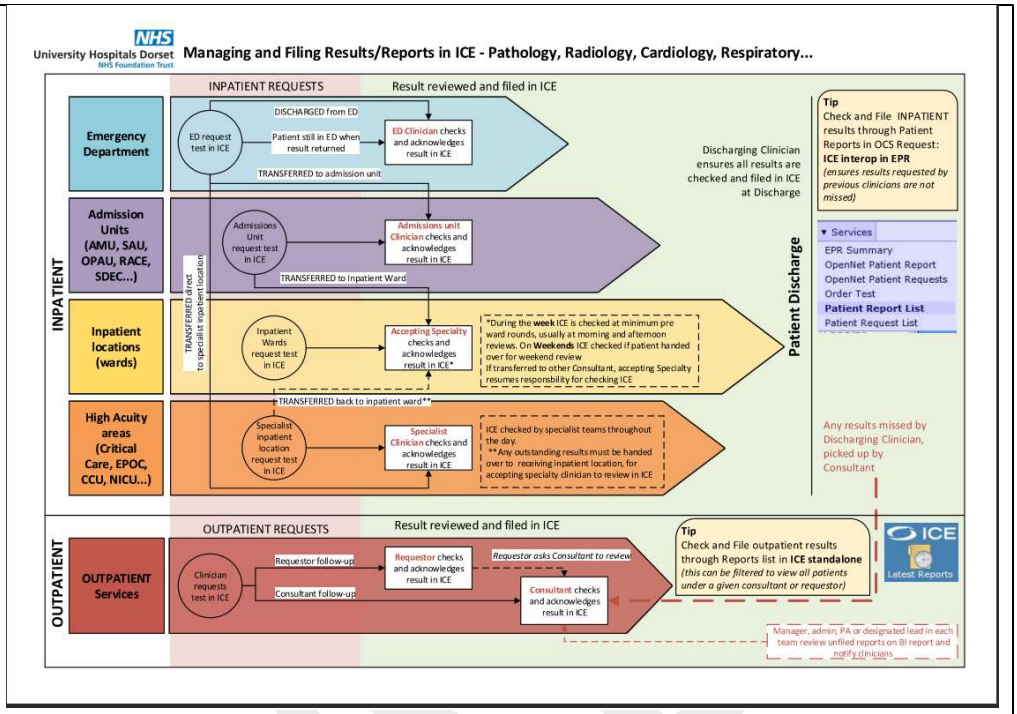
2024 sessions	Topic	Time	Link
February	**What is patient safety and how can we measure it**		Catch up here
19 March	**PSIRF: What is it and what does it mean for me?**		Catch up here
23 April	**Safety language - old and new**		Catch up here
17 May	**How human factors IS essential to patient safety**		Catch up here
26 June	**What happens at clinical governance group**		Catch up here
10 July	**The principles of good family engagement within patient safety investigations**		Catch up here
17 September	**World Patient Safety Day**		Catch up here
October	**Clinical Quality Accreditation Scheme.**		Catch up here
22 November	**Staff safety**		Catch up here

In March 2025 we launched our new campaign – “See something, Say something”. The focus of the campaign is site safety and security during our current extensive estate transformation programme, however the message applies to everything we see and do.

Support staff involved in a patient safety incident and create safe spaces for open and honest reporting and learning.	It is important to acknowledge that significant incidents are not only traumatic for the patients, but also can be traumatic for our staff. Ensuring staff receive psychological support following a significant / traumatic incident is vital. UHD offer many services to support the mental and physical health of all staff, such as: ❖ Psychological Support and Counselling Services ❖ Mental Health First Aid ❖ Freedom to Speak Up ❖ Trauma Risk Management (TRiM) ❖ Information about accessing Urgent Support All of these services are completely confidential and are included within the Staff Benefits programme. Staff are able to self-refer with the reassuring knowledge that they can access the help and support they need without anyone finding out. 

	TIM is a communication tool used to guide group conversations, using psychological first aid, immediately following any clinical event which may cause distress. Use of the "TIM Tool" is encouraged to be used immediately post incident to ensure psychological safety is achieved for all staff members involved.  STOP Debrief is a tool which allows for open engagement in intentional conversations immediately following a significant patient safety incident. It ensures the wellbeing of staff involved in the incident as well as allowing the staff to identify any immediate actions to be taken to maintain staff and patient safety and wellbeing and note any learning opportunities. **S -** Summarise the Case **T -** Things that went well **O -** Opportunities to improve **P –** Points to action and responsibilities
As part of our Patient Safety Incident Response Plan focus on: **Reducing Patient Falls**	A Patient Safety Incident Response Plan (PSIRF) Patient Safety Incident Investigation (PSII) Thematic Review of Falls across UHD has been undertaken. The commissioned report is likely to be completed in June 2025. The recommendations from the report will form the basis of the Fundamentals of Care – Safer Activity Improvement plan for 2025/26. The actions will be managed through the Fundamentals of Care (FOC) Group with oversight by the Clinical Governance Group and Trust Quality Committee.
As part of our Patient Safety Incident Response Plan focus on: **Medication Safety (Reducing Hospital Acquired Venous Thromboembolism (VTE))**	A VTE Quality Improvement Plan has been developed with regular reporting on quality metrics to Thrombosis Group. VTE Risk Assessment compliance has achieved the 95% target each month for 2024/25.

	
As part of our Patient Safety Incident Response Plan focus on: **Reducing Hospital Acquired Pressure ulcers**	A PSIRF PSII Thematic review of hospital acquired pressure ulcers was undertaken between November 2024 – January 2025. The final report was agreed at the Trust PSIRF Oversight meeting in March 2025. A Quality Improvement project plan has been developed to action the report recommendations and a new 'Skin Integrity Group' has been formed to manage the actions. Oversight of this group will be via the FOC group which in turn will report into the Trust Clinical Governance Group and Quality Committee. Improvements made in year include: • Implementation of a new pressure ulcer risk assessment tool – Purpose T to simplify the assessment and care planning process. • Education and training sessions for ward teams • Implementation of a new Total bed management contract that will enable patients to be cared for on a bed, mattress and chair cushion that suits their individual need. • Local initiatives: including safety briefings, senior nurse weekly rounds and use of quality boards. • Pan Dorset Alignment for wound and skin care products. • Weekly rapid review process for reported patient safety events involving pressure damage. The new process supports early decision making, improvement and shared learning.
As part of our Patient Safety Incident Response Plan focus on: **Diagnostics processes, specifically the follow up of Radiology and laboratory investigations.**	A new Order Communication IT system – ICE was implemented in October 2024 across UHD. ICE provides robust processes and systems that ensure that all results are reviewed and actioned by the appropriate person, and there is visibility of when results have not been checked. To support implementation an ICE filing flowchart was introduced alongside staff training and an information sheet.



The use of UHD ICE is now how we mark pathology, radiology and cardiology results as reviewed / actioned.

As part of our Patient Safety Incident Response Plan focus on: **Deteriorating patient management.**

The Trust has made good progress against this PSIRF objective in 2024/25.

A project plan has been produced and the identified workstreams will be monitored by the Deteriorating Patient Group which feeds into the Trust Clinical Governance Group and also the Quality Committee.

Deteriorating Patient PSIRF A3

University Hospitals Dorset NHS Foundation Trust

Step 1: Problem Statement

Deteriorating patient agenda for the trust needs to cover all causes of deterioration with appropriate resources and governance to enable the trust to learn and change culture to prevent patient harm from deterioration.

Step 2: Current State

- Incident themes around the Identification, Escalation and Resuscitation of the deteriorating patient
- There is limited learning from incidents associated with deterioration
- There is limited visibility of deteriorating patient workstreams and data
- Martha's rule is in the process of being implemented
- There is no sepsis lead for the organisation coordinating data and improvement
- There is a theme around TEPs not being updated as expected
- The education program on BEAT is outdated
- There is no ratified deteriorating patient policy

Step 3: Goal & Target

- To have a deteriorating policy ratified and cascaded
- Streamline processes and data collection to improve visibility and learning.
- Formal governance structure around deteriorating patient incidents and local ownership
- Clear process to facilitate learning from deteriorating patient incidents
- Updated training package
- Updated deteriorating patient intranet page as a central repository for all information and learning
- Development of a Sepsis practitioner role and appointment
- Sepsis link person for each directorate/specialty
- Marthas rule (PWS) on eObs and Trustwide implementation
- Appropriate CCOT cover on both sites to facilitate rapid escalation when required.
- Empower staff to be involved in discussing limitations of care in a timely fashion
- Agreed process to learn from deaths, particularly from those patients that experienced acute deterioration

Step 4: Analysis: Top Contributors & Root Causes

- Lack of staff knowledge and understanding of recognising, escalating and resuscitating deteriorating patients
- Lack of staff knowledge and understanding of deteriorating patient processes to learn from incidents
- Resources
- Human factors
- New national legislation and guidance
- UHD culture
- Workforce planning
- Multiple systems
- Outputs from other groups/meetings not being fully shared/ communicated with DP group

Step 5: Refined Problem Statement

Step 6: Opportunities & Countermeasures

Contributor	Contributory factors	Counter-measure	Impact (e.g. High, medium)	Ease of implementation
Incident themes and management	Staff knowledge and culture	Ratified Policy	medium	easy
Lack of visibility of data and workstreams	Lack of knowledge, multiple systems, communication	BI dashboard, on cosmos (emergency calls and escalation prior, sepsis). To include data from Datix, medicus, existing cosmos reports, HED (mortality), BEAT	high	medium
Incident themes and management	Staff knowledge and culture	BEAT to include both deteriorating patient and sepsis education that is completed on an annual basis and compliance is over 95%	medium	medium
Communication with patients	Human factors	TEP Audit	low	easy
Governance and learning	Staff knowledge and culture, change fatigue	Regular, well attended Deteriorating patient and resus committee	medium	easy
Incident themes and management	Staff knowledge and culture	Intranet page as a central repository	low	easy
Incident themes and management	Staff knowledge and culture	Learning from deaths to be coordinated and cascaded across the organisation	medium	medium
Marthas rule	New process	Marthas rule information auditable	high	hard
No Sepsis nurse	Lack of clear funding stream	Sepsis Nurse in place and coordinating data and improvement	High	hard

Step 7: Summary Action Plan

Counter-measure	Action	Who / By when	Complete (Y/N)
Ratified Policy	Get it ratified	MS to PPG by March	
BI dashboard. on cosmos	Work with the BI team to get all the data in one place	Beth to work with BI team by May	
BEAT training	Update the BEAT training including content, name and access frequency	MS to speak to Lisa MacManus by March	
Audit on TEP	Occurs annually on audit plan	SHW	Y
Deteriorating patient and resus committee	Update TOR and engage with each speciality/director ate for link colleagues	BA/LR/MS by March	
Intranet page as a central repository	DP and Resus Intranet page to be a centralised resources both education, policies and audit	BA and LR by March	
Learning from deaths to be coordinated and cascaded across the organisation	MS to meet with BP to agree the process	MS by April	
Marthas rule information auditable	Speak to BJ to get Marthas rule on EObs	MS by May	
Sepsis Nurse	Escalate the lack of dedicated sepsis nurse to senior leaders	MS by March	

Step 8: Progress & Follow up

Step 9: Insights

	Other progress includes: • UHD is a Pilot site for roll out of Marthas Rule. • A thematic review on difficult IV access (DIVA) has been produced and discussed at the PSIRF Oversight meeting January 25. An action plan is currently being worked through and will include creation of a IV checklist list to ensure patients with expected difficult access are seen appropriately.
As part of our Patient Safety Incident Response Plan focus on: **Mental health (management and reducing restrictive interventions)**	An external review has been undertaken and presented to Trust Management Group and Quality Committee. Following the review findings a Trust wide Project Charter and Improvement plan has been produced with 4 main workstreams established. The workstreams are: • Environment • Education and Training • Clinical Processes • System wide pathways **Project Charter: Mental Health** **1. Problem Statement** **Background:** University Hospitals Dorset has for several years accepted patients on a section into the organisation, what it has seen is an increase in complexity and acuity as opposed to an increase in numbers. This has seen UHD and DHC need to work more collaboratively to achieve better outcomes and patient experience. This collaboration is promoted by GIRFT and the CQC Report written in 2020 entitled 'How are people's mental health needs met in acute hospitals, and how can this be improved' **Problem:** Staff are finding it difficult to safely and effectively support people with mental health conditions. The major contributors to this are understanding of the best clinical processes and legal framework along with a suitable environment and support. **Impact:** This increases the risks for patients, staff and the Trust and delivers poorer outcomes, experience and performance. **2. Scope** **In Scope:** All UHD Mental Health care provision and premises. System- wide agreement of pathways in and out of acute care. **Out of Scope:** **3. Project Goal** Improvements will address root causes and deliver sustainable solutions, underpinned by a process for on-going continuous improvement to mental health provision across UHD. **4. Exit Criteria** Improved patient and staff experience. 50% reduction in Long length of stay. **5. Sponsor and Project Team** **Executive Sponsor: CNO** **Project Lead** **Workstream Leads:** 1. Environment: 2. Education and Training: 3. Clinical Processes: 4. System wide pathways review **6.Governance Structure** **Responsible:** Person or Role to directly manage and deliver the project **Accountable:** Person or Role to oversee the project and ensure delivery of the stated objectives and outcomes — CNO **Consulted:** Person or Role to be engaged in the development and delivery of the project. To ensure engagement with the wider organisation — CNO **Informed:** Person or Role to be assured about progress towards the delivery of the project — CEO **7. High Level Project Milestones** Milestone / Lead / By When / Status Develop the Head of Mental role to further progress UHD strategy Co-design a system wide admissions policy / best interests conversations. Continue to develop and embed the work from the MH workstreams to further develop the benefits Clinical Processes and associated policies that are adopted organisation wide. Develop ED Co-streaming pilot and alternatives to admission **8. Critical Success Factors and Key Risks** **CSFs:** 1. Funding re any Estates issues 2. Stakeholder engagement/support 3. Retaining the scope of the project 4. Sufficient time for project to progress **Risks:** CSFs not met **9. Project Targets and KPIs** **Targets:** 1. All UHD Estate signed off as safe/fit-for-purpose 2. Defined/standardised training 3. UHD SOPs in place as required 4. Legislation incumbent within SOPs **KPI's (metrics)** 1. Volume of staff trained 2. No of restraints 3. Data around Sections 4. Reduction in LOS **10. Impact:** planned benefits relating to True North strategic priorities **Population and System:** Equal access for all to mental health services regardless of presentation site **Patient Experience:** Timely access and collaborative and consistent care **Quality Outcomes and Safety:** Optimised mental health care across UHD within a safe environment **Sustainable Services:** Potential reduction in MHSW requirement and associated cost **Our People:** Staff feel competent and safe when providing mental health care Progress against the workstream actions will be reported to the Trust Mental Health Steering Group with oversight from the Trust Quality Committee.
As part of our Patient Safety Incident Response Plan focus on: **Maternity Safety** including post-partum haemorrhage, Avoiding term admission to neonatal unit (ATAIN) and Still births	A Terms of Reference meeting to scope a PSIRF PSII Thematic review of unexpected term admissions to neonatal intensive care (NICU) was undertaken in February 2025. An independent reviewer has been identified and the review is in progress. The review will include considering how the current National 'Avoiding Term Admissions into Neonatal units' (ATAIN) process functions currently within UHD to identify if there are any areas for improvement. The following actions have already been taken following avoidable term admissions to NICU in Q4 2024/25: • A QI project 'Warm Bundle' is in place across maternity inpatient areas.

- Work continues with staff awareness of escalation to Consultant Obstetricians to open a second theatre when required.
- Ensuring equipment levels are adequate, and equipment is standardised across NICU and Maternity.
- A Red hat initiative has been relaunched for easy identification of babies requiring additional support to avoid admission to NICU.

The following graphs demonstrate UHD performance against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality at the UHD. From March 2024 the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2022 perinatal mortality revised national averages.

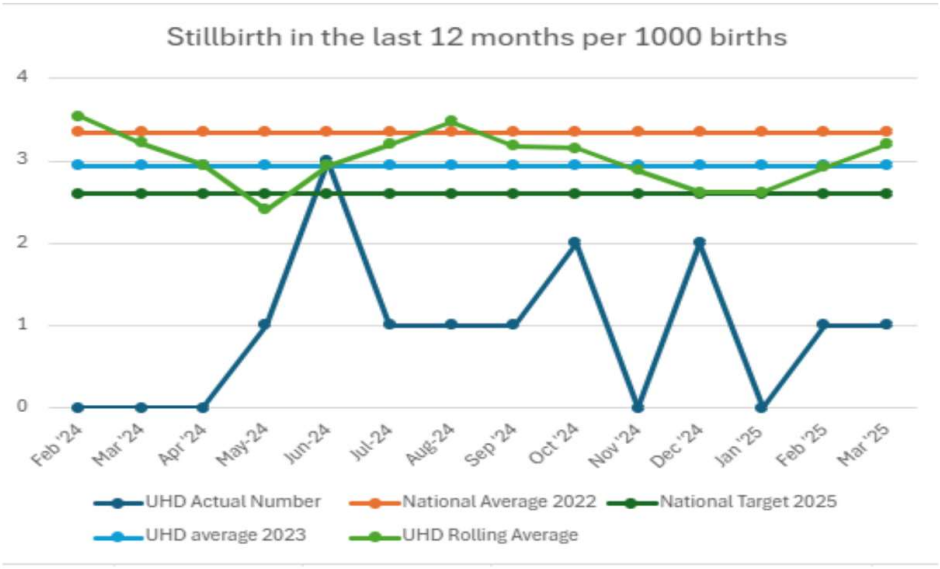


Table 1: UHD NHS Trust stillbirth 3.51 rate per 1000 births over last 12 months.

All cases are reported using the National Perinatal Mortality Review Tool (PMRT) and fully investigated in line with national and local requirements. Actions generated from reviews include:

- Updating Induction of labour (IOL), Perinatal Investigation of Placenta, Identifying Head Trauma in Neonates and Antenatal Care Policies and procedures.
- Ensuring discussion notes are completed at every contact.
- Improving Translation Services in Maternity:
- Ensuring Holistic risk assessments to be carried out at every contact.
- Requiring all IOLs require Obstetric review prior to transfer to low-risk suite.

Post-partum haemorrhage (PPH) is routinely monitored and data compared monthly against the national average. The causes for blood loss include perineal trauma and surgical trauma.

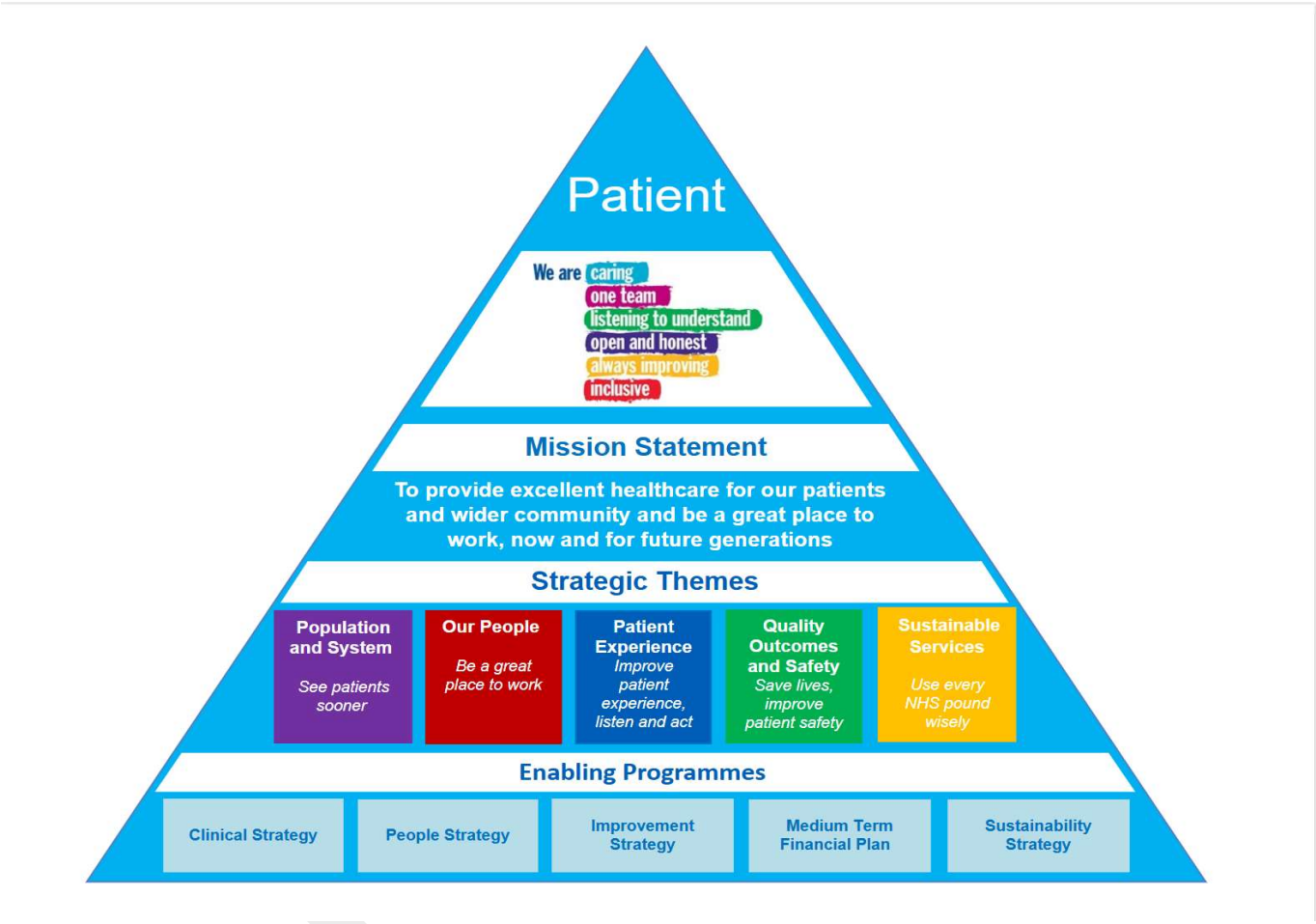
	In March 2025 there were 9 incidences of a PPH ≥ 1500mls. This equates to an incident rate of 29.1 per 1000 women, which is below the national target of 30 per 1000 women. Monthly PPH meetings are in place to review learning from all cases. The Maternity service is also in the process of updating the PPH Review Proforma and new drug cupboards have been installed in all birthing rooms on Haven and Woodlands ward. PPH emergency trolleys have also been provided to Woodlands and Haven so during a PPH staff will not need to waste valuable time leaving the room. A more in-depth PSII thematic review of PPH's is due to commence in April 2025 in line with PSIRF.
Engage with patients, carers, relatives and Patient Safety Partners in our improvement and learning responses to patient safety incidents and we will provide.	The Framework for Involving Patients in Patient Safety was published by NHS England in 2021. This framework sets out approaches and standards that help to make a positive difference to how patient safety is viewed and managed in the NHS. A key part of the framework introduced Patient Safety Partners; empowering patients and their carers to be involved in their own safety, as well as being partners alongside staff in improving patient safety in NHS organisations. The introduction of Patient Safety Partners at UHD is part of a commitment and journey to improve patient engagement and is included in the UHD Patient Engagement Strategy. The importance of patient engagement is deeply embedded into the Trust objectives and Patient Safety Partners are an essential part of the UHD Patient Engagement strategy. A framework document for the strategic involvement of patient safety partners in patient safety in UHD has been produced and approved via the Patient Experience Group. We have appointed 5 Patient Partners to support a wide range of activities across the Trust including patient safety, staff safety and patient experience. Patient Safety Partners now attend our Clinical Governance Group and are involved in several of our PSIRF and Patient First workstreams including Fundamentals of Care and Deteriorating Patient groups. We look forward to developing the role of the PSP further in 2025/26 and working with them to support our Quality and Safety Strategy.

Our quality priorities for 2025/26

Our quality priorities for 2025/26 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 2025/26 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 objectives are:

Quality Outcomes and Safety
Trust objective: Save lives, improve patient safety

Long term vision

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) and patient safety (Patient Safety Incidents).

Medium term strategic goal (3-5 years)

•In the top 20% of trusts in the country for Hospitalised Standardised Mortality Ratios.

• Rated as 'Outstanding' by CQC for safety.

• Decrease severe / moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30%.

• Over 80% of employees believe the Trust promotes a safety culture (Data from NHS Staff Survey).

Short term breakthrough objective (12-18 months)

• To statistically reduce our rate of falls per 1,000 bed days.

• To ensure the % of patients given timely VTE prophylaxis is 95% or higher.

• To statistically reduce the rate of pressure ulcers (hospital acquired) per 1,000 bed days.

• Doctors to achieve 100% compliance in eMortality reviews.

Lead by Dr Peter Wilson
Chief Medical Officer

For Patient Experience it is:

Patient Experience
Trust objective: Improve patient experience, listen and act

Long term vision

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.

Medium term strategic goal (3-5 years)

•Rated as outstanding by CQC for Caring.

• Over 80% of our employees see patient care as a top priority for UHD.

• In the top 20% of NHS Acute Hospital Trusts on the 'overall experience' section in all CQC national surveys.

Short term breakthrough objective (12-18 months)

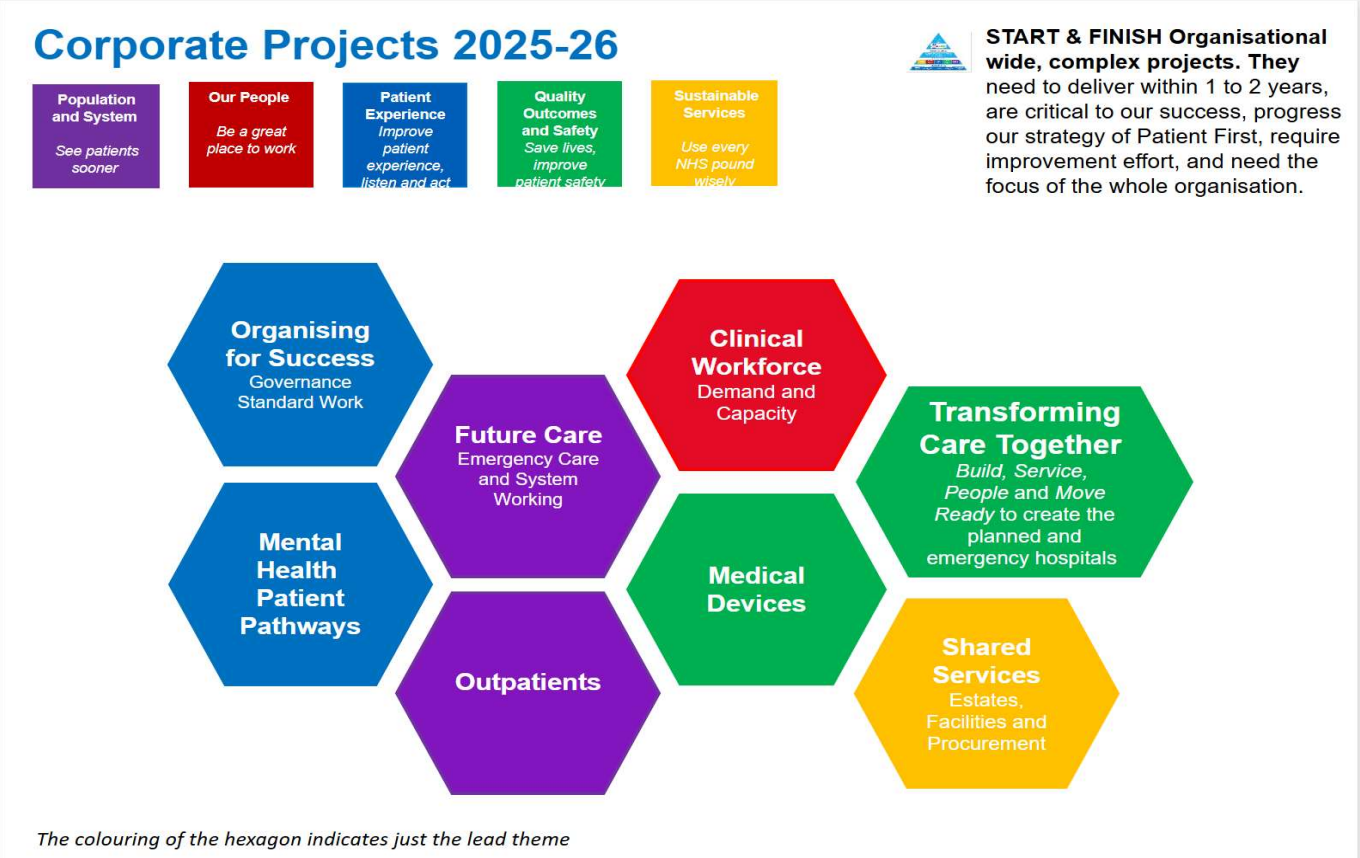
• 100% of complaints to be closed within 35 days, with associated action plan.

• Increase the number of early resolution of complaints by 20%.

• Reduce the number of complaints received per 100 contacts for clinical services by 10% from baseline.

Led by Sarah Herbert
Chief Nursing Officer

To help us achieve our strategic objectives we have established eight organisational wide corporate projects and/or complex projects. They are, each in their own right, a 'blockbuster' programme with their own governance and projects.



All of the corporate projects will be overseen by the Trust Management Group (TMG) - the most senior operational group in the Trust.

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 2024/25 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 2024/25, there were 71 national clinical audits and 6 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 89% of national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that University Hospitals Dorset NHS Foundation Trust participated in, and for which data collection was completed during 2024/25 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 2024/25	Eligible	Participated in 2024/25	% of cases submitted	Purpose of audit
BAUS Data & Audit Programme: BAUS Penile Fracture Audit	Y	Y	No relevant cases identified	To collect descriptive data on the presentation, investigations, management and outcomes of patients undergoing surgical repair of penile fracture; and to determine variations in pathways and treatments received in the UK, including the use of imaging in diagnosis and involvement of tertiary centres
BAUS Data & Audit Programme: BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Y	100%	To assess national practices for the diagnostic evaluation of patients with suspected UTUC and the impact of diagnostic ureteroscopy on the outcomes of RNU, and to evaluate national compliance with standard-of-care practices such as MMC administration and adjuvant chemotherapy in T2 or higher disease.
BAUS Data & Audit Programme: Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Y	100%	Audit practice related to the most important GIRFT decarbonisation recommendations for the bladder cancer care pathway, assess the variation in these practice areas across the UK, estimate hospital level excess greenhouse gas emissions compared to optimal “low carbon” practice.
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 and is voluntary data entry only
Case Mix Programme	Y	Y	100%	The CMP is an audit of patient outcomes from adult general critical care units.
Child Health Clinical Outcome Review Programme	NCEPOD	Y	See table below	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities.
Cleft Registry and Audit Network Database	N	N		

Emergency Medicine QIPs: Adolescent Mental Health	Y	N		Identify current performance in Eds against nationally agreed clinical standards and show the resultsi n comparison with other departments.
Emergency Medicine QIPs - Care of Older People	Y	N	Local audit undertaken	As above.
Emergency Medicine QIPs: Time Critical Medications	Y	N	Local audit undertaken	As above.
Epilepsy 12 - National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	100%	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	Data not currently available	Measure against NICE technology assessments and guidance on osteoporosis and clinical standards for FLSs.
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Y	Y	100%	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals.
Falls and Fragility Fracture Audit Programme – National Hip Fracture Database	Y	Y	100%	Audits of patients with hip and femoral fractures aiming to improve their care through auditing which is fed back to hospitals through targeted reports and online reporting.
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
Medical and Surgical Clinical Outcome Review Programme	NCEPOD	Y	-	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities.
Mental Health Clinical Outcome Review Programme	N	N		

National Adult Diabetes Audit -National Diabetes Core Audit	Y	N	Unable to submit data. Alternative IT solution being developed to enable upload next year.	Measures the effectiveness of diabetes care compared to NICE guidance.
National Adult Diabetes Audit: Diabetes Prevention Programme (DPP) Audit	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: Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	N	The Trust is participating in a different national project on this subject instead - "Diabetes Transition and Young Adult (TYA) Project"	As above.
National Adult Diabetes Audit: Gestational Diabetes Audit	Y	Y	100% (automatic data extract)	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	94%	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 Bariatric Surgery Registry	Y	Y	100% registered	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% (automatic data extract)	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% (automatic data extract)	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 Cancer Audit Collaborating Centre: National Bowel Cancer Audit	Y	Y	100% (automatic data extract)	A high-profile, collaborative, national clinical audit for bowel cancer, including colon and rectal cancer.
National Cancer Audit Collaborating Centre: National Kidney Cancer Audit	Y	Y	100% (automatic data extract)	The audit process will look at diagnosis and treatment, and how patients are managed, to give the right support and expertise in order to provide the best possible care.
National Cancer Audit Collaborating Centre: National Lung Cancer Audit	Y	Y	100% (automatic data extract)	Measure lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best
National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit	Y	Y	100% (automatic data extract)	One of the main objectives of the audit will be to focus on equity, to work towards a service where all patients are given access to the appropriate diagnostic procedures and treatments.
National Cancer Audit Collaborating Centre: National Oesophago-gastric Cancer	Y	Y	100% (automatic data extract)	The audit evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.

National Cancer Audit Collaborating Centre: National Ovarian Cancer Audit	Y	Y	100% (automatic data extract)	This new audit, drawing on the work of a feasibility pilot audit which began in 2019, will produce granular information on diagnosis, treatment and surgery, to allow the audit team to assess how to improve care in England and Wales, and create better results for patients.
National Cancer Audit Collaborating Centre: National Pancreatic Cancer Audit	Y	Y	100% (automatic data extract)	The audit will gather real world information from databases across England and Wales, allowing better comparisons to be made, and revealing where shortfalls need to be addressed
National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	Y	Y	100% (automatic data extract)	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes.
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: Congenital Heart Disease (adult & paediatric)	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: 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)	Y	Y	100%	As above

National Cardiac Audit Programme (NCAP): The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N	N		
National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAAO) Registry	N	N		
National Cardiac Audit Programme (NCAP): Patent Foramen Ovale Closure (PFOC) Registry	N	N		
National Cardiac Audit Programme (NCAP): Transcatheter Mitral and Tricuspid Valve (TMTV) 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: National Comparative Audit of NICE Quality Standard QS138	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: National Comparative Audit of Bedside Transfusion Practice	Y	Y	Poole Hospital 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 - Laparotomy	Y	Y	Data not currently available	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales
National Emergency Laparotomy Audit – No Laparotomy	Y	N	New audit requirement introduced in year	NoLap is an extension of the National Emergency Laparotomy Audit (NELA), focussing on patients who present with a surgical condition requiring operative treatment but who do not have surgery.
National Joint Registry	Y	Y	At least 95% * The Trust have had gold awards for NJR compliance for the last 4 years. The standard is not 100%")	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety
National Major Trauma Registry	Y	Y	100%	Analyses data of trauma care to improve emergency care management and systems.
National Maternity and Perinatal Audit	Y	Y	100% (automatic data extract)	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	Y	Y	100%	The National Obesity Audit (NOA) brings together data to drive improvement in quality of care available to those living with overweight and obesity in England.
National Ophthalmology Database: Age-related Macular Degeneration Audit (ARMD)	Y	Y	100%	Project includes large-scale audit for both cataract surgery and age-related macular degeneration
National Ophthalmology Database Audit: National Cataract Audit	Y	Y	100%	As above

National Paediatric Diabetes Audit	Y	Y	100%	Audit of the care processes received, and outcomes achieved by all children and young people attending paediatric diabetes units.
National Perinatal Mortality Review Tool	Y	Y	100%	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units.
National Pulmonary Hypertension Audit	N	N		
National Respiratory Audit Programme: COPD Secondary Care	Y	Y	100%	Aims to improve the quality of care, services and clinical outcomes for patients with asthma and chronic obstructive pulmonary disease (COPD).
National Respiratory Audit Programme: Pulmonary rehabilitation	Y	Y	100%	As above.
National Respiratory Audit Programme: Adult Asthma Secondary Care	Y	Y	100%	As above.
National Respiratory Audit Programme: Children and Young People's Asthma Secondary Care	Y	Y	100%	As above.
National Vascular Registry	Y	Y	Data not currently available	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%	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
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: Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	N	N		
Prescribing Observatory for Mental Health Audit Programme: The use of melatonin	N	N		
Prescribing Observatory for Mental Health Audit Programme: The use of opioids in mental health services	N	N		
Quality and Outcomes in Oral and Maxillofacial Surgery: Oncology & Reconstruction	Y	Y	No cases submitted	To set up and develop a sustainable quality management and clinical effectiveness programme that delivers continuous improvement in the care of patients undergoing OMFS, within all parts of the NHS and demonstrates health-related benefits to patients from selected core OMFS activities.
Quality and Outcomes in Oral and Maxillofacial Surgery: Trauma	Y	Y	100%	As above.
Quality and Outcomes in Oral and Maxillofacial Surgery: Orthognathic Surgery	Y	Y	Data not currently available	As above.
Quality and Outcomes in Oral and Maxillofacial Surgery: Non-melanoma skin cancers	Y	Y	Data not currently available	As above.
Quality and Outcomes in Oral and Maxillofacial Surgery: Oral and Dentoalveolar Surgery	Y	Y	Local audits and data capture only	As above.
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').
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		

National Confidential Enquiries for Inclusion in Quality Report 2024/25	Eligible to Participate	Participated in 2024/25	% of required cases submitted
Juvenile Idiopathic Arthritis	Yes	Organisational questionnaire submitted	Report published Feb 2025
Rehabilitation following Critical Illness	Yes	Data collection is closed	Report due Spring 2025
Blood sodium	Yes	Clinical and Organisational data collection currently open	Clinical and Organisational data collection currently open
Emergency (non-elective) procedures in children and young people	Yes	Organisational questionnaire distributed	Clinical questionnaires distributed x2
Acute Limb Ischaemia Study	Yes	Identification spreadsheet submitted Organisational questionnaire submitted	Clinical questionnaires distributed x10
Acute Illness in people with a Learning Disability Study	Data collection commences Spring 2025	Identification spreadsheet submitted	Data collection commences Spring 2025
Stabilisation of the critically ill child	To commence Aug 2025	To commence Aug 2025	To commence Aug 2025

Learning from National Audits

The reports of 44 national clinical audits were reviewed by University Hospitals Dorset NHS Foundation Trust in 2024/25 and, as examples, the Trust intends to take the following actions to improve the quality of healthcare provided as a result:

- NHSBTS 2023 National Comparative Re-Audit of NICE Quality Standard 138 - Transfusion Prescription Chart updated with box to confirm written information has been given to the patient, there is a tear off section for the clinician to give to the patient at the time of verbal consent – completed.

- National Respiratory Audit Programme (NRAP) – Children and Young People's Asthma Secondary Care (Breathing Well – Clinical Audit Report 2022/23) - Raise the importance of inhaler technique training before discharge, establish a regular training schedule for new nurses and junior doctors about various new inhalers, their knowledge base approach and techniques. Update the admission proforma to include smoking / vaping question in the family history – in progress.

- National Stroke Audit (SSNAP) 1st April 2023 to 31st March 2024 (Annual Results Portfolio) - All 10 SSNAP domains are reported in the stroke performance and delivery action plan. Within these specific actions relating to each of domains are captured and reported on. This is reviewed regularly in the stroke operational leads meeting – in progress.

- National Audit: National Perioperative Quality Improvement Programme (PQIP) - (Report 5 2023-24) – Report data used to support local audits : Pain management in colorectal surgeries and use of neuraxial analgesia, and, Temperature management of patients perioperatively. – in progress.

- National Respiratory Audit Programme (NRAP) - 2024 Organisational Audit: Adult Asthma/COPD - work with paediatrics to set up a pathway/transition clinic for young people with Asthma – completed.

- Fracture Liaison Service Database (FLS-DB) Annual Report 2025 (Data from 1 January 2023 to 31 December 2023) - FLS Integrated Care Service project in progress.

Learning from Local Audits

The reports of 264 local clinical audits were reviewed by the Trust in 2024/25 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- 'Do Not Attempt Cardiopulmonary Resuscitation / Allow A Natural Death' (DNACPR / AAND) Decisions - Re-design E-form to allow direct sharing with GP/primary care and OOH services, and E-learning guide to increase rates of Consultant ratification – completed.

- Comfort Score Audit - Encourage discharging staff to observe and escalate any discrepancies of comfort score (differences of 2+) to raise with nurse in charge and clinician on the day– completed.

- Re-audit of Use of Interpreting Services in Maternity Services - Produce/access quick reference flash cards to ask patients essential safeguarding questions in their own language when able to speak to patient away from partner/family member/friend. – completed.

- Re-audit: Waiting lists for paediatric grommet insertion - Offering of hearing aids in OME (Otitis media with effusion) with hearing loss cases that are delayed. – in progress.

- Audit to see if stroke patients receive stroke bloods within 24hrs of admission – Change made to the stroke clerking booklet management page to include a checklist mentioning the need for these bloods to be taken in ischaemic stroke – completed.

- WHO 2023/24 Surgical Safety Checklist: Quality Audit – Theatres - Standardised debrief form to be introduced to both sites – in progress.

- Inherited Bleeding Disorders Emergency and Out of Hours (OOH) Care - In clinics, bleeding disorder patients to be given contact information for out of hours consultant – completed

- Documentation of X-ray Report by Neonatal Team - Change ward round documentation sheet to include section specifically for imaging and if report had been reviewed – completed.

- Audit of Observations at triage on Patients Presenting with Head Injuries in the Minor Injuries Unit Against NICE Guidelines- Poster produced of audit result and provided to department leads and sent out in weekly summary. Highlighting the importance of obtaining observations on patients with head injury and ensuring patient safety– completed

- Comfort Score Re-Audit - Improve compliance of score completion with random spot checks– in progress.

- Efficacy of Escalation of NEWS2 Scores - Filming of an educational video to support the correct completion of observations and highlighted the existing escalation policy – completed.

- An audit to determine compliance with National Guidelines for patients admitted with confirmed Pulmonary Embolism - Teaching session to the ACM/on call team to celebrate good practices highlighted, share audit results, reinforce importance of documentation, refresh staff on National guidelines and focus on patient safety – completed.

- Timing of Perfusion or Ventilation/Perfusion Scanning and CXR in the investigation of acute pulmonary embolus (PE) - Implement a system to monitor delay to VQ scan after CXR – in progress.

- Hepatitis B & C Monitoring in Patients with Bleeding Disorders - To start an annual joint hepatology/haemophilia clinic to review patients' bleeding disorder and liver simultaneously – in progress.

- Uptake of the Venous Thromboembolism (VTE) Prophylaxis e-form in Emergency Department at UHD - VTE e-form added to Bluespier (Virtual Fracture Clinic) as the next stage in the pathway so that patients requiring it are not missed – in progress.

- Bariatric Clinic performance audit - Review clinic scheduling to maximise capacity. Consider introducing more group education sessions for certain aspects of the pathway to free up clinician time for individual consultations. – in progress.

3. Participation in clinical research:

Recruitment at UHD was 4146 in the financial year, with an additional 111 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.

Our research portfolio actively supports the Dorset ICS ambition to make Dorset the healthiest place to live. Early Child Health is a priority and our two highest recruiting studies are looking at early diagnosis of conditions in newborn children, Spinal Muscular Atrophy and cataracts. We also support innovative treatments and health prevention across many specialities. Some highlights include participation in a cancer vaccine platform, which if successful, would prevent the recurrence of a variety of cancers. Also, through our Wessex research hub, we recently delivered a norovirus vaccine study. This would be a world first vaccine for norovirus and was delivered through a collaborative hub model; sharing innovative commercial research opportunities within Wessex. This compliments an increase in commercial research in UHD offering treatments not otherwise available to NHS patients.

UHD also develops its own research including the CLEAT study, which investigated the CHAIN intervention using a group-based cycling and education programme for the treatment of hip osteoarthritis. This proved to be more effective than standard physiotherapy care in terms of function, symptoms and quality of life. There has already been interest from other trusts in implementing the CHAIN intervention more widely and the research team are developing the resources needed to make this freely available via the Orthopaedic Research Institute's website.

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

The Trust's income in 2024/25 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 Trust received an announcement inspection of surgical services at Poole Hospital and Royal Bournemouth Hospital on 28 and 29 January 2025. A post inspection feedback letter was sent by the CQC in February however the full report is not expected to be published until June 2025.

The feedback letter highlighted a few areas for improvement including the availability of clinical equipment, low level environmental infection prevention and control concerns at Royal Bournemouth Hospital and general oversight of the environment. Actions have already been taken to respond to the concerns raised. The feedback letter also noted improvements with the timeliness of the fractured neck of femur pathway at Poole Hospital and reported that generally the environment was clean and free from clutter. Across surgical services they highlighted that internationally trained staff gave positive feedback about working in the Trust, patients gave positive feedback about the care they received and overall staff were caring and responsive to their patients.

The CQC have also undertaken a visit to our new BEACH building at Bournemouth Hospital as part of routine registration assessment under the New Hospital Programme (NHP) framework. On the 5 and 6 March 2025, the CQC visited the BEACH building to assess ED, Critical Care, Maternity and Radiology and focused on the following areas:

- Suitability of premises and equipment
- Safe care and treatment
- Staffing
- Good governance

The Trust received a post visit letter on the 7 May 2025 with positive feedback across all areas visited. The CQC letter noted in summary that "the *opening of the BEACH will have a positive and beneficial effect on life for patients attending it and staff working in it".* The CQC also extended thanks for the arrangements that were made at short notice to help organise the assessment and for the cooperation that they experienced from all staff who were involved in the visit.

6. Data Quality

The University Hospitals Dorset NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS number was 99.8% for admitted patient care; 100% for outpatient care; and 99.3% 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 100% for accident and emergency care. (Taken from the National M12 24-25 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 24/25 DSPT submission at the end of March 2025.

Information Governance incidents within the Trust are managed through consistent, rigorous processes. Incidents are reviewed monthly through the Information Governance Steering Group with engagement from the Caldicott Guardian, Senior Information Risk Owner and Dta Protection Officer where required.

During the year ending March 2025, the Trust notified the Information Commissioner's Office (ICO) of one Information Governance related incident, using the Data Security Incident Reporting Tool**.** The incident that was reported did not originate within the Trust but affected a third-party supplier who process personal data regarding Trust staff; the incident was reported to the ICO for awareness. The ICO deemed that no action against the Trusts was necessary.

This incident involved the supplier of dosimetry monitoring services to the Trust. The supplier reported a cyber-attack which resulted in the exfiltration of personal data. This includes the first name and surname, plus radiation dose received, of 439 staff who use dosimeters for radiation exposure monitoring. The supplier reported that this information was exfiltrated in September/October 2023, and their subsequent investigations found that it was posted to the "dark web" by the "threat actor" who had infiltrated their network. This breach was only reported to the affected parties in November 2024, with the justification being that the supplier had had to review the data that was exfiltrated to establish its origin.

The Data Security Protection Toolkit (DSPT) is a mandatory annual self-assessment audit produced by NHS England. In 2024/25 the DSPT provided Acute Trusts with numerous assertions to which a response was required, with the intent being to help to determine the extent to which an organisation is compliant with national guidance and legislation.

In advance of the 2024/25 publication of 30 June 2024, the Trust's internal auditors conducted a high-level review of a sample of Data Security Standards, which provided moderate overall assurance, and high levels of confidence in the Trust's submission. The purpose of the audit was to provide an independent review of the assertions and evidence items in the Trust's DSP Toolkit self-assessment return at the time of the audit and, where necessary, to identify how compliance could be improved for the year-end return.

As of 30 June 2024, the Trust submitted a fully compliant DSPT, with a confirmed status of "Standards Met".

8. Learning from deaths

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 a full “e-mortality” case note review or patient safety investigation.

All inpatient deaths that are highlighted for e-mortality review receive a consultant review against a specific structured judgement questionnaire. The review looks at the full patient journey and highlights both good practice and any issues for learning or improvement.

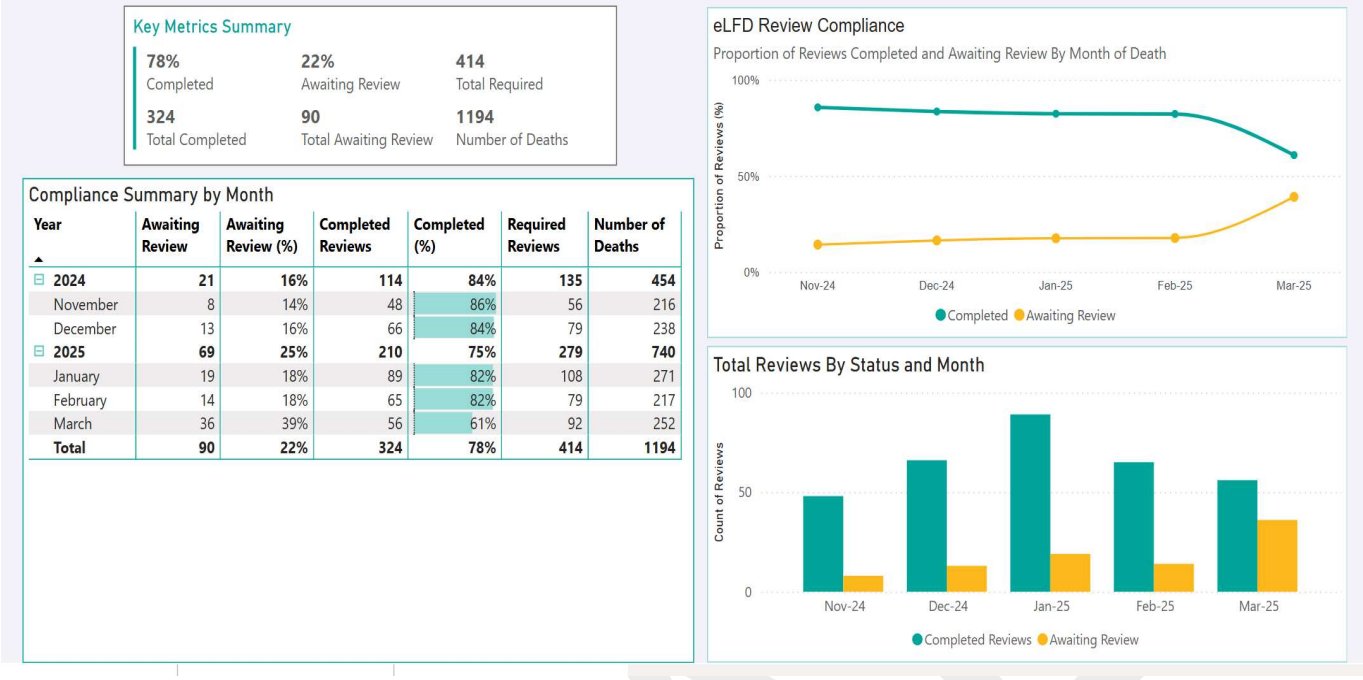
The Trust Mortality Surveillance Group (MSG), chaired by the Chief Medical Director or Deputy, meets monthly and reviews the Trust mortality metrics including the Trust’s Hospital Standardised Mortality Ratio (HSMR) and any internal or external mortality risk reports. The group discusses areas of potential concerns regarding clinical care or coding issues and identifies further work, including detailed case note audit and presentations from relevant specialties. Any learning points from the Group are disseminated through Directorate and Care Group governance structures as well as the Trust Clinical Governance Group and Quality Committee.

Themes for action and learning from mortality reviews and medical examiner feedback are linked to the development of patient safety incident response plan priorities and patient first quality improvement initiatives for 2025/26.

Learning from Death figures for 2024/25

The Trust introduced a new e-mortality process and IT system across all specialities in November 2024. Once the need to complete a full case note review has been identified by the Medical Examiner Office a 3 month timescale is allowed for completion of the review and discussion at the relevant speciality mortality meeting. Data for 2024/25 is therefore only available for a limited dataset.

Results for February 2025 reflect compliance with reviews required in November 2024. Overall compliance was 82%.



The “e-mortality” 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.

Figures for reviews completed since November 2024:

e-Mortality by Grade	Nov 24	Dec 24	Jan 25	Feb 25	March 25
Grade 0	**45**	**49**	**65**	**36**	**28**
Grade 1	**6**	**12**	**10**	**3**	**1**
Grade 2	**1**	**1**	**1**	**1**	**0**
Grade 3	**0**	**1**	**1**	**0**	**0**

Reviews are discussed at specialty Mortality and Morbidity meetings and the chairs of these meetings report into their respective Care Group Quality meetings as well as the Trust Mortality Surveillance Group. This ensures that the reviews of all deaths within the hospital are discussed both locally and centrally and ensures actions for improvement are fully considered.

9. Freedom to Speak Up

The benefits to developing a speak up culture is well documented and includes promoting innovation and productivity, improving employee engagement and retention but above all to stop potential harm. At UHD, we have many channels that our staff can 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.

It is five years ago this summer, when our staff developed a set of values for our new organisation. Two of those values explicitly relate to speaking up; “open and honest” and “listening to understand” illustrating our commitment to creating a culture where staff feel safe to speak up. We have made significant inroads, and our staff survey this year tells us that (see later). There is however more to do. 2025 is the year when we need to mature our speaking up culture where we are not only confident that we give our staff a voice, but that we show this voice counts by acting and following up through a positive interaction.

The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. They are also an ally and a critical friend that works in partnership across an organisation to encourage action to improve culture.Creating a speaking up culture however requires positive actions at all levels of the organisation, to create psychologically safe working conditions for staff to raise questions and to have them answered in a responsive way.

At UHD we have 2 FTSU Guardians alongside a network of 13 FTSU Ambassadors. Our team help us raise awareness and promote the value of speaking up, listening up and following up thereby addressing challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

Freedom to Speak Up training programme.

‘Speak Up, Listen Up, Follow Up’, are e-learning packages, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

In October 2024 a decision was made to make the Speak Up e-learning module mandatory in UHD. By the end of March 2025 almost 6000 staff had completed the training. A great success 😊.

Key Themes from F2SU Referrals

Staff approach the FTSU team for a number of reasons. Five hundred and thirty-five (535) cases were raised with the team in 2024/25. This is an increase of 30% on the previous 12 months.

Speaking up via the FTSU team continues to be used predominantly for concerns relating to our working environment or relationships rather than patient safety issues and may be a product of our strong LERN culture in capturing our patient safety issues.

The greatest theme had an element of behaviours (38%). This is followed by process and procedures (30%) and then worker safety and wellbeing (109 staff; 20%).

Learning from concerns about incivility at work to the F2SU Team have directly feed into the development of the UHD Behaviour Charter mentioned earlier in this report. The Behaviour Charter sets out clear standards that we expect from our staff, patients, and visitors.

A busy 2024/25 for the F2SU Team – A year at a glance:

April-March "Looking in and out" –Networks

- UHD FTSU Network
- UHD staff Networks
- Dorset and Somerset Network
- South-west regional Networks

April – March "Data Submissions" UHD continues to be an active contributor and submits requirements from the NGO. These include quarterly submissions, census information and other surveys.

JUNE: The UHD Awards is an important way to recognise each-other. In 2024, over 860 nominations were received. The "Open and Honest" category, recognising an individual or team that works hard to promote an open and safe culture. This year's worthy recipient was Kelly Phillips, lead midwife for safeguarding. The Chair Award was bestowed to Helen Martin for the work she and her team do for speaking up at UHD.

JULY: Published national documents (discussed at Bi-annual report)

- Building a Culture of Confidence: NGO refreshed Strategy.
- NGO Data Annual Report (2023/4)

OCTOBER FTSU Month: The Power of Listening. Mandatory launch of Speak Up - eLearning

The National Guardian, Jayne Chidgey- Clark came to UHD with her national lens and facilitated discussions with our board, our FTSU team and patient safety leads. Focusing on barriers and openness of speaking up.

JANUARY 2025

- NGO Detriment Guidance
- NGO guidance on Employment Tribunal

In 2023/24, 4% (1285) of cases indicated workers believed they experienced some form of disadvantageous and/or demeaning treatment because of speaking up. At UHD this was less than 1% (1 case). This guidance lays out the responsibilities of us as an organisation and leader highlighting guiding principles. This guidance is now within our FTSU policy.

FEBRUARY/MARCH – NGO Conferences
Conference attendance is integral to the role of the FTSUG alongside networking within and outside the region. Additional roles such as Mentor are also part of our role to increase our exposure to national arena.

MARCH Annual NGO report (2023/4) laid before parliament highlighting say/do gap, the importance of belonging and leadership.

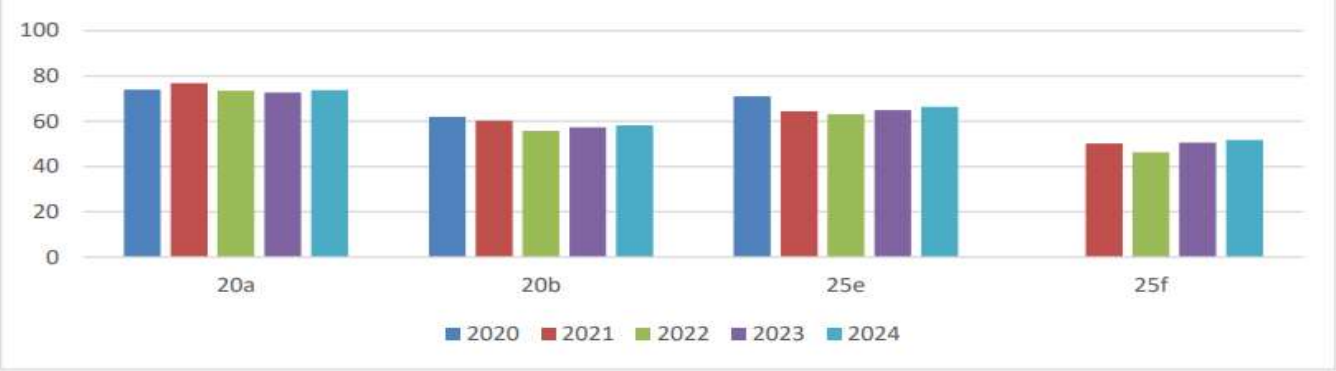
Speaking out – National Staff survey results 2024

Speaking up is measured within the People Promise Element of the National Staff Survey. Scores are on a 0-10 scale, where a higher score is more positive than a lower score. The graph below shows the results for 2024 and highlights the year-on-year improvement since 2022.

Question 25f, which is highly regarded to reflect a speaking up culture, shows that 51.8% of staff who completed the staff survey felt UHD nurtured a speaking up culture as compared to 46.3% in 2022. This is a 5.5% increase and is significantly better than the sector comparison (49%). It is positive to see that more staff at UHD feel that they have a voice that counts.

Table and Graph: National Staff Survey – People Promise Questions – “we have a voice that counts”.

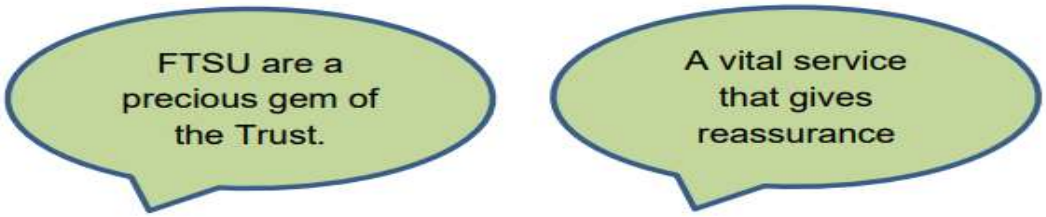
Q	Speaking up - clinical safety
20a	I would feel secure raising concerns about clinical practice
20b	I am confident that my organisation would address my concern
	Speaking up -raising concerns
25e	I feel safe to speak up about anything that concerns me in this organisation
25f	If I spoke up about something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



Annual User Survey

The FTSU team run an annual service user survey sent to all staff who use the service. Of those who used the service over 50% said that it supported their health and wellbeing and over a third of respondents said that they remained in work as a direct consequence of speaking to the FTSU team.

FTSU Survey Question	Results 2023	Results 2024
Speaking to the team supported my Health and Well being	64%	58%
Reduced staff sickness	25%	21%
Supported staff retention	26%	**42%**
Staff satisfaction – given experience if the FTSU team would you speak up again	90%	84%



"I felt for the first time that my concerns were listened in an unbiased manner and not brushed under the carpet".

"It provided me with an outlet to voice my concern without feeling suppressed think the FTSU service is a brilliant asset to our organisation".

Fostering a speak-up culture requires positive actions, at all levels of the organisation, to create psychologically safe working conditions for staff to raise questions and concerns and to have them answered in a responsive way.

More staff are telling us that our speaking up culture is improving, we need also not only to be confident that we give our staff a voice but that we show that this voice counts by acting and following up.

10.0 Guardian of Safe Working Hours

The full Guardian of Safe Working Hours Annual report (January-December 2024) was received by the People and Culture Committee in April 2025.

For the last calendar year there has been a (positive) 23% decrease in the number of exception reports (ERs) on both sites. The majority of reports relate to hours of working accounting for 91% of the 2024 reports received compared to 89% in 2023.

11.0 National 7 Day Services Clinical Standards

In recent years there has been an increasing focus nationally on the need to strengthen emergency and acute care in hospitals in England during evenings, nights and weekends (generally known as "seven day working").

The national Clinical Standards (published 2017 and updated 2022) set out expectations for the patient admitted to an acute Trust. These standards are independent of the day of the week. They are quality standards, one component of which is timeliness, ensuring that the patient pathway continues seamlessly throughout the weekend. Although the Standards are constructed from a patient focus, their implementation should also lead to an improvement in patient flow and efficiencies.

The standards are included within the NHS Standard Contract. The National Board Assurance Framework covers the 4 (out of 10) priority national standards:

- *Standard 2 - Time to first consultant review*
- *Standard 5 – Diagnostics*
- *Standard 6 – Interventions*
- *Standard 8 – Ongoing Review*

An annual assessment was completed in October 2024 and reported to the Trust Board of Directors in November 2024.

The assessment indicated that most services provided some level of extended day/weekend services. However, there did remain some gaps and variation which impacted potential for improved compliance against the standards. The key areas for improvement are outlined below and linked with the System-wide (FutureCare) work:

- Front Door decision making
- Discharge – cover on downstream wards, effective reviews and process/flows to support timely discharge and community transfers
- Time to surgery and benefits to elective pathways as well as cross benefit to urgent surgery
- Embedding Seven Day Services improvement against standards in Service Reviews, Option papers and Business Cases.

Consistent high-quality services 7 days per week are a key tenet of the UHDs “Transforming Together” service reconfiguration (planned and emergency hospitals). In addition to supporting timely, quality care and effective clinical outcomes for all patients regardless of day/time of admission, achieving these standards will be critical to optimising our bed base and hospital flow on hospital reconfiguration.

Further improvement to compliance against the standards is expected to be delivered following reconfiguration, particularly Phase 3. Therefore, further audit will be planned for Spring/Summer 2026 to measure improvements and identify any further gaps. Monitoring will continue through service and speciality planning, workforce plans and Service Reviews continues.

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)	NHS England	January 2024 – December 2024 0.8711	1.000	1.3323	0.6991
		January 2023 – December 2023 0.8682	1.000	1.2548	0.7202
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://digital.nhs.uk/data-and-information/publications/statistical/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 2024 – December 2024 51%	44%	66%	17%
		January 2023 – December 2023 32%	42%	67%	16%
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://digital.nhs.uk/data-and-information/publications/statistical/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	24/25 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 2023 – March 2024 (i) = 12.5% (640) (ii) = 12.8% (5560) April 2022 – March 2023 (iii) = 14.2% (1185) (iv) = 12.0% (7535)	12.8% 11.8% 12.0% 11.8%	69.1% 99.6% 302.9%** 46.8%	1.6% 1.7% 3.7% 2.5%

* 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	2024 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	2024 – 67.0% 2023 – 67.3%	61.5% 63.3%	89.5% 88.8%	39.7% 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)	2023/24 – 18.6 per 100,000 overnight bed days. 2022/23 – 16.5 per 100,000 overnight bed days.	18.81 18.48	56.65 73.34	0 0
The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors 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 Care Group and Directorate Quality and Safety meetings. There is a clear quality reporting structure where scheduled reports are presented 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 2024/25 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 (PSIRF)

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

In November 2023 we set out our UHD Patient Safety Response Plan and the patient safety priorities we would focus for the next 18 months. In April 2024 we moved over completely to adopting PSIRF principles and methodology.

How have we delivered against the principles of PSIRF over the first 12 months?

Improvement is the focus.

Themes from safety incidents are linked with improvement groups for Trust wide actions. For example, Medicines Optimisation Group, Thrombosis Group, Deteriorating Patient Group, Fundamentals of Care Group, Mental Health Group and End of Life Care Group.

Learning from patient safety incidents is a proactive step towards improvement.

Recommendations are made direct from stakeholder feedback. The message is that everyone is involved in patient safety learning.

Curiosity is powerful.

During our Learn at Lunch on World Patient Safety Day one of our fabulous Patient Safety Incident Investigators coined the phase "*Be curious not critical*". That mantra has stuck and is applied to everything we do in our patient safety incident response fraework. We have created a PSIRF Toolkit to set out how to use different types of methodology to find out what, how and why in our learning responses. We encourage direct observations of care and current practice as part of investigations and focus on *work as done* rather than *work as imagined* or *work as prescribed*.

Collaboration is key.

Those involved in a safety incident contribute to improvements and recommendations, have input into the learning response and signoff processes. Using safety huddles, clinical case reviews, multidisciplinary team reviews and After Action Reviews allows teams to understand interaction and where improvements can be made across shared pathways and processes. We have introduced a weekly PSIRF Insight meeting where cases can be discussed and relevant learning responses for cross Care Group incidents agreed. We have also introduced a monthly PSIRF Oversight meeting where there is a collaborative approach to agree and sign off investigation recommendations and actions. There is oversight and integration with Integrated Care System partners to facilitate systemwide shared learning discussion and development.

Our Patient Safety Partners attend UHD PSIRF Oversight meetings and the ICB NHS Dorset Shared Learning Forum. Our PSPs also participate in the Southwest PSP Network meetings and input into Fundamentals of Care working groups.

Psychological Safety facilitates learning.

We have acknowledged the importance of having mechanisms in place to support staff. Actions have been taken to ensure staff have signpost to support. There is good collaboration between the Patient Safety, Staff Well Being, Freedom to Speak up and, Education and Training teams. There is also good links with leads for junior doctors, students and bank and agency staff.

Blame restricts insight.

Patient safety incident investigations and After Action Review learning responses focus on system analysis using the SEIPS (Systems Engineering Initiative for Patient Safety) model to understand system, environmental, tasks and human factors that influence safety. Using this model ensures that the focus is taken away from looking for individual acts or omissions.

Senior leadership support is vital.

We have engaged our Board in supporting our PSIRF approach. A specific Board development session was held to outline our PSIRF processes and change support and understanding on the cultural change challenges ahead.

What have we learned over the last 12 months about our PSIRF journey?

What have we achieved?	• PSIRF priorities identified.
	• PSIRF plan and policy available on both internet and intranet
	• PSIRF process of triage, rapid review, Insight and Oversight meetings established.
	• PSIRF Toolkit on Intranet, learning response tips and tools.
	• All “old” Serious Incidents and Board reports closed.
	• Team established including dedicated Investigators.
	• 30 Individuals trained externally in Systems approach.
	• Developed in house training program. Since 1 April 2024 the Patient Safety Team have provided the following training:
	  ○ After Action Review – 113 staff
	  ○ PSIRF learning response - 56
	  ○ Duty of Candour – 47
	  ○ Reporting LERNS – 164
	  ○ Reviewing LERNS - 200
	• Thematic reviews commissioned on DIVA, Pressure Ulcers, Falls and Term admission to NICU.
	• A3s improvement plans have been created for VTE, Deteriorating patients, Pressure Ulcers and Mental Health
	• Just and restorative culture is being role modelled within PSIRF meetings.
	• Audit of patient safety events including reconciliation with LFPSE, level of harm, DoC and learning responses has taken place.
	• Datix dashboards and trackers produced to facilitate PSIRF processes.
	• Learn at lunch programme monthly fully established and well attended.
	• Links between PSIRF and the NHS Dorset Learning Disabilities mortality review (LeDeR) process established.
	• Links with Health Innovation Wessex PSIRF leads.

What went well	• Executive Director support • Care Group engagement to establish local weekly Rapid Review Meetings • Engagement at weekly PSIRF Insight meetings and the monthly PSIRF Oversight meeting • Open and honest conversations at PSIRF meetings • Working collaboratively with the ICB • Appointing and involving our new Patient Safety Partners in PSIRF • Change in language from “serious incidents” to patient safety events. • Moving away from investigation relating to harm to investigation for learning • Less focus on the numbers more focus on the themes.

What are the challenges	• Lack of a dedicated Family Liaison Officers for safety incidents • Staff availability and engagement to undertake Systems based approach investigations. • Opposing requirements with PSIRF and coronial process and claims (learning vs culpability) • Staff management time to review LERNs and undertake learning response. • More triangulation with audit and Quality Improvement needed. • Staff knowledge of reporting forms on Datix
What are the next steps?	• Embedding PSIRF at ward level • Engagement and Involvement training and resources • Engagement with education teams to support learners at the very start of their career. • Undertake review/audit of learning response for systems based approach and safety actions. • Procurement of a new Local risk management system to provide better data sets/oversight and triangulation. • A3/Improvement projects for priorities and evidence improvement • Coordinate shared learning from patient safety events, deaths, inquests, complaints and claims and audit. • Greater promotion of just and restorative culture • Build on Patient Safety Partners roles and involvement. • Look at how we can report on learning responses including linking complaints and PALS enquiries to our PSIRF processes.

Patient Safety Events – Themes in 2024/2025

We have amended our LERN database to be able to record the PSIRF themes for each reported patient safety incident.

Table: LERNS by patient safety theme – April 24- March 2025

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Other	214	275	265	348	332	311	347	306	305	294	289	326	**3612**
Falls	176	227	192	237	207	174	253	203	223	242	234	224	**2592**
Medication	132	147	153	151	143	166	154	113	149	161	156	164	**1789**
Pressure Ulcers	100	111	104	145	130	121	130	99	141	126	152	191	**1550**
Diagnostics - Radiology/Laboratory	45	59	64	60	66	68	88	61	61	62	53	66	**753**
Deteriorating Patient	29	32	21	13	14	24	11	12	16	13	20	22	**227**
Unexpected term admission to NICU	18	22	10	14	25	26	24	6	18	18	18	14	**213**
Mental Health	14	4	15	16	20	21	21	27	19	12	10	16	**195**
Postpartum Haemorrhage	12	9	15	10	15	17	8	15	9	17	14	9	**150**
VTE	3	4	3	0	4	3	4	1	3	3	2	1	**31**
Stillbirth	0	1	3	1	1	2	2	0	3	1	1	0	**15**
Total	**743**	**891**	**845**	**995**	**957**	**933**	**1042**	**843**	**947**	**949**	**949**	**1033**	**11127**

The patient safety theme is chosen at the time of reporting and can be updated by the 'reviewer' of the LERN. As the 'improvement' element of PSIRF develops, these themes will undergo greater scrutiny to ensure data quality and provide assurance on learning.

Learning from patient safety investigations is shared in several 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 Safety 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

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 2024 – 31 March 2025) the Trust reported 4 never events, this compares to three in 2023/24, and four in 2022/23. Two incidents related to a retained foreign object, one wrong site surgery and one regarding window restrictors. 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 NHS Dorset Shared Learning 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.

The questions in the NHS Staff survey are aligned to the NHS England 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 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.

NHS Staff Survey – 2024 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 2024 showed improvement in relation to staff feeling safe to raise concerns and report staff and patient safety events.

Question	2022	2023	2024	Movement	UHD Comparison to national average (all acute Trusts) 2024
My organisation treats staff who are involved in an error, near miss or incident fairly	62.4	64.71%	**65.0%**		Better than 60.4%
My organisation encourages us to report errors, near misses or incidents	88.6	88.9%	**89.0%**		Better than 85.6%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	66.9	69.1%	**69.5%**		Better than 68.9%
We are given feedback about changes made in response to reported errors, near misses and incidents	57.2	60.1%	**60.6%**		Slightly worse than 62.0%
I would feel secure raising concerns about unsafe clinical practice	73.5	73.1%	**73.8%**		Better than 70.7%
Care of patients/service users is my organisation's top priority	72.9	76.3%	**76.4%**		Better than 75.1%

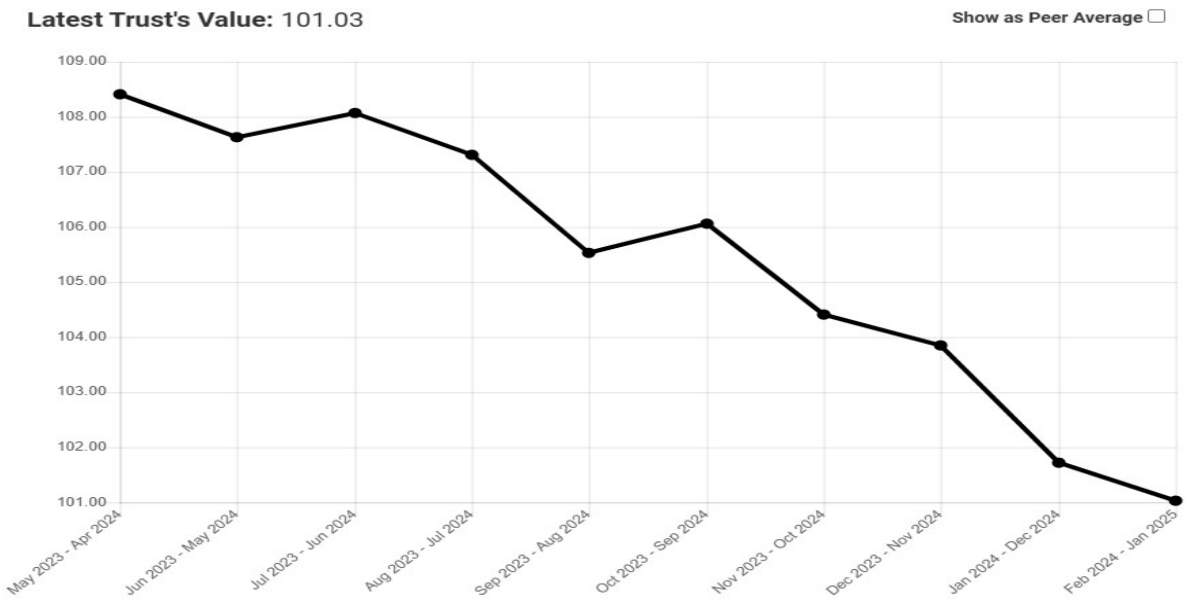
CLINICAL EFFECTIVENESS

Reducing Mortality

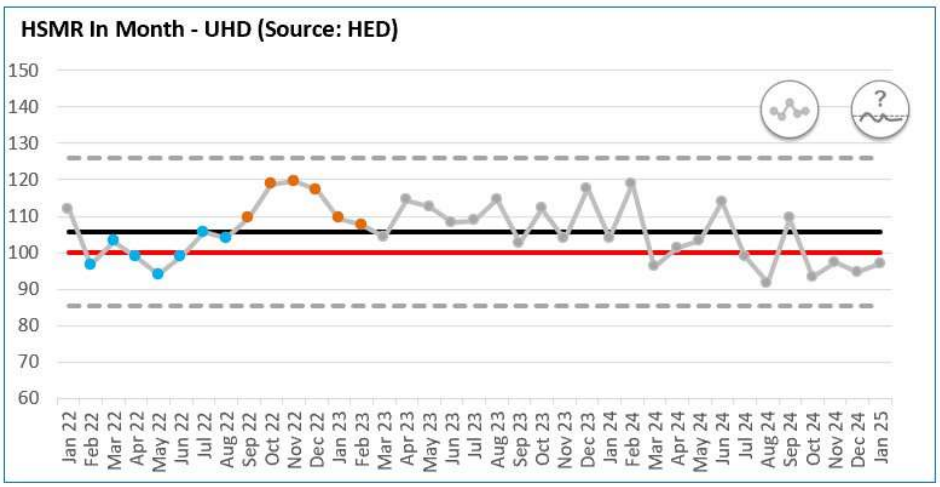
Hospital mortality is normally assessed using two measures. The first is the hospital standardised mortality ratio or HSMR.

HSMR (Hospital Standardised Mortality Ratio) is the ratio of observed number of in-hospital inpatient deaths compared to the expected* number of in-hospital deaths. UHD report both the in-month and rolling 12-month positions and data is usually a few months in arrears. Data is extracted from HED (Healthcare Evaluation Data) and excludes the latest month which is not yet fully coded. The national average is 100.

HSMR Rolling 12 Month: February 2024 to January 2025 is 101.03. This continues to decrease.



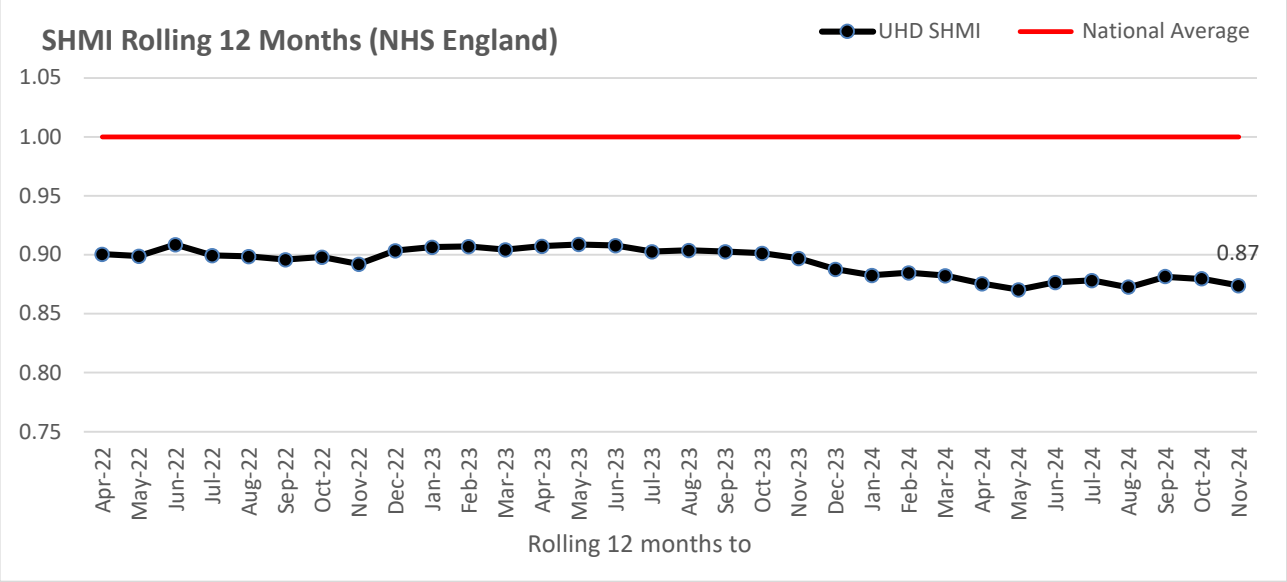
HSMR In Month : The latest fully coded position is January 2025 at 96.9. This is below the national average of 100 for 6 of the last 7 data points.



** The expected deaths are calculated from logistic regression models with a case-mix of; age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.*

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the number of patients who die up to 30 days following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. Data is provided for rolling 12 months and always in arrears. Hospices are excluded. The national average is 1.

UHD's SHMI is in the 'lower than expected' range at 0.87 for the 12 months to November 2024.



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 2024/25; developments undertaken in 2024/25; developments planned for 2025/26.

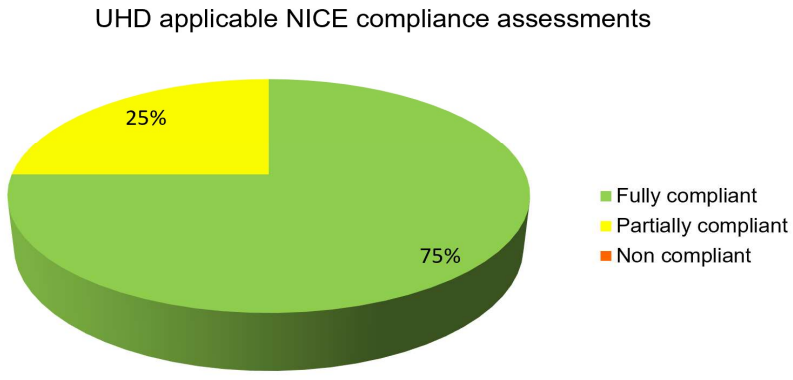
The final reportable position on current NICE Guidance for UHD (newly published from 1 April 2024 to 31 March 2025) for the financial year at Q4 2024/25 is as follows:

Care Group	Compliant	Partially Compliant	Non-Compliant	Not applicable	Grand Total
Medical	2	1	0	5	8
Surgical	1	0	0	8	9
WCCSS	0	0	0	6	6
Operations	0	0	0	0	0
Corporate	0	0	0	0	0
Grand Total	**3**	**1**	**0**	**19**	**23***

*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 2024 to 31 March 2025), the compliance status is recorded as follows:

Overall assessed compliance for 2024/25



*These figures exclude NICE Technical Appraisals

Of those that were rated as partially compliant for UHD (newly published from 1 April 2024 to 31 March 2025), 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**
DG59	CYP2C19 genotype testing to guide clopidogrel use after ischaemic stroke or transient ischaemic attack	Stroke/TIA	NICE is working with NHS England, who are delivering a national pilot to produce an implementation guide for providers and information to support future commissioning decisions. The pilot will run from October 2024 to April 2025. UHD are waiting for the outcome of this pilot to assist in future implementation - point of care vs laboratory testing.	Await results of national pilot currently running

Case studies of improvement following implementation of NICE Guidance

CG179 *Pressure ulcers: prevention and management*
The Trust was previously not compliant with the recommendations around pressure ulcers. However, the Trust has now implemented the Purpose-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) system. It is a pressure ulcer risk assessment framework intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). The Trust has now achieved compliance with this guidance for adult, maternity and paediatric services.

IPG528 *Insertion of a double balloon catheter for induction of labour in pregnant women without previous caesarean section.*
The Trust is now compliant with this guidance offering pregnant women a more natural option for inducing labour where appropriate.

QS160 *End of life care for infants, children and young people*
The Trust now meets the criteria outlined in this NICE Quality Standard ensuring that any family with a baby, child or young person under UHD's care who is reaching the end of their life has the best possible care at such a tragic time. UHD have 24/7 access to the children's palliative care team for babies, children and young adults cared for in any setting at the end-of-life.
For children 0 - 16 years with cancer the two consultants in Paediatric Palliative Medicine (PPM) PPM write symptom management plans which can be used as a guide for symptom management out of hours. For young people with cancer 16-18 years and those going through transition at the end-of-life, paediatrics work collaboratively with colleagues in Adult Palliative Medicine at Forest Holme. They provide 24/7 nursing and specialist consultant medical advice in any setting, including home.

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 2025-2026 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 2025/26, 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	**2024/25**	**2023/24**	**2022/23**	**2021/22**
	UHD	**UHD**	**UHD**	**UHD**
	803	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 a further increase in the number of concerns being raised informally over the past year.

PALS concerns	2024/25	2023/24	2022/23	2021/22
	UHD	UHD	UHD	UHD
	6624	5982	5530	5200

Subjects of complaints

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

Complaint Themes	2023/24	2023/24	2022/23
Clinical treatment	**131 (15.9%)**	**505 (33.7%)**	664 (35%)
Access to treatment	**6 (0.7%)**	**64 (4.3%)**	94 (4.9%)
Admission, discharge, transfers	**90 (10.9%)**	**101 (6.7%)**	97 (5.1%)
Delays & cancelled appointments	**36 (4.3%)**	**38 (2.5%)**	153 (8%)
Communication	**208 (25.3%)**	**272 (18.1%)**	435 (22.9%)
Consent	**9 (1.1%)**	**7 (0.5%)**	27 (1.4%)
End of life care	**0 (0.0%)**	**14 (0.9%)**	21 (1.1%)
Facilities	**8 (0.9%)**	**6 (0.4%)**	0 (0%)
Integrated care	**0 (0.0%)**	**3 (0.2%)**	0 (0%)
Patient care	**0 (0.0%)**	**72 (4.8%)**	90 (4.7%)
Mortuary	**0 (0.0%)**	**2 (0.1%)**	0 (0%)
Prescribing	**0 (0.0%)**	**37 (2.5%)**	43 (2.2%)
Privacy, dignity & wellbeing	**154 (18.7%)**	**41 (2.7%)**	22 (1.1%)
Staffing numbers	**1 (0.1%)**	**1 (0.1%)**	9 (0.5%)
Administration	**82 (9.9%)**	**48 (3.2%)**	0 (0%)
Values & Behaviours	**46 (506%)**	**264 (17.6%)**	146 (7.7%)
Waiting Times	**51 (6.2%)**	**24 (1.6%)**	95 (5%)

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: Concerns raised that patient was not wearing an ID band when family member visited them on the ward.
We Did: Ward have changed practice to ensure patients are wearing two ID bands at all times. They are conducting a twice monthly audit to ensure compliance with this and are regularly raising the issue at the daily safety briefings

You Said: It was highlighted that that the appropriately sized blood pressure cuff was not available when a patient came for their surgery, leading to a delay whilst this was sourced
We Did: Stock in theatres has been reviewed and redistributed to ensure that there is a range of cuff sizes available in each theatre

You Said: A patient's family raised concerns regarding the end of life ward setting, stating that the environment was too noisy for their loved one receiving end of life care
We Did: Staff on the ward now place three battery operated candles at the entry of the ward with a sign informing staff and visitors that family members are spending their last hours with their loved ones. This is also being introduced across other wards

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 regarding accessing support following dermatology procedures
We Did: The dermatology post-operative information leaflet is under review. This will include one telephone number for patients to use to enable them to access support quicker and easier

You Said: Feedback received from patient that it was difficult to find information about maternity appointments and what to expect once they complete a referral to our maternity team.
We Did: This information is available on the Maternity Matters Dorset website and has now been added to the front page of the website so it is more accessible for patients

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: Concerns raised by a patient that there was a delay in them being referred to the Menopause Clinic following radiotherapy.
We Did: Clinical Team recognise that this is an opportunity to improve processes and are working to have a streamlined referral process in place to ensure patient who have received pelvic radiotherapy are referred to the menopause clinic as standard

You Said: It was highlighted that women in our maternity unit were not always aware that there is a senior staff member available 24/7 to escalate concerns to
We Did: Posters to be added at bedsides and in bathrooms to make this information widely available to service users

You Said: Patient experienced a delay in referral for treatment for osteoporosis
We Did: Database introduced to keep track of all patients referred and to ensure appointments booked within reasonable timeframes

You Said: Concerns raised regarding poor communication from department and delays in care
We Did: Changes to process in department made and additional administrative staff has resulted in improved communication

Action plan for 2025/26

A further 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:

- Continue to improve and reduce response times.
- Improve communications with complainants to explain about potential delays.
- The complaint team User survey continues to be shared and responses shared via quarterly reports.

The improvement work around response times, communication and shared learning will continue to progress.

Performance against national priorities 2024/25

National Priority	2024/25 Actual	2024/25 Target	2021/22	2022/23	2023/24
18 week referral to treatment waiting times – admitted (31/03/2025)	**46.1%**	92%	45.5%	49.8%	46.0%
18 week referral to treatment waiting times – non admitted (31/03/2025)	**65.3%**	92%	65.1%	54.6%	66.1%
18 week referral to treatment waiting times – patients on an incomplete pathway (31/03/2025)	**60.9%**	92%	61.0%	53.8%	62.0%
Proportion of patients staying for over 12 hours in Emergency Departments	**7.5%**	<2%	1.85%	7.3%	7.0%
62 Day General Standard (all cancers)	**72.0%**	85%	73.8%	67.8%	68.9%
31 Day General Treatment Standard (all cancers)	**96.6%**	96%	97.0%	97.1%	96.1%
28 Day General Faster Diagnosis Standard (FDS - all cancers)	**79.8%**	75%	70.9%	67.4%	67.1%
Clostridium difficile year on year reduction	**102**	100	70	84	103
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	**Compliance certified**	Compliance certified	Compliance certified	Compliance certified	Compliance certified
Maximum 6 week wait for diagnostic procedures (31/03/2025)	**92.5%**	>99%	84.1%	93.0%	89.3%

Annex A – Feedback from Stakeholders

NHS Dorset

Nursing & Quality Directorate
County Hall
Colliton Park
Dorchester
DT1 1XJ

Re: Quality Account 2024/25

Thank you for asking NHS Dorset to review and comment on your Quality Account for 2024/25. 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 2024/25. In 2024/25, University Hospitals Dorset continued to make strong progress on its quality priorities, maintaining a clear focus on safety, learning, and patient experience. A strengthened safety culture was supported by the rollout of UHD's bespoke safety framework and implementation of PSIRF, with thematic reviews driving learning across key areas. Patient experience initiatives led to improved feedback mechanisms, and staff engagement remained strong, with positive trends in national survey responses. The Trust also deepened its commitment to compassionate leadership and psychological safety, embedding supportive practices and developing a new safety and risk strategy to guide future improvements.

The 'Patient First' strategy continues to set a strong and focused direction for improvement, with safety rightly at the heart of its quality ambition. The emphasis on high-impact targeted priorities supported by system-wide alignment and robust governance, lays the foundation for sustained progress. Embedding safety across all strategic themes, from patient experience to workforce and system working, reflects a mature and values-led approach. The ICB remains committed to supporting the Trust in building upon collaborative working with all health and social care partners within the Dorset Integrated Care System.

Healthwatch Dorset welcomes the opportunity to provide a comment for the University Hospitals Dorset NHS Foundation Trust Quality Account report for 2024-2025.

Healthwatch Dorset exists to provide a strong voice for local people. We believe those who make decisions about health and social care can best improve services if they listen to people's experiences and feedback. We want everyone in Dorset to be included in the conversation, so we strive to hear from as wide a range of people as possible from our diverse community. We share those views with University Hospitals Dorset and others who provide local health and care services, to help create positive change.

This year we've worked with University Hospitals Dorset NHS Foundation Trust to share our report about people experiencing homelessness:
https://www.healthwatchdorset.co.uk/report/2024-09-11/voiceless-unheard-and-socially-excluded-accessing-health-and-care-while-homeless
We have also attended meetings with UHD to share the feedback we gather, worked jointly on carers support and our volunteers visited the new A&E department before it opened to offer their advice on patient access and experience.

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

www.healthwatchdorset.co.uk

Annex B

Glossary of Terms

AAR – After Action Review (a type of learning response)

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

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 review 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.

LFPSE – Learning from Patient Safety Events Service

Never Event - Never Events are patient safety that are deemed to be 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. 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.

PSIRF Patient Safety Incident Response Framework

R&I – Research and Innovation

RCP – Royal College of Physicians

University Hospitals Dorset NHS Foundation Trust

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

Poole Hospital
Longfleet Road, Poole, BH15 2JB

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

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