The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

QUALITY ACCOUNT 2017/18

CONTENTS

PART ONE

1.1 STATEMENT FROM THE CEO

We are firmly committed to the delivery of high quality services which are both safe and effective. The Quality Accounts 2016/17 is evidence of this. Our goal is to become 'first choice for orthopaedic care' and the past year has seen us take steps towards realizing this goal.

During 2016/17 we have seen real progress against our CQC action plan. A further unannounced inspection took place in July 2016 and it was acknowledged that material changes had been made to improve the quality of care provided in our Paediatric HDU.

Last year we also invited the Royal College of Paediatrics & Child Health to carry out a review of our Paediatric service provision, and in response to their report, we have increased our paediatric staffing levels, introduced a dedicated Children's Board and improved the processes by which we care for some of our most vulnerable patients.

We have made significant progress in delivering our Quality Priorities for 2016/17, which included achieving consistent compliance with WHO Surgical checklist, developing a robust programme of Quality Assurance visits, improving our compliance with NJR standards of consent and reporting and reducing the length of time patients are starved before surgery. Those priorities not achieved in 2016/17 have been taken forward to 2017/18 as part of our continued commitment to excellent patient care.

We recognise that quality must underpin every improvement that we make. We have identified 9 improvement priorities for 2017/18 which are detailed below:

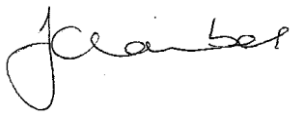
- Reduce number of incidences of consent on day
- Medical ward rounds to be supported by the wider MDT
- Reduce the number of avoidable pressure ulcers
- Learning from deaths – implement and embed a culture of learning from deaths to include involving families in serious incident investigations
- Ensure that learning identified from serious incidents and complaints are embedded in practice
- Ensure that all clinical and corporate policies are in date and have an appropriate audit plan
- Reduction in waiting times in OPD clinics
- Reduction in cancellation on day of surgery (Board of Governors)
- Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas

Sustaining improvement relies on our ability to listen to the people who use our services. The introduction of the 'I Want Great Care' system which helps us fulfil our statutory duty to deliver the Friends and Family Test, has proved an excellent tool to capture actionable feedback. Patient experience at the Royal Orthopaedic Hospital is consistently positive. We are committed to listening to our patients in order to provide the best experience possible.

2016/17 has also seen us focus on the development of the National Orthopaedic Alliance (NOA), a new care model which aims to improve the quality of orthopaedic care in England. This is particularly important work for the future and has the potential to transform how orthopaedic care is delivered. For 2017/18, our plans and priorities are centered on recruiting new members, replicating our model across other specialties and launching and promoting the NOA quality standards.

As for every other Foundation Trust, the environment in which we operate continues to be challenging. We are focused on ensuring that the services we offer are of a high quality and sustainable so that we can meet demand and continue to improve. The Trust will continue to work with other organisations and commissioners to develop new models of care delivery and ensure we provide high quality care.

The Trust has a number of different processes in place for the collection and interpretation of data and not all of these are subject to external audit and review. With this caveat, I confirm to the best of my knowledge that the information contained in this report is accurate.



Jo Chambers
Chief Executive Officer
The Royal Orthopaedic Hospital

30 May 2017

1.2 ABOUT THE TRUST

The Royal Orthopaedic Hospital NHS Foundation Trust is a single specialty orthopaedic hospital offering both elective and specialist services to the people of the Midlands, North of England and Wales. It has the ambition to be "First Choice for Orthopaedic Care' for these communities by ensuring delivery of world class outcomes and excellent patient experience.

The Trust works closely with local partners including Birmingham Children's Hospital and University Hospitals Birmingham and in doing so ensures that best orthopaedic practice is shared across the local health community. Our patients benefit from a team of highly specialist surgeons, many of whom are nationally and internationally recognised for their expertise. Our links with other local hospitals ensures that we can draw on their expertise if our patients require it.

We are proud of our commitment to teaching; learning and innovation here at ROH and during 2015/16 have developed our local "Knowledge Hub" to drive this important agenda forward. The Knowledge Hub brings together three key components: research and development, education and learning and audit and outcomes in order to enable greater partnership working and drive innovation and quality improvement at every level across the Trust.

The Trust strategic intentions were outlined in the Trust Five Year Strategic Plan (2014-2019) and are detailed below:

1. Delivering exceptional patient experience and world class outcomes.
2. Developing services to meet changing needs, through partnership where appropriate.
3. At the cutting edge of knowledge, education, research and innovation.
4. With safe, efficient processes that are patient centered.
5. Delivered by highly motivated, skilled and inspiring colleagues.

A detailed delivery plan has been developed shown in Table 1 opposite:

TABLE 1: STRATEGIC PLAN

OUR VISION: 'TO BE FIRST CHOICE FOR ORTHOPEADIC CARE'

OUR VALUES: the aim of the Trust's values is to create a culture of excellent patient care by ensuring that we all:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenged ourselves to deliver the best
- Learn innovate and improve to continually develop orthopaedic care.

STRATEGIC TRANSFORMATIONAL INITIATIVES

1. CREATING A CULTURE OF EXCELLENCE, INNOVATIONA AND SERVICE: Agreed clinical culture and associated behaviours; organisational development to support change; clinical leadership development; clinical outcomes strategy; strong partnerships (clinical, local, business and international); innovation pipeline

2. EXCEPTIONAL PATIENT EXPERIENCE, EVERY STEP OF THE WAY: setting standards and expectations; new outcome collection measures; patient access review programme; access to diagnostic service review; patient support and information

3. SAFE AND EFFICIENT PROCESSES

- 7 day working
- Productive theatres
- Electronic prescribing
- RTT- 18 weeks
- Standards and protocols i.e. care of the deteriorating patient and emergency admissions.
- Enhanced recovery
- Expert and guidance (to GPs)
- Standardised clinical practice

4. FULLY ENGAGED PATIENTS AND STAFF

- New communications and engagement strategy
- New communications skills website, intranet and use of social media
- Staff, patient and GP engagement
- Branding
- Communications effectiveness measures

5. DEVELOPING CLINICAL SERVICES

- General surgery expansion including revisions
- Paediatric surgery
- Oncology
- MSK Wellbeing, advice, diagnostics
- Bone Infection Unit and services
- Clinical partnerships and orthopaedic network

6. INFORMATION FOR EXCELLENCE

- Electronic patient record development
- Outcome measurement and comparison
- Clinical decision support
- Audit and monitoring
- IT infrastructure improvement
- Mobile devices
- Patient administration

7. ROH THE KNOWLEDGE LEADER

- Integrated audit, teaching research and development evaluation
- Innovation strategy
- Academic strategy
- International Partnerships

Support by **Trust Enabling Strategies**: Quality and Safety, Clinical Outcomes Strategy, Communication and Engagement, Organisational Development, Research, Evaluation and Innovation, Estates, People, IM&T, Finance, Programme and Change Management, Governance, Business Continuity Planning

Underpinned by **Strong Risk Management.** Key risks (with migration): Changed commissioner intentions (work closely with them); Failure to deliver cost and activity assumptions (excellent planning and execution); Resistance to change and change capability (invest and develop); Major incident (business continuity planning)

Each of the 7 strategic work streams has an executive sponsor (SRO – senior responsible officer) and each project has a nominated project lead who reports by exception on a monthly basis. SROs attend the bi-monthly Transformation Committee which is a formal committee of the board. The Transformation Committee is chaired by the Trust's Deputy Chairman and the membership of the committee includes the Chairman and Chief Executive.

SROs present a work stream update to the committee to highlight progress, risks and planned actions. At each committee, a different project is scrutinised and challenged to ensure the delivery of the project benefits are still on track. If there have been any new strategic initiatives which impact on a project, they are debated and agreed at the committee.

The Trust strategy will be delivered through the hard work and commitment of our colleagues and underpinned by the Trust values which guide us in delivering high standards of patient care and experience and help us understand the importance of developing relationships with and supporting each other.

TABLE 2: TRUST VALUES

Value	We expect to see these behaviours
Respect Respect and listen to everyone	• Courtesy at all times • Listen without interrupting, sensitive to others views, show patience • Acknowledge and empathise with others, irrespective of their needs, views and beliefs • Politeness in person, by email and on telephone • Greet each patient with 'hello my name is..' and where care is to be provided, explain this clearly before commencing delivery of care • Recognise the right of each individual to be treated with dignity at all times • Value the contribution of all colleagues, irrespective of their role • Thank colleagues for their contribution • Maintain strong personal discipline with meetings, respects time as a resource for self and others
Compassion Have compassion for all	• Focus on the needs of others • Demonstrate care and concern for the physical comfort and mental wellbeing of patients and colleagues • Accept that others will have different priorities, needs and values, and seek to understand them • Develop and deliver working practices and plans which are centered on patient needs • Make time for patients and colleagues when they need it • Demonstrate kindness and humanity while respecting rules, guidelines and frameworks • Deliver difficult messages with warmth, concern and empathy
Excellence Work together and deliver excellence	• Establish clear standards, reporting lines, accountability/objectives • Collaborate with colleagues, patients and other care providers to plan and deliver high quality care for patients • Set and maintain consistent high standards for own work, accept responsibility and critically review own performance • Deliver improvement and fulfil promises made to others • Seek to maximise own contribution to the team and build team relationships • Actively seek to understand other areas of work. Seek feedback from other teams, use to resolve problems & improve collaborative working • Actively participate in Trust-wide events to build shared understanding • Undertake effective handover at change of shift / annual leave / other absence to ensure continuity of care/service

Pride Have pride in and contribute fully to patient care	• Show pride in own work and strive to deliver the best within available resources • Utilise all knowledge, skills and experience for the benefit of patients and the Trust • Take responsibility for own work • Overcome obstacles and adopt a 'can do' approach • Set and maintain high standards of personal conduct for self and colleagues • Take responsibility for independent audit or self – audit of work • Celebrate and share successes of Trust, own team and other teams • Acknowledge shortfalls in standards/performance and take steps to correct them
Openness Be open honest and challenge ourselves to deliver the best	• Recognise and acknowledge when things don't go to plan, truthful and transparent with patients and colleagues when explaining what happened. • Support colleagues and promote learning & improvement by seeking and giving balanced, honest and timely feedback • Communicate in a way that is clear and concise • Courageous in challenging unsafe practice and inappropriate behaviour • Raise concerns appropriately when things are not right • Understand and fulfil the 'Duty of Candour'
Innovation Learn innovate and improve to continually develop orthopaedic care	• Embrace new ideas and challenges self and others to adopt new ways of working/ alternative approaches • Network with others within and outside ROH to maintain good practice • Lead on developing and effectively sharing good practice • Seek new and better ways of caring for patients for today and for the future • Demonstrate active ownership of ongoing learning and development for self, both mandatory and optional • Learn from own and others experience • Seek to learn from incidents/shortfalls in standards/performance • Maintain knowledge of NHS structures and strategies outside ROH, ensure innovations fit the wider environment • Prefers 'support and challenge' management style

1.3 ABOUT THE QUALITY ACCOUNT 2017/18

1.3.1 WHAT IS A QUALITY ACCOUNT?

A Quality Account is a report about the quality of services by an NHS provider and each year all NHS providers are required to publish a Quality Account. The report is an important way for local services to publish information on the quality of care it provides and to demonstrate improvements and developments in its services. The report enables local communities and stakeholders to review the progress that the Trust is making in delivering its quality priorities and to hold the provider to account.

ROH is committed to continuously improve the services it provides to patients and their families. Within the Quality account we aim to make the following information available to stakeholders, patients and the public.

- Our quality priorities for the year 2017/18
- Our progress against delivery of the quality priorities we outlined in 2016/17
- How we have performed against national quality indicators for patient safety, patient experience and clinical effectiveness
- How we have performed against local quality measures as agreed with our commissioners
- How we will ensure that ROH maintains continuous quality improvement

1.3.2 WHO HAS BEEN INVOLVED IN PRODUCING THE QUALITY ACCOUNT?

The Quality Account has been developed by the Trust with input and the help of a range of stakeholders including:

- Consultation with staff through the Trust Intranet site, seeking views on the proposed priorities
- Presentation of the Quality Account and priorities at the Trust Patient and Carers Forum and Trust wide Clinical Quality Group
- Discussion of Quality Account priorities through the local Contract Quality Review Group
- Sharing of Quality Priorities and draft Quality Account with local Healthwatch
- Sharing of Quality Priorities and draft Quality Account with lead commissioner BCC CCG

PART TWO

PRIORITIES FOR IMPROVEMENT 2017/18 AND STATEMENT OF ASSURANCE FROM THE BOARD

2.1 QUALITY PRIORITIES

The quality priorities set by the Trust for 2017/18 focus on some key areas of improvement which have been informed by discussion with staff, patients and the public. During 2016/17 the Trust identified a total of 8 improvement priorities. Table 3 below shows a summary of achievement against those priorities. Greater detail about each of these priorities is provided in Section 3 of this report.

TABLE 3: ACHIEVEMENT OF QUALITY PRIORITIES 2016/17

Reduce number of incidences of consent on day
Reduce the number of avoidable pressure ulcers
Reduce the number of avoidable VTE events
Ensure that learning identified from serious incidents and complaints are embedded in practice
Reduction in waiting times in clinic
Reduction in cancellation on day of surgery (Governors Priority)
Deliver the commitments outlined in the first year of the Dementia Strategy-
Improve patient reported experience of pain

The Trust has made good progress on 3 of the priorities outlined above and considers this sufficient to conclude that the priorities have been achieved. Whist there has been some progress made against the other four priorities it was felt that further progress could be made during 17/18.

Table 4 below summarises the areas of focus for 2017/18 and their alignment to the 3 domains of quality.

TABLE 4: QUALITY PRIORITIES 2017/18

Quality Priorities 2017/18	Clinical	Patient safety	Patient experience	2015/16	2016/17	2017/18
Reduce number of incidences of consent on day	✔	✔	✔		✔	✔
Medical wards rounds to be supported by the wider MDT	✔	✔				✔
Reduce the number of avoidable pressure ulcers		✔	✔		✔	✔
Learning from deaths – implement, embed a culture of learning from deaths to include involving families in SI investigations	✔	✔				✔
Ensure that learning identified from serious incidents and complaints are embedded in practice	✔	✔		✔	✔	✔
Ensure that all clinical and corporate policies are in date and have an appropriate audit plan	✔	✔	✔			✔
Reduction in waiting times in OPD clinic	✔		✔		✔	✔
Reduction in cancellation on day of surgery (Board of Governors)	✔		✔		✔	✔
Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas			✔			✔

Priority 1: Reduce number of incidences of consent on day

Why?

The consent process has two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage. Good practice guidance recommends that patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process

How we will monitor this?

During June 2016 we undertook an audit of compliance and found that some the of patients who had been admitted through the Admissions and Day Case Unit were consented for the first time on the day of surgery. This finding was shared with the wider organisation.

As a result, the Consent Policy has been rewritten and was launched in Quarter 4 2016/17 with a workshop at a Clinical Audit meeting in February 2017. This prescribes a two stage consent process, with initial consent obtained at the outpatient appointment and a final consent obtained on the date of surgery. A re-audit is planned for Quarter 1 2017/18.

Priority 2: Medical wards rounds to be supported by the wider MDT

Why?

Ward rounds play a crucial part in reviewing and planning a patient's care. They are an opportunity to inform and involve patients, and for joint learning for healthcare staff. This priority calls for the multidisciplinary team – doctors, nurses, pharmacists, therapists and allied health professionals – to be given dedicated time to participate, with clarity about individual roles and responsibilities during and after ward rounds.

How will we monitor this?

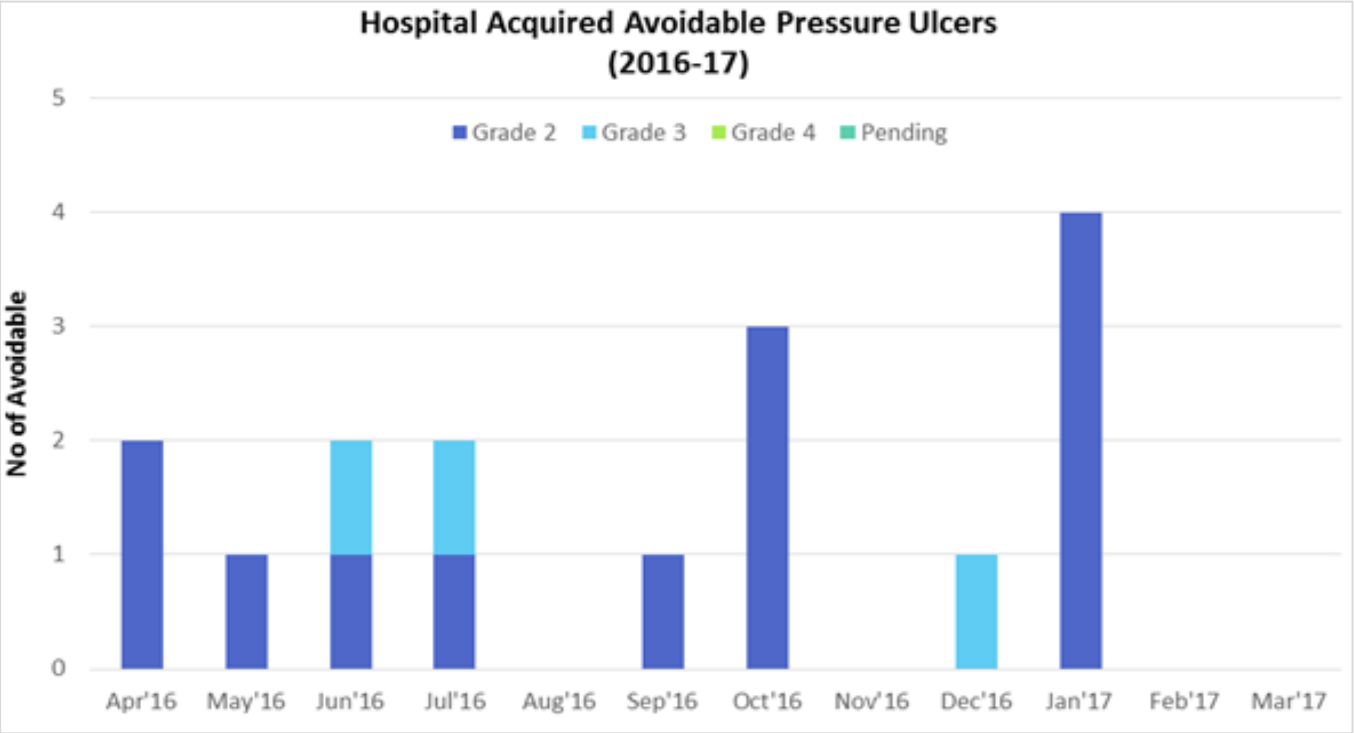
As a multidisciplinary group, we will review all current ward round practices to streamline and coordinate an MDT approach, embedding these principles into the Ward routine and individual's job plans.

Priority 3: Reduce the number of avoidable pressure ulcers

Why?

Pressure ulcers, which are often preventable, have a significant impact on patients and their families and may lead to long periods of treatment either on the hospital or community. They cause unnecessary pain and distress for the patients involved. The Trust failed to meet its target against zero hospital acquired grade 3 pressure sores for 16/17; there were none in August, November, February or March. There were no avoidable Grade 4 pressure ulcers during the year.

TABLE: 5 HOSPITAL ACQUIRED AVOIDABLE PRESSURE ULCERS



How will we monitor this?

A detailed action plan has been developed further for 17/18 to respond to this priority which is overseen by the Trust Clinical Quality Group. Measuring will take place through monthly audit in each clinical area and review of Safety Thermometer data. The results will be reported and monitored through the monthly Quality Report received by the Trust Board.

Priority 4: Learning from deaths – implement, embed a culture of learning from deaths to include involving families in all Serious Incident I investigations

Why?

NHSI have published guidance on Learning from Deaths (2017) the aim of the guidance is that each organisation has in place a standardised governance framework. The guidance concludes that reviews and investigations into deaths which problems in care nay have contributed to learning should occur to prevent reoccurrence. In addition the guidance promotes the inclusion of families during any reviews or investigations. The Trust has already in part achieved this standard, all deaths are reported externally and a case review conducted. As an elective referral center the ethos of the Trust is that deaths are classified as unexpected in the first instance until a formal review is carried out. However, further work is required in developing a Trust policy and approach in achieving this standard.

How will we monitor this?

This standard will be monitored through Clinical Audit and Effectiveness Committee and an upward report to the Quality and Safety committee. The guidance states that a quarterly report should be tabled and presented at the Trust Public Board due to commence in Q2.

Priority 5: Increase the evidence of learning identified from serious incidents and complaints are embedded in practice

Why?

ROH is committed to becoming the safest provider of Orthopaedic services in the UK. In order to do this effectively it is imperative that we learn from incidents where harm has occurred to patients. This learning is essential if we are to improve our care processes and the safety of the care we give to patients

How will we monitor this?

We will benchmark the number of serious incidents in comparable peer Trusts and aim to reduce the number of Serious incidences that occur at ROH to below this number by March 2018.

We will continue to embed our 'action tracker' against every recommendation made following a Serious incident report and ensure that this is shared widely across the Trust through both corporate and Divisional Structures.

Priority 6: Ensure that all clinical and corporate policies are in date and have an appropriate audit plan

Why?

In accordance with the Trust's Policy for the Development, Approval and Management of Trustwide Policies, all Trustwide Policies are due for review every 3 years, unless otherwise indicated as being required earlier within the body of the policy. It is important that Trustwide polices are reviewed regularly and kept up to date, to ensure that both clinical and corporate practices across the Trust adhere to current statutory requirements, as well as national and NHS guidelines.

Early review may be required in response to or following any event which highlights the need to review urgently a particular policy or following new legislation, NHS guidance or changes in clinical practice.

How will we monitor this?

In regards to assurance, the Corporate Governance Team will provide a reminder to Policy Authors six months prior to a policy's scheduled review date and a quarterly report will be submitted to the Trust's Quality and Safety Committee, noting policies that are due for review.

Priority 7: Reduction in waiting times in all OPD clinics to less than 60 minutes.

Why?

Patients tell us via the local Friends and Family test that they are sometimes frustrated by the length of time they have to wait when attending for clinic appointments, there has been a steady improvement in many areas however, we continue to see long waits primarily within oncology. Clinic templates have been developed to help reduce our patients waiting time within our outpatients. Further work is required to reduce waiting times to less than 60 minutes across all areas

How will we monitor this?

We will continue to monitor performance against our Standard Operating Procedure (SOP) for clinic waits across all clinics and services within Out Patients Department (OPD).

We will ensure that the electronic monitoring system, 'In Touch', enables production of weekly 'waiting times reports' and share this information across our services.

The Division 1 Governance Board will take responsibility for monitoring waiting times and for developing action plans to respond to 'off track' reports. A monthly upward progress report will be provided to the Clinical Quality Group (CQG).

Priority 8: Reduction in cancellation on day of surgery (Board of Governors)

Why?

Cancellation on the day of surgery is both distressing for patients and their families and wasteful of NHS resources. Better planning and organisation of theatre lists and capacity will continue to reduce the number of on the day cancellations for non-clinical reasons through 2016/17. During 16/17 we have seen a decline in cancelled operations due operational issues. However, we recognise that we can improve and reduce on the day cancellations further during 17/18 by enhancing our pre-operative assessment phase of care.

How will we monitor this?

This is already an NHS wide quality standard and is reported internally and externally on a monthly basis. The national requirement is to treat those patients cancelled on the day of surgery within 28 days.

TABLE 6: ON THE DAY CANCELLATIONS 2016/17

Month	Operations cancelled on the day by hospital
Apr-16	19
May-16	10
Jun-16	51
Jul-16	24
Aug-16	22
Sep-16	20
Oct-16	29
Nov-16	28
Dec-16	13
Jan-17	20
Feb-17	10
Mar-17	16
Total	**262**

(Data taken from QMCO)

The number of on the day cancellations at ROH has seen a reduction during 2016/2017.

From November 2016 onwards, a detailed daily record has been kept by the Senior of the Day in theatres of the reasons for on the day cancellations. Initial analysis of cancellations in November and December 2016 revealed that the majority were due to the patient being medically unfit. Since then, and led by one of the Consultant Anaesthetists working in the Pre-Operative Assessment Centre (POAC), there is now a running permanent audit of cancellations attributed to the patient being medically unfit. This has led to changes in the booking form design, the nature of questions posed at the phone call made to patients 72 hours before surgery, and also to the POAC process itself.

The audit tool continues to evolve, as well as further changes to theatre listing protocols, for example, aiming to ensure that lists are finalised 6 weeks prior to date of surgery to enable patients to have sufficient forward notice to make sufficient domestic arrangements to enable them to attend for their surgery on the planned date. As shown on the chart below, the number of cancellations on the day initiated by the patient now outweighs the number initiated by the hospital - we continue to work hard to understand the underlying reasons and to reduce this waste of resources.

Priority 9: Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas

Why?

This year has seen a 75% increase in PALS contacts. A contributing factor to this is the Trust's decision to actively publicise PALS as a point of contact on all correspondence. Many of the reasons for contacting patients and carers contacting the PALS department relates to communication and access to treatment. The Trust plan to introduce a scheme called 'time to talk' at ward level the aim of this is to deal with concerns/issues in real time. The aim is to resolve patients or carers concerns at the time and improve general communication by having protected time to talk.

How will we monitor this?

This will be monitored monthly through the PALS department and an upward report sent to the Clinical Quality Group to monitor compliance.

2.2 STATEMENT OF ASSURANCE FROM THE TRUST BOARD

2.2.1 PROVISION OF SERVICES BY THE TRUST

During 2016/17, The Royal Orthopaedic Hospital NHS Foundation Trust provided 14 NHS services. The Trust has reviewed all the data available to them on the quality of care in 14 of these NHS services.

The 14 services provided by the Trust are listed below.

- Anaesthesia
- Bone infection Unit
- Functional Restoration
- Imaging
- Large Joints
- Small Joints
- Spinal surgery
- Paediatric Orthopaedics
- Pain Management
- Orthopaediccancer
- Orthotics
- Podiatry
- ROCs
- Therapy Services

2.2.2 PERCENTAGE OF INCOME GENERATED BY TRUST SERVICES

The income generated by the relevant Health services reviewed in 2016/17 represents 92.87% of the total income generated from the provision of relevant services by The Royal Orthopaedic NHS Foundation Trust for the reporting period 2016/17. This is defined as the total income from activities (excluding private patients) as a proportion of the Trust's total operating income.

2.2.3 PARTICIPATION IN CLINICAL AUDIT

During April 2016 – March 2017, six national clinical audits and one national confidential enquiry covered relevant health services that The Royal Orthopaedic Hospital provides.

During that period The Royal Orthopaedic Hospital NHS Foundation Trust participated in all six national clinical audits (100%) and one national confidential enquiry (100%) of the national clinical audits and confidential enquiries of which it was eligible to participate in. Listed below these are:

1. Elective Surgery (National PROMS Programme Elective Surgery (National PROMS Programme)
2. Emergency use of oxygen
3. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
4. National Cardiac Arrest Audit (NCAA)
5. National Comparative Audit of Blood Transfusion Programme
6. National Joint Registry (NJR)
7. ICNARC

The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during April 2016 – March 2017, 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.

TABLE 7: PARTICIPATION IN CLINICAL AUDIT

Audit	Participation	% Cases Submitted
PROMS	Yes	100% (2016/17)
Emergency use of oxygen	Yes	Awaiting confirmation of Outcome
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death	Yes	Sepsis published Nov 2015 by NCEPOD. Report available at www.ncepod.org.uk/2015sepsis_org.html
National Cardiac Arrest Audit (NCAA)	Yes	All required cases submitted (100%)
National Comparative Audit of Blood Trans- fusion Programme	Yes	Minimum number of cases required was submitted- full data
National Joint Registry (NJR)		96.2% (Apr 2016 – Feb 2017)
ICNARC	Yes	Q3 and Q4

The reports of seven national clinical audits that were reviewed by the provider in 2016/17, and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The level of compliance with the NJR and PROMS continues to attain high levels throughout the year. NJR data is being reported monthly to the Trust's Clinical Audit and Effectiveness Committee.

- PROMS data has been reviewed at Clinical Audit and Effectiveness Committee and has provided assurances regarding the quality of outcomes in hip and knee replacement.

- PROMS reports have shown that for 2016/17 the Trust is above the national average in all hip primary and revision arthroplasty. With reference to knees, the figures show that during the period, although the Trust has improved its position for primary knee arthroplasty we do continue to be slightly below the national average for EQ5D.

- The NJR process has undergone a full review and there have been many changes to the way consent is collected and compliance is monitored, which will help increase the compliance figures.

- The Trust has improved the processes around collecting national audit data by using innovative IT solutions to increase efficiency.

TABLE 8: LOCAL AUDIT OUTCOMES

Audit	Committee Reviewed/ Monitored	Description of Actions Taken
SSI Surveillance	Quality & Safety Committee	In 2016, a total of 41 Surgical Site Infections for Primary Hip and Knee replacements were reported. 2015 saw the lowest rates of infections in Primary Hip and Knee Replacements at 30 days since surveillance began in 2009. In 2016, the rate of Surgical Site Infections for Primary Knee replacements remained relatively steady at 1.8%, compared to 1.7% reported in 2015. The rate of Surgical Site Infections for Primary Hip Replacements was 2.3%, which was up significantly from 2015 where the rate was 0.9%. This is due to a cluster of infections identified, primarily in Hip Replacement surgery and which led to a closedown of theatre for a period of 5 days to carry out a deep-clean.
Oxygen prescription audit	Anaesthetics Department – presented by Dr Siddaiah	Background: Emergency oxygen audit – BTS: emergency oxygen guidelines. – Recommendations: new audit tool, teaching medical & nursing staff – ROH Guidelines produced.
Venous Thrombo-Embolism (VTE) Audit	VTE Committee – presented by Dr Siddaiah	Background – NICE Guidelines. VTE documentation on the prescription chart. Understanding of relevant issues regarding indications & contraindications. Recommendations - Documentation of VTE risk factors, prescription of Sequential Compression Devices, relation to Central Neuraxial Block & 24 hours VTE reassessment needs improvement. This will be re-audited after a year.
Functional Outcomes and local recurrence rates following surgery for Giant Cell Tumour of Distal Radius	Oncology Directorate MDT – presented by Mr Richard Knight, Specialist Registrar	Background: Retrospective case series – all GCT of the distal radius treated at the ROH Bone Tumour Unit between 1988-2013 treatment received & outcome including recurrence & functional status. Post- operative complications, functional limitations or recurrence identified, up to date Toronto Extremity Salvage Score (TESS) score obtained & new problems/recurrences occurring since discharge recorded. Findings: Curettage + PMMA of GCT of the disal radius reduces the risk of recurrence vs. curettage in C2 tumours. Higher recurrence rates seen in C3 tumours with intralesional curettage + PMMA vs. en bloc excision. No difference in pain/functional outcomes. Recommendations: No longer advocate simple curettage of a distal radius C2 tumour. Advocate en-bloc excision in C3 tumours. Discussions need to be had with patient. C1 = Curettage. C2 = Curettage + PMMA + EPR. C3 = EPR.

Audit of National Joint Registry consent	Arthroplasty Directorate – Large Joints. Presented by Mr George Cooper, Specialist Registrar.	**Background:** HQIP consent target should be a minimum of 95% "Yes" and best practice tariff for primary hip/knee replacements is conditional to minimum NJR compliance of 75% and <25% "not known" recorded. **Recommendations**: 1. The green NJR consent form could be filed in a specific area of patient notes so it is not overlooked by health professionals. 2. Data collection at point of entry – theatre staff could input data online, reducing the number of steps & likelihood of human error. 3. Theatre staff to be reminded of formal process & confirmation added to the theatre proforma for arthroplasty procedures to avoid incomplete forms being held in the "Edit Stack". 4. A senior member of staff (consultant or registrar) should be identified to take on the responsibility of ensuring the H1/K1 forms are correctly & adequately completed. 5. The Audit Department could maintain an internal deadline to highlight patients on the "Edit Stack" in March 2016. 6. Re-audit in 12 months to assess the benefit of these recommendations.
An Audit of the Outcome of Proximal Femoral Osteotomies in Adolescents & Young Adults	Young Adult Hip Service – presented at Audit Meeting on 24/5/16 by Mr H. Mourkus, Fellow.	**Background** Proximal femoral osteotomy a recognised technique for treating anatomical abnormalities of the proximal femur or femoral head • Congenital: Retroversion (torsion), Anteversion (torsion), Varus, Valgus. • Acquired - Post SUFE, Post Perthes, Neuromuscular Mr McBryde had concerns that there were a number of patients who had required re-operation **Recommendations:** 1. Avoid Full weight bearing before at least 8/52 in selected cases 2. Routine use of Exogen (at least) in select patient groups : – BMI <25 and > 35 – Blade Plate – Previous Delayed / Non-union 3. Have an accelerated access to Exogen to start immediately if no good callus 3 months post op. 4. No metalwork to be removed before 55 weeks

Safety Thermometer	Quality & Safety Committee	Our compliance has been above 95% for eleven months of the year [2017/18]. The Trust has achieved 100% for two months of the year: November 2016 and March 2017. We have again managed to avoid new UTI & catheter harms for the full year. Our lowest compliance of the year was in September 2016 (93.62%) which was partly due to two old pressure ulcers, thus out of our control but also two further pressure ulcers of which one was attributable to ROH and one was not. There were also 3 falls with harms in this month. The Trust has continued with data collection as set out in the SOP in February 2016 and a 'snap shot' view at 2pm on audit day each month is completed. National collection tools with descriptors continue to be used. The Trust started collecting the CYPST (children and young person's safety thermometer) data in April 2016, which again is a national tool and is used on ward 11 and children in HDU to better capture the findings for this patient group. Results for both sets of data collected are reported in the Trust's monthly quality report and are presented at Clinical Quality Group and the Quality and Safety Committee.
Infection Control indicators	Quality & Safety Committee	Mandatory Surveillance of Healthcare Associated Infections (HCAI) The Infection Prevention and Control Team (IPCT) at the ROHFT are required to report on a number of different Healthcare Associated Infections (HCAI) through a number of mandatory surveillance schemes which include monitoring of Methicillin-Resistant Staphylococcus Aureus (MRSA) and Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemias as well as Clostridium Difficile, E.coli and Glycopeptide-Resistant Enterococcus (GRE). MRSA: There have been no MRSA bacteraemias at ROHFT since May 2008. This is against a national picture of a continual year on year reduction of MRSA bacteraemia cases across England. MSSA: There were no MSSA bacteraemias reported at ROHFT during 2016-17.

<table>
<tr>
<td>Falls risk assessment Quality Indicators</td>
<td>Clinical Quality Group</td>
<td>Falls Risk Assessment & Care Planning – Quality indicator requirements

Qu1. Has the falls assessment been completed within 6 hours of admission? 91% compliance required each month by ward

Qu2. If the patient is identified as high risk fall, is a care plan in place? 91% compliance required each month by ward

Table of compliance per Quarter
<table>
<tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>Qu1</td><td>98%</td><td>100%</td><td>98%</td><td>100%</td></tr>
<tr><td>Qu2</td><td>93%</td><td>92%</td><td>97%</td><td>97%</td></tr>
</table>
</td>
</tr>
<tr>
<td>Gap Analysis for VTE prevention</td>
<td>VTE Advisory Group</td>
<td>Recommendations following audit: Apply ERP, with shorter starvation times to encourage early mobilisation

VTE committee to clarify appropriate duration of A EDs

Improve assessment of patients at admission & 24 hours for VTE risk.

All TKR and THRs should be consented for the risk of a VTE including the risk of death</td>
</tr>
</table>

In addition to the national audits, 10 local clinical audits were reviewed by the provider in 2016/17 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions as detailed in Table 8 above.

2.2.4 PARTICIPATION IN CLINICAL RESEARCH

Underpinning the Trust's strategic vision to become a knowledge leader in orthopaedics and elective care processes is a long history of delivering innovative research which has shaped the way orthopaedic injuries and conditions are treated today. A key objective in the delivery of this vision is the continued expansion of the Trust's research portfolio and our ability to offer more of our patients the opportunity to participate in important, ethically approved research.

2016/17 saw the launch of the new 'Knowledge Hub' encompassing the Trust's research, audit, learning and development functions under the leadership of Professor Phil Begg, Director of Strategy and Delivery. Prof Begg is supported by Carolyn Langford as the new Head of Research, Audit and Development together with David Richardson as Head of Education and Training in leading the delivery of this cohesive new unit.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee totaled 800 patients, this represents an increase of 35% compared with the previous year. Thirty-six studies were open to patient recruitment within the Trust, an increase of 13% compared with 2015/16. Thirteen of these were new studies which opened in the Trust in 2016/17. A further 42 studies which are no longer recruiting new patients were still actively collecting follow-up data. The portfolio of studies encompassed 12 clinical orthopaedic sub-specialties with 67 medical, nursing and allied health professionals engaged in the delivery of research studies within the Trust.

Whilst most (89%) of the studies delivered within the Trust are led by academic or NHS sponsors, we are participating with international pharmaceutical and bio-technology companies including Pfizer, Piramal, Daiichi Sankyo and Amgen in the development of new vaccines, medical devices and treatments for a range of orthopaedic conditions. We are also supporting collaborative partnership between bio-tech company Sensium and Aston University in the development of a novel monitoring technology which aims to improve orthopaedic post-op care. Our long term vision is to continue to strengthen our local, national and international collaborations with NHS, academic, and industry partners. In doing so we will ensure our patients have accessing to, and contribute towards, the development of the latest innovations in orthopaedic care.

2.2.5 USE OF THE CQUIN PAYMENT FRAMEWORK

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to NHS Trusts based on delivery of improvement work. A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between The Royal Orthopaedic Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment Framework. For 2016/17 this figure was £1.56 million (2015/16: £1.56m).

Further details of the agreed goals for the year ending 31st March 2017 and the following 12 month period are available on request from Alexandra Gilder, Deputy Director of Finance and Interim Head of Contracting (alexandra.gilder@nhs.net)

2.2.6 CARE QUALITY COMMISSION (CQC) REGISTRATION AND COMPLIANCE

The CQC monitors, inspects and regulates services to make sure that they meet fundamental standards of quality and safety. They ask five key questions of all service providers which are:

- Are they safe?
- Are they effective?
- Are they responsive?
- Are they well–led?
- Are they caring?

All NHS hospitals are required to register with the CQC in order to provide services and are required to show that they are compliant with CQC standards in order to maintain their registration. The Royal Orthopaedic Hospital is required to register with the CQC and its current registration status is 'without conditions'. The ROH has not participated in any special reviews or investigations by the CQC during this period nor has there been any enforcement action against ROH by the CQC during this reporting period.

ROH was first inspected, under the new regulations, by the CQC in June 2014 and received a rating of 'Requires Improvement' In July 2015 a focused follow-up inspection was completed. At that inspection the core services of Critical Care (HDU) and Outpatients Department (OPD) were reviewed. Both had an inadequate rating in one domain following the inspection completed in 2014. This was within Safe for HDU and Responsive for OPD. The CQC revised the inadequate rating for OPD during their inspection in July 2015 to requires improvement but maintained the inadequate rating for safety in HDU. Both services were rated as 'Requires Improvement' overall.

The overall status for the Trust therefore remains as 'Requires Improvement'. Individual ratings for each of the domains are shown in Table 9 below:

TABLE 9: OVERALL RATING FOR ROH

The key findings of the follow up review were as follows:

- Staffing of HDU with regards to children was not suitable. The CQC found that children were being cared for within the unit but not always by a paediatric trained member of staff, nor were the facilities suitable for children.
- Within both core services the CQC found that infection control practices were well embedded, and staff followed trust policy and procedures.
- The CQC found that although the trust and its staff worked to the essence of the regulations of the Duty of Candour, in being open and transparent when things went wrong, they did not meet all of the requirements of that regulation.
- Multi-disciplinary working was effective in improving patient experience within the hospital.
- 100% of staff in both core services had received their appraisals, which was higher than the hospital's overall rate.

The CQC noted several areas of outstanding practice including:

- The unit manager had ensured that staff were both aware and understood the values of the trust.
- A post box had been put on the unit to enable staff to identify what the values meant to them in their work on HDU. Staff views on the values displayed on a noticeboard and had also been discussed during staff meetings.

- Within Outpatients the CQC observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient l at the clinic.
- These findings have been communicated widely across the Trust to ensure that good practice is shared.

The Trust has developed a detailed action plan in order to respond to the findings of the CQC report which includes the following:

- Improving Safeguarding training compliance for both adults and children in OPD.
- HDU information for the Intensive Care National Audit & Research Centre was uploaded so that it can be benchmarked against other similar trusts.
- Addressing the layout and design of the HDU to ensure that adequate toilet and bathroom facilities were provided for all patients.
- Addressing the layout of HDU in order to ensure that children are always cared for in an appropriate environment.
- Developing management reports in OPD to monitor clinic wait times and cancellations. There must to be an agreed process which all staff followed in the event of a clinic being canceled.
- To improve medical and nursing cover must be improved on HDU when children are accommodated.
- Improving local leaders' understanding of the processes involved in exercising the duty of Candour, in particular what they should expect beyond ward level and at a practical level, including record keeping.

The Trust is making good progress towards delivery of the actions to address the issues identified within the CQC report with the major achievements and outcomes at end of 2017/18 as follows:

- All staff in OPD has been trained to the appropriate level of Safeguarding training. A trust wide review of Safeguarding training across the organisation has been completed. In addition the Trust has appointed a Learning Disability Lead Nurse.
- The systems and processes required to ensure that information can be uploaded to the Intensive Care National Audit & Research Centre (ICNARC) have been put into place.
- A review of paediatric services by the Royal College of paediatrics was completed in March 2016. During 2016/17 a capital build has been undertaken to improve children facilities within the HDU. In addition ROH have been successful in appointing a paediatric Matron with recruitment ongoing to aim to provide two RSCN twenty four hours per day. The trust has an established Children Board chaired by the Director of Nursing which provides oversight and scrutiny to ongoing developments.
- A HDU board has been established to address and monitor the ongoing developments of service improvements sponsored by the Director of Nursing.
- A new electronic information system 'In touch' has been employed into the OPD and will enable better management information about waiting times and clinic cancellations.

- A new Duty of Candour Policy has been approved by the Trust and Duty of Candour training has been added to the timetable at local induction and mandatory training days.

2.2.7 DATA QUALITY AND INFORMATION GOVERNANCE

NHS Number and General Medical Practice Code Validity

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2016/2017 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are published in the Data Quality Dashboard from NHS Digital. The percentage of records in the published data which included the patients' valid NHS Number was:

- 99.8% for admitted patient care
- 99.9% for outpatient care

The percentage of records which included the patient's General Medical Practice Code was

- 100% for admitted patient care
- 100% for outpatient care

The percentage of records reported in the published data is shown in Table 10

TABLE 10: PERCENTAGE OF RECORDS

	Total with NHS number	Total Records	Percentage
Inpatients April 2016 - Feb 17	12683	12711	99.8%
Outpatients April 2016 - Feb 17	77479	77586	99.9%

2.2.8 INFORMATION GOVERNANCE ASSESSMENT REPORT

Information Governance (IG) assesses the way in which an organisation handles and processes the information that is available to it. It covers both personal (e.g. patient records, complaints) and corporate (e.g. financial records) information. 45 standards are assessed and the Trust must score at level 2 or above against each of these standards to achieve compliance

The Royal Orthopaedic Hospital Foundation Trust Information Governance Assessment Toolkit overall score for 2016/2017 was 78% and graded as green (satisfactory).

2.2.9 PAYMENT BY RESULTS CLINICAL CODING AUDITS

The Royal Orthopaedic Hospital Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/2017 by the Audit Commission, Department of Health or NHSI.

2.2.10 IMPROVEMENT OF DATA QUALITY

The Royal Orthopaedic Hospital NHS Foundation Trust takes the following actions to monitor and improve data quality:-

- Regular data quality review undertaken by the Director of Operations with support from the finance, informatics and clinical teams.
- Addressing concerns identified through this regular review by sharing learning through the

Governance structures.

2.3 REPORTING CORE INDICATORS

All data reported in this section has been taken from internal Trust systems unless otherwise specified.

2.3.1 SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The measure for SHMI is not applicable to this Trust.

2.3.2 PATIENT REPORTED OUTCOME MEASURES (PROMS)

Patient Reported Outcome Measures (PROMs) provide information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. Patients complete a questionnaire before the operation and six months after the operation.

The EQ5D Index asks patients 5 questions regarding their general health (mobility, self-care, usual activities, pain/ discomfort, and anxiety/depression).

The Oxford Hip/Knee Score comprise of 12 questions relating to the patient's experience of pain, ease of joint movement and ease of undertaking normal domestic activities such as walking or climbing stairs.

The adjusted average health gain is used for comparison between providers and the England average; (this is adjusted for case-mix- age, sex, co-morbidity etc.).

This data is the latest available and is for the period April 2015

– March 2016. The percentage of cases submitted is 91.3%

(Apr 15-Mar 16).

TABLE 11: ADJUSTED AVERAGE HEALTH GAIN

PROMS April 2015 - March 2017 (Provisional Data)

Procedure Type	Measure	England Average	England Highest	England Lowest	ROH	Position
Hip Replacement Primary	EQ-5D Index	0.440	0.510	0.320	0.452	Above average
Hip Replacement Primary	Oxford Hip Score	21.62	24.97	16.89	22.16	Above Average
Hip Replacement Revision	EQ-5D Index	0.289	0.372	0.225	0.306	Above Average
Hip Replacement Revision	Oxford Hip Score	12.95	16.19	9.51	13.67	Above Average
Knee Replacement Primary	EQ-5D Index	0.321	0.398	0.198	0.325	Above Average
Knee Replacement Primary	Oxford Knee Score	16.37	19.92	11.96	17.23	Above Average
Knee Replacement Revision	EQ-5D Index	There are too few revision knee replacements with completed data in 2015/16 for comparison with the England average.				

The Royal Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons; PROMS reports have shown that for 2016/17 the Trust is above the national average in all hip primary and revision arthroplasty. With reference to knees, the figures show that during the period. There has been an improvement in the position for primary knee arthroplasty during 16/17 against the national average for EQ5D.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve PROMS scores and so the quality of its services:

- We will maintain a high focus on submitted cases and continue to monitor submitted case totals and EQ5D and Oxford score data through the Clinical Audit and Effectiveness Committee.

Data available from The Health and Social Care Information Centre at http://content.digital.nhs.uk/catalogue/PUB23060

2.3.3 EMERGENCY READMISSIONS WITHIN 28 DAYS OF DISCHARGE

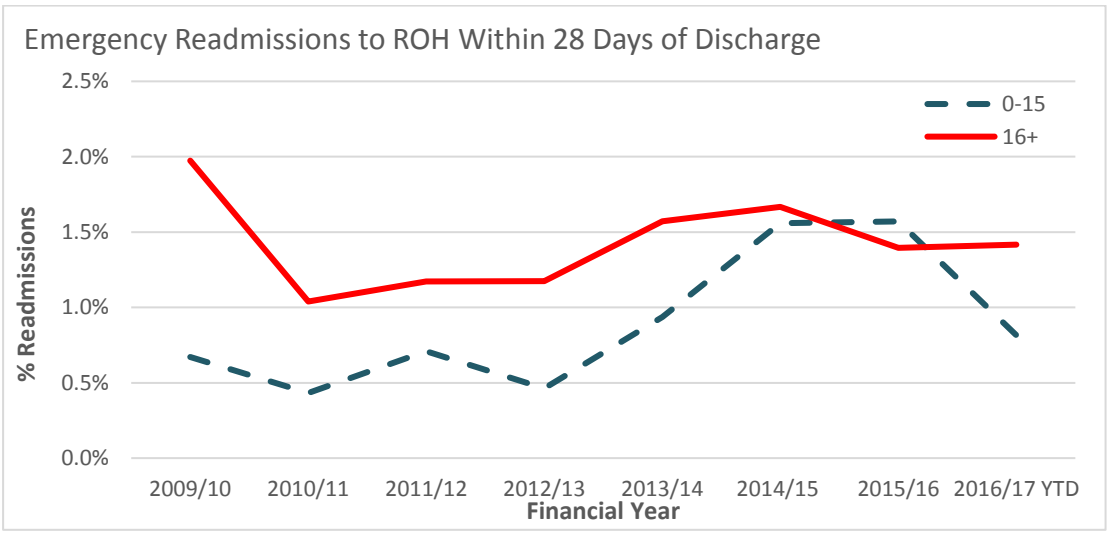
The percentage of patients aged:

(i) 0 to 15 and

(ii) 16 or over

Who are readmitted to a hospital which forms part of the trust within 28 days of being discharged during the reporting period as shown in Table 12 below:

TABLE 12: EMERGENCY ADMISSIONS WITHIN 28 DAYS OF DISCHARGE



Financial Year

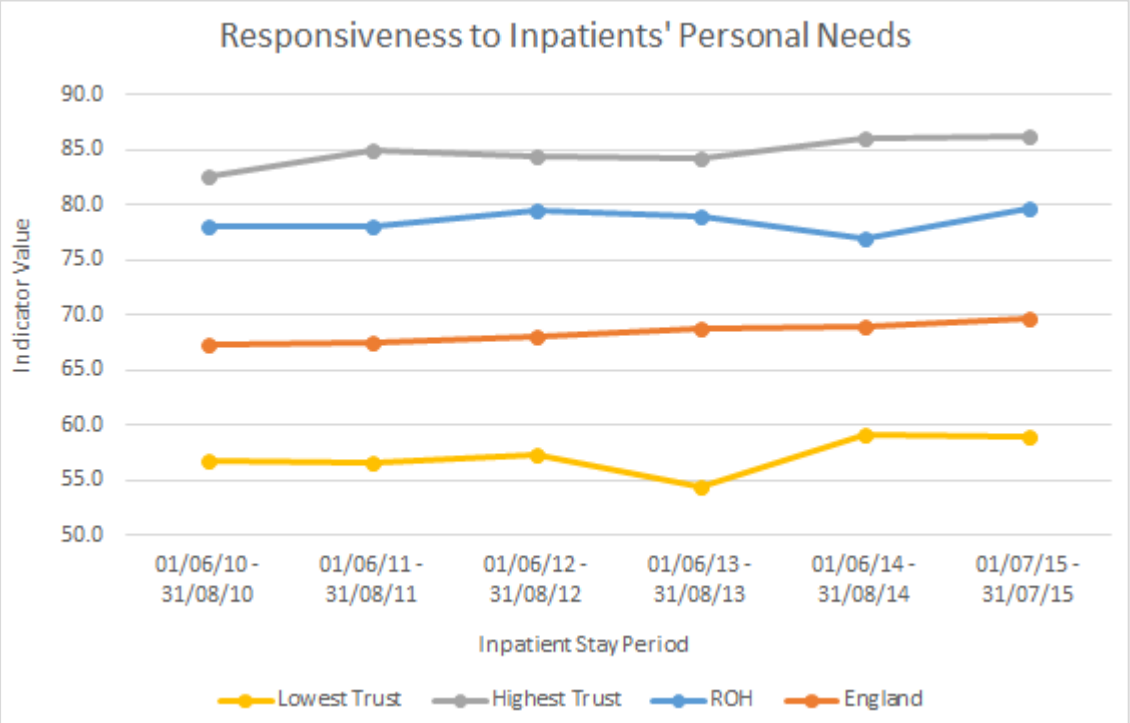
Readmission Rate	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 YTD
0-15	0.7%	0.4%	0.7%	0.5%	0.9%	1.6%	1.6%	0.8%
16+	2.0%	1.0%	1.2%	1.2%	1.6%	1.7%	1.4%	1.4%
All	**1.8%**	**1.0%**	**1.1%**	**1.1%**	**1.5%**	**1.7%**	**1.4%**	**1.4%**

The 28 day readmissions as defined by NHSI for the Quality Accounts is a local indicator and therefore cannot be benchmarked or compared to a national average.

The Royal Orthopaedic Hospital intends to take the following actions to improve the specific readmission indicators and so the quality of its services

- The trust is currently reviewing its data including the area, specialism and reason behind readmission.
- Dependent on the data analysis further focused actions will be taken to reduce readmissions if and where possible.

2.3.4RESPONSIVENESS TO PERSONAL NEEDS



Inpatient Stay	ROH	England	Highest Trust	Lowest Trust
01/06/10 - 31/08/10	78.0	67.3	82.6	56.7
01/06/11 - 31/08/11	78.1	67.4	85.0	56.5
01/06/12 - 31/08/12	79.5	68.1	84.4	57.4
01/06/13 - 31/08/13	78.9	68.7	84.2	54.4
01/06/14 - 31/08/14	77.0	68.9	86.1	59.1
01/07/15 - 31/07/15	79.6	69.6	86.2	58.9

The Royal Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons; this report has shown that ROH is above the national average in England in being responsive to personal needs.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve: This year has seen an improvement in responsiveness to personal needs we will continue to monitor progress.

2.3.5 FINDINGS FROM THE STAFF SURVEY/STAFF FRIENDS AND FAMILY TEST 2016/17

This section presents the findings from the annual staff survey in respect of indicators K1, K21 and K27 together with a summary of the findings of the Staff Friends and Family test through 2016/17.

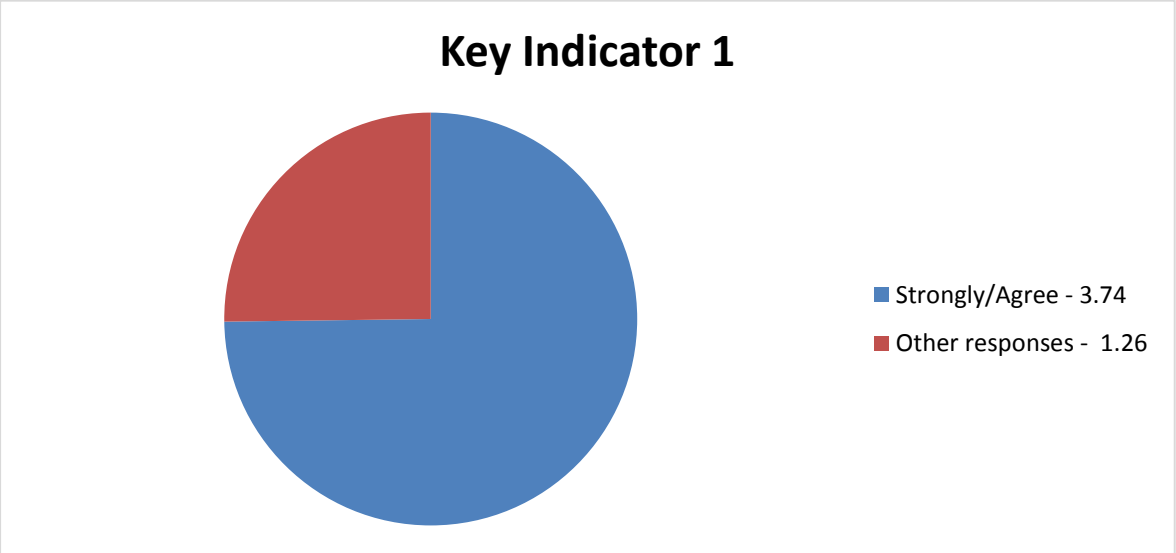
The Royal Orthopaedic Hospital considers that this data is as described for the following reasons:

- Each year the Trust participates in the annual NHS staff survey and shares the findings with staff members through communication channels and team meetings as well as at the range of management meetings including Executive Directors, Trust boards and other committees.

- In addition the Trust takes part in Staff Friends and Family test which asks the question 'How likely are you to recommend ROH' as a place to work'? All staff are invited once a year to take part in this survey.

Table 13 below presents the results from the 2016 staff survey whilst Table 14 provides the findings of the Staff Friends and Family test for 2016/17.

TABLE 13: STAFF SURVEY RESULTS KEY INDICATOR 1 'I WOULD RECOMMEND MY ORGANISATION AS A PLACE TO WORK' 2016



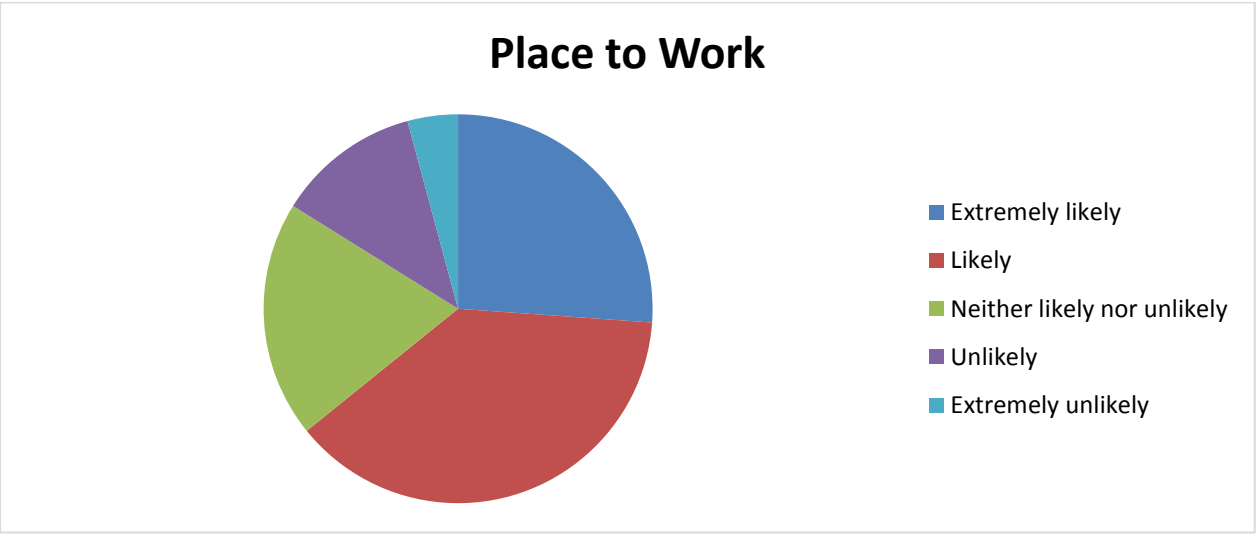
In 2016, all staff were invited to take part in the National Staff Survey. 46 % of staff (n=428) responded, with 12% paper questionnaires and 88% online completions. 56% of staff who completed the survey confirmed that they would recommend the organisation as a place to work.

This shows a deterioration of 7% but is not considered statistically significant, as it is 'unweighted' data.

The results of the Staff Friends and Family Test for 2016/17 are presented in Table 14 below.

In 2016/17, 319 staff responded to this survey with 64% of those indicating that they would recommend the Trust as a place to work. This represents an increase on the percentage reported in 2015/16 of 62 %.

TABLE 14: RESULTS FROM STAFF FRIENDS AND FAMILY TEST 2016/17 (319 RESPONSES) – HOW LIKELY ARE YOU TO RECOMMEND THE ROH TO FAMILY AND FRIENDS AS A PLACE TO WORK?



The Royal Orthopaedic NHS Foundation Trust considers that the data is as described for the following reasons:

- The Trust has undergone a significant period of reorganisation with the development of new Divisional teams and management restructure.

- There has also been additional financial pressure in line with national NHS challenges.

- The Trust has increased its focus on performance management across all teams.

- The Trust ran a Patient Safety conference in 2016 which consists of presentation from outside speakers and discussion groups. This has provided a wealth of information for managers and actions have been taken in different parts of the Trust as result.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve the response to the annual staff survey indicator, and the staff Friends and Family test results:

- Future events will be run for all staff to upskill in continuous improvement and setting performance objectives.

- We will continue invested in line managers to build their capability through development programmes and coaching initiatives.

- We will continue to offer staff members additional training courses to support both individual competence and confidence.

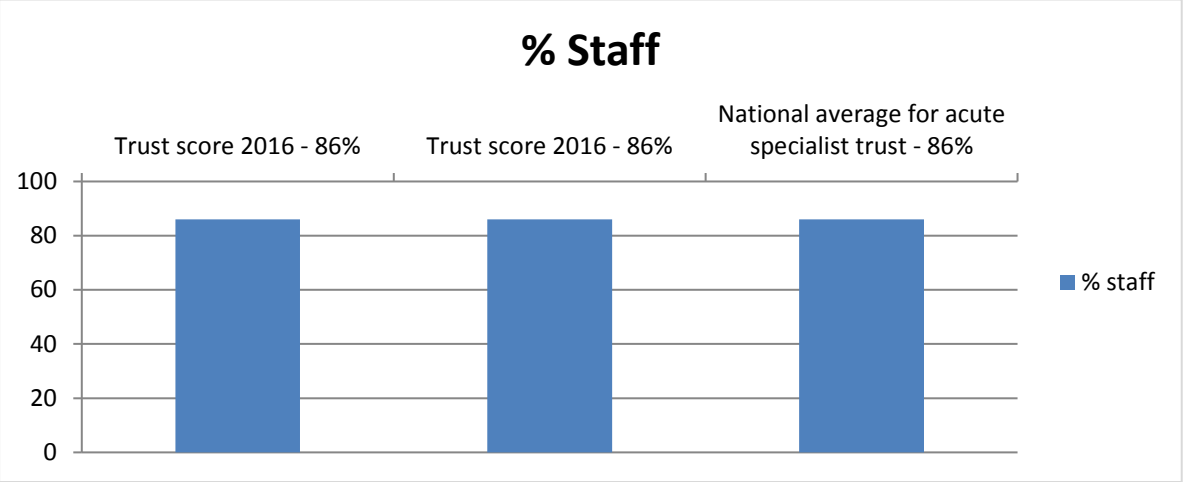
- We will ensure a clear action plan and updates are regularly communicated to all staff.

- Throughout 2016/17 work will be completed to raise awareness of this measure with all staff groups to encourage more staff members to take part.

- A detailed review of the comments completed by staff will be undertaken in Q1 2016/17 in order to identify themes which will be used to inform the next steps in developing the Staff Engagement Strategy.

In addition to the key findings detailed above, the Trust is expected to report on Key Indicators 21 and 27. The data for both indicators is presented below in Tables 15 and 16.

TABLE 15: INDICATOR 21 – PERCENTAGE OF STAFF BELIEVING THAT THE ORGANISATION PROVIDES EQUAL OPPORTUNITIES FOR CAREER PROGRESSION OR PROMOTION (THE HIGHER THE SCORE THE BETTER)



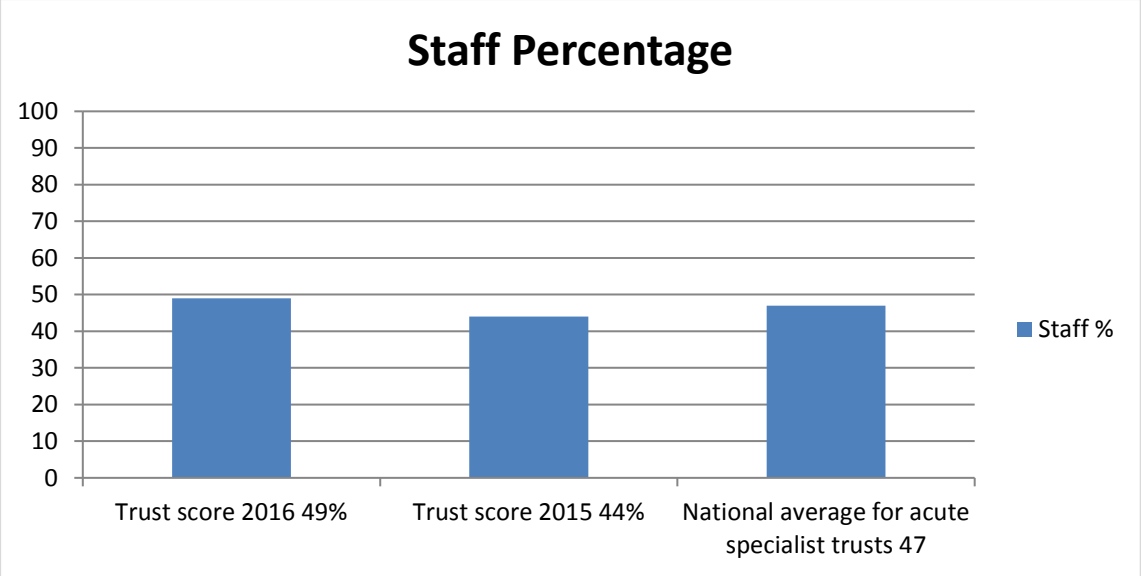
The Royal Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The score has been consistent at 86% over the last few years.
- This percentage is same as the national average for acute specialist trusts.
- The Trust has continued to offer opportunities to all staff members particularly as part of the PDR process.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve the staff response to this indicator and so the quality of its services:

- The Trust has completed the Equality Delivery System assessment and the relevant report will be published shortly.
- The Trust Board has instructed that a formal plan is developed to address the potential improvements identified in the report. As a first step, the Trust will engage with staff to confirm actions for 2017.
- Value Based recruitment (VBR) will be further embedded in the organisation to support fair recruitment practices.

TABLE 16: INDICATOR 27 – PERCENTAGE OF STAFF/COLLEAGUES REPORTING MOST RECENT EXPERIENCE OF HARASSMENT, BULLYING OR ABUSE



This indicator provides the Trust with a positive finding and is better than average. The 2016 Trust score is 49% (out of a possible 100) which is just higher than the National 2015 at 44%. This is also higher than the average acute specialist trust at 47%.

The Royal Orthopaedic Hospital NHS Trust considers that the data is as described for the following reasons:

- There has continued focused by the Inclusion team to raise the importance of reporting incidents of harassment, bullying or abuse, and the types of actions that constitute these behaviours.

- The ROH Freedom to Speak Up (FTSU) Guardian has been recruited and is working with colleagues to raise awareness of the importance to report incidents of Patient safety.

- All staff members attend presentations on joining at Trust induction and at core mandatory training day on Inclusion and Incident reporting. Both sessions emphasis the importance of reporting incidents and where to go for help.

- If staff members have a concern and are unsure who to speak to, there is a network of contact officers who can offer support. Their role is not to solve the issue but help individuals decide next steps.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve the staff response to key findings:

- All leadership modules in future workshops will include a session on inclusive leadership. This will help to embed the correct behaviours in the Trust.

- Contact officers will undertake a training programme to review and refresh the required skills to support the staff with speaking out about issues.

- A new module on Assertiveness will be designed and delivery for key staff

members to give them the confidence to speak about bullying and harassment.

2.3.6 VTE

The Royal Orthopaedic Hospital NHS Foundation Trust considers that this data is described for the following reasons:

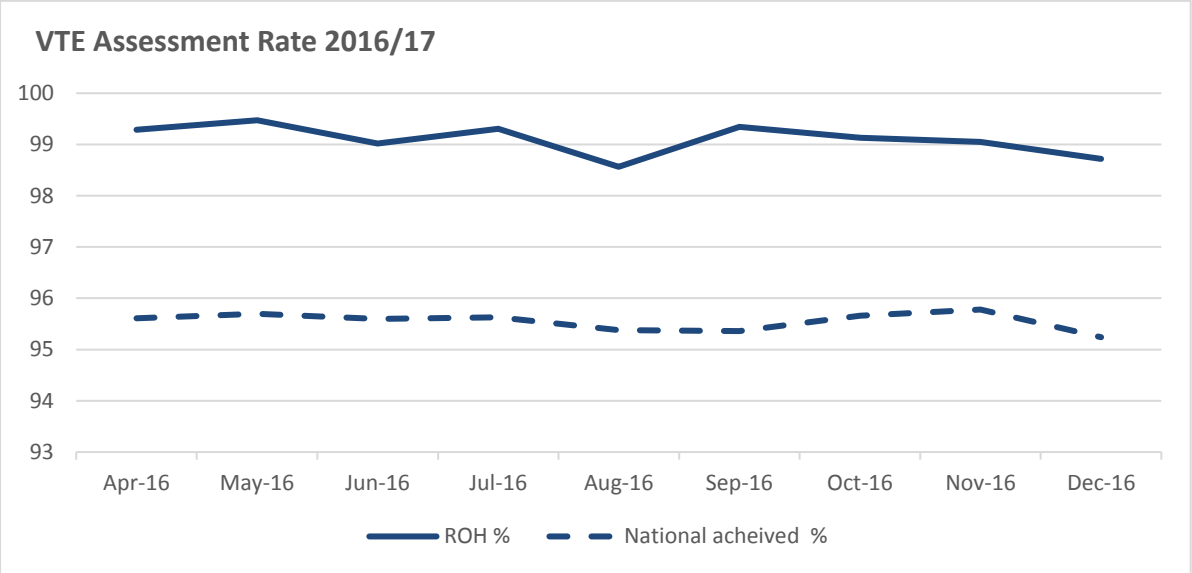
- Monitoring of compliance against the national standard to ensure that > 95% of all patients admitted to the hospital are risk assessed for VTE.

Table 12 below shows the percentage of patients who were risk assessed for VTE against the numbers admitted to hospital in this time frame, whilst Table 13 provides benchmarking data.

TABLE 17: RISK ASSESSMENTS BY MONTH 2016/17

Month	No. Assessed	No. Admitted	ROH %	National Achieved %
Apr-16	975	982	99.29	95.61
May-16	943	948	99.47	95.7
Jun-16	911	920	99.02	95.6
Jul-16	1004	1011	99.31	95.63
Aug-16	824	836	98.56	95.38
Sep-16	1057	1064	99.34	95.36
Oct-16	1026	1035	99.13	95.66
Nov-16	1146	1157	99.05	95.78
Dec-16	923	935	98.72	95.24
Jan-17	1006	1019	98.72	Not Published at Present
Feb-17	996	998	99.80	Not Published at Present
Mar-17	1078	1097	98.27	Not Published at Present

TABLE 18: VTE RISK ASSESSMENTS OVERTIME VS NATIONAL AVERAGE



It can be seen that ROH continues to consistently report rates of VTE risk assessment that are greater than the national average.

2016/17 CQUIN: To identify lessons learnt and improve prevention strategies associated with VTE: All requirements have been met to date and we are on target and expecting to achieve VTE exemplar Centre status by end of Quarter 4 (March 2017).

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions in order to ensure that it continues to report zero avoidable cases for 2017-18 and so improve the quality of its services:

- Aim is to continue to reduce the number of avoidable VTE's. This will be monitored via existing reporting and monitoring methods led by the VTE lead and VTE Advisory Group chair. The VTE Advisory group reports quarterly to The Clinical Quality Committee.

2.3.7 CLOSTRIDIUM DIFFICILE INFECTION (C-DIFFICILE)

The Royal Orthopaedic Hospital NHS Foundation Trust considers that the rate of C.difficile infection per 1000 bed days shown in Table 19 below is as described for the following reasons:

- The control of infection is of paramount importance for our patients and the Trust has continued to meet its objective of 2 avoidable cases of Clostridium difficile during this reporting period. There have been zero (0) avoidable cases reported during 2016-17.

- The Trust is compliant with Department of Health Guidance against which C.difficile is reported

- and is subject to external scrutiny of its data for audit purposes.

In addition the Trust remains committed to the prevention of Infection by:

- Prompt isolation of patients
- Obtaining stool specimens for rapid detection.
- Maintaining rigorous attention to good infection control practices through education and audit of practice.
- Undertaking regular ward rounds as part of the Bone Infection Unit in order to ensure that antibiotic therapy is correctly and appropriately prescribed.
- Taking action to improve practice when concerns are identified through audit and review.
- Reporting and monitoring of actions through the Trust Infection Control, Committee with upward reporting to the Quality and Safety Committee.
- Terminal cleaning followed by Bioquell fogging.

TABLE 19: RATES OF C.DIFFICILE INFECTION - PATIENTS AGED 2 YEARS AND OLDER - TRUST APPORTIONED CASES INCLUDING ENGLAND AVERAGE

	April 2010 - March 2011	April 2011 - March 2012	April 2012 - March 2013	April 2013 - March 2014	April 2014 - March 2015	April 2015 - March 2016	April 2016 - March 2017
The Royal Orthopaedic Hospital	**24.5**	**16.3**	**3.2**	**5.7**	**4.9**	**20.0**	**13.5†**
All England Rate	**29.6**	**21.8**	**17.3**	**14.7**	**15.1**	**14.9**	
Lowest England Rate	0	0	0	0	0	0	
Highest England Rate	71.8	51.7	30.8	37.1	62.2	66.0	

Note: † Data for 2016-17 is currently awaiting national release and this will not be available until July 2017. Therefore, this data is preliminary as it has been calculated using internal trust bed occupancy figures, and may be subject to change in later reports.

Four cases have occurred during this time frame. All were subject to investigation and agreed as unavoidable with local commissioners for the following reasons:

Case No.	Previous C.difficile	BIU Patient	Laxative Use	Antimicrobial policy compliance?
Case 1	No	Yes	Yes	Yes
Case 2	Yes	Yes	Yes	Yes
Case 3	Yes	Yes	No	Yes
Case 4	No	No	Yes	Yes

- 3 cases were patients who were under the care of the Bone Infection Unit and targeted antibiotic therapy was required for all of these patients in order to treat prosthetic joint infections. A balance of risk is required as both Clostridium difficile and deep infection can pose a risk to the patient's life.
- 2 cases had a previous past medical history of C.difficile and therefore would be at greater risk of developing an episode, particularly as they were both under the care of the Bone Infection Unit and required targeted antibiotic therapy.
- 3 cases had been given laxatives for the treatment of constipation, which could have been a causative factor for diarrheal episodes and subsequently C.difficile

infection.
- All patients were treated according to Trust protocol and made an uneventful recovery from their Clostridium difficile infection.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions in order to ensure that it continues to report zero avoidable cases for 2017-18 and so improve the quality of its services:

- We will maintain our focus on Infection Prevention and Control, so that exemplary standards of hand hygiene and use of personal protective equipment is maintained.
- We will review our Uniform and Dress Code Policy to ensure that all staff adhere to the principles of bare below the elbows in clinical areas.
- We will develop a business case to support creation of a stand- alone Bone Infection Unit which will maximise effectiveness of ward rounds and ensure that best practice is upheld in respect of antibiotic prescribing.
- We will develop schedules for terminal cleans and Bioquell to minimize the risk of ongoing transmission.
- Continue to monitor isolation within 2hr is achieved.

2.3.8 PATIENTSAFETYINCIDENTS

The Royal Orthopaedic Hospital considers that the number of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or patient death are as described for the following reasons:

- The Trust actively promotes a culture of incident reporting so that issues can be identified, actions initiated and lessons learned.

- The Trust categorises incidence from no harm to severe harm and uses the definitions provided by the National Reporting and Learning System (NRLS) to categorise the level of harm

- All reported incidents are subject to review by a member of the governance team at ROH who will seek clarity on level of harm from clinical staff where necessary and amend the initial categorisation if required.

- The Trust submits patient safety incidents to the NRLS which enables benchmarking against other similar organisation in respect of numbers and types of patient safety incidents.

The ROH has taken the following actions in order to ensure learning from incidences is shared and embedded across the organisation:

- Continues to actively encourage reporting of incidents

- Continue to deliver Root Cause Analysis Training to members of senior staff who undertake investigations.

- A review of the way actions from incidents are tracked and shared across the organisation, including the development of action trackers that are used to monitor progress against action at Divisional Governance meetings.

- Currently trustwide information relating to Patient safety and patient experience activity is contained within the quality report that is presented monthly at the Clinical Quality Meeting, The Quality and Safety Committee.

- The Trust now has established weekly Governance meetings that included any incidents that are graded by the reporter as moderate harm or above, any complaints and any other risk or issues.
- Following incident RCA's and reviews anonymised reports are sent to all clinicians trust wide and are discussed at local and trust wide committees.

- Serious incident are presented at the Clinical Audit meeting.

TABLE 20: INCIDENT DATA OVER PAST FOUR YEARS

Indicator	2013/14	2014/15	2015/16	2016/17
Number of Patient safety	883[1]	897	1113[2]	1530 [2]
Rate of Patient safety Incident per 1000 bed days (NB this indicator changed in 2014/15 from rate of	14.77 per 100 Admissions (this indicator changed in the reporting	34.72[1]	36.3 1] (April 2015 to Sept 2015)	19.43 [1]
Number of patient Safety Incidents with Severe harm/ death	11[1]	8[1]	12[2]	2 [2]
% of patient safety incidences that resulted in severe harm/death	1.1 %[1]	0.9[1]	1.0[2]	0.1 [2]

[1] Data taken from NRLS [2] Data taken from Trust Source

The Trust has seen a significant increase in the number of patient safety incidents reported over the four year period represented above which reflects the focus through the year on encouraging staff to actively report incidents of concern. It is to be noted that Trust did not upload to the NRLS for 5 months at the beginning of 2016/17.

There have been no themes identified from the severe harm incidents recorded during 2016/17. Learning from review of these incidents has been widely shared across the Trust at clinical audit meetings and through the Clinical Quality Group.

During 2016/17 ROH reported three never events against zero which were reported in the same period 2015/16. These were a wrong side block, wrong site incision and wrong side implant. An external audit review was commissioned by the Trust into the three never events.

The Trust recognises that it has work to do to improve the standard of incident reporting and to ensure that feedback from incidents is regularly provided to the incident reporter. The ROH intends to take the following action to improve the standard of incident reporting and engage staff in feedback and sharing lessons from incidents and so improve the quality of its services:

- Continue to actively encourage the reporting of incidents by actively reviewing our feedback mechanism through our incident reporting system Ulysses.

- There is planned improvement work on the Ulysses system that will allow better triangulation of data between complaints and patient safety incidents.

- Further Delivery of Root Cause Analysis Training.

2.4 IMPLEMENTATION OF DUTY OF CANDOUR AT ROH

During 2015/16 the Trust undertook significant work in order to respond to concerns raised by the CQC about Regulation 20: Duty of Candour was fully embedded across the organisation. This included:

- Approval of a new Duty of Candour Policy and process.
- Amendment of the Incident Reporting System to include a Duty of Candour tab to make it easier for staff to identify concerns and upload evidence of discussions with patients.
- The inclusion of Duty of Candour Training at induction and mandatory training days.
- The development of a Duty of Candour Action tracker to ensure that all requirements of Regulation 28 are adhered to.
- Executive oversight of the Duty of Candour process at Senior management team meetings.

ROH was subject to two external reviews by CCG colleagues in respect of Duty of Candour through 2016/17. Significant improvement in compliance was shown between the first audit which took place in July 2015 (25% compliance) and the second which took place in March 2016, following the implementation of the actions outlined above (100%) compliance.

The Trust considers that the improvement in compliance is evidence that good progress has been made in embedding Duty of Candour across the organisation but recognises that the good work undertaken must be sustained.

Regular bi annual audit of compliance with Duty of Candour will be included as part of the audit plan for 2016/17 in order to monitor compliance with Regulation 20.

2.5 SIGN UP TO SAFETY PLEDGES

Sign up to Safety is a national campaign which supports the mission to make the NHS the safest health system in the world.

Organisations who Sign up to Safety commit to strengthen patient safety by:

- Setting out the actions they will undertake in response to the five Sign up to Safety pledges and agree to publish this on their website for staff, patients and the public to see.
- Committing to turn their actions into a safety improvement plan (including a driver diagram) which will show how organisations intend to save lives and reduce harm for patients over the next 3 years.

The Trust continues to embed the process of signing up to this national campaign and of developing its sign up to safety action plan based on the five key pledges outlined in the

programme as detailed below:

1. Putting safety first. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.

3. Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

4. Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

5. Being supportive. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

PART 3:

REVIEW OF QUALITY PERFORMANCE 2016/17

3.1 REVIEW OF QUALITY PRIORITIES 2016/17

During 2016/17 the Trust outlined 8 areas for improvement and successfully achieved 2 of these as summarised in Table 21 below:

TABLE 21: PROGRESS AGAINST QUALITY PRIORITIES 2016/17

Reduce number of incidences of consent on day
Reduce the number of avoidable pressure ulcers
Reduce the number of avoidable VTE events
Ensure that learning identified from serious incidents and complaints are embedded in practice
Reduction in waiting times in clinic
Reduction in cancellation on day of surgery (Governors Priority)
Deliver the commitments outlined in the first year of the Dementia Strategy-
Improve patient reported experience of pain

3.2 PATIENT SAFETY OBJECTIVES

3.2.1 Reduce the number of incidences of consent in the day.

During 16/17 the main focus has been to develop a robust Consent policy. During the year we have provided training and education across the MDT ensuring that we have a policy that is applied in practice. It is recognised the limited progress that has been made against this objective which is one of the reasons this objective will continue into 17/18. Further details on the plans to progress this object have been detailed within section 2 of this report.

3.2.2 Reduce the number of avoidable pressure ulcers

In total, from 1st April 2016 the Trust has reported the following avoidable pressure ulcers:

13 avoidable Grade 2 pressure Ulcers against a limit (target) of 15. (One Grade 2 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures).

3 avoidable Grade 3 pressure Ulcers against a limit of 0. (One Grade 3 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures).

		Apr'16	May'16	Jun'16	Jul'16	Aug'16	Sep'16	Oct'16	Nov'16	Dec'16	Jan'17	Feb'17	Mar'17	Total
Avoidable	Grade 2	2	1	1	1	0	1	3	0	0	4	0	0	**13**
	Grade 3	0	0	1	1	0	0	0	0	1	0	0	0	**3**
	Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Unavoidable	Grade 2	1	0	0	0	0	2	4	1	0	0	1	0	**9**
	Grade 3	0	0	0	0	0	1	0	0	0	0	0	0	**1**
	Grade 4	0	0	2	0	0	0	0	0	0	0	0	0	**2**
	Pending	0	0	0	0	0	0	0	0	0	0	0	0	**0**

The Trust has not met the target set for avoidable pressures ulcers relating to grade 3 pressure ulcers against a target of 0. However, there have been no reported avoidable hospital acquired grade 4 pressure ulcers during 16/17, with the Trust achieving its target set for grade 2 pressure ulcers.

The Trust has developed an action plan for 17/18 with the aim to reduce avoidable hospital acquired pressure ulcers further during the year. Due to the unmet targets for grade 3 avoidable pressure ulcers the Trust has included in the Quality Priorities for 2017/18. This should have resulted in a financial penalty however; our local commissioners have agreed to reinvest the money into enhancing quality care at ROH.

3.2.3 Reduce the number of avoidable VTE incidents

A hospital acquired VTE is one defined as any new episode of VTE diagnosed during hospitalization or within 90 days of discharge following an in-patient stay. It is our commissioners' requirement that all positive VTE'S are reported and a Root Cause Analysis (RCA) completed. These RCA's are shared with patients and relatives.

2016/17 achievements:

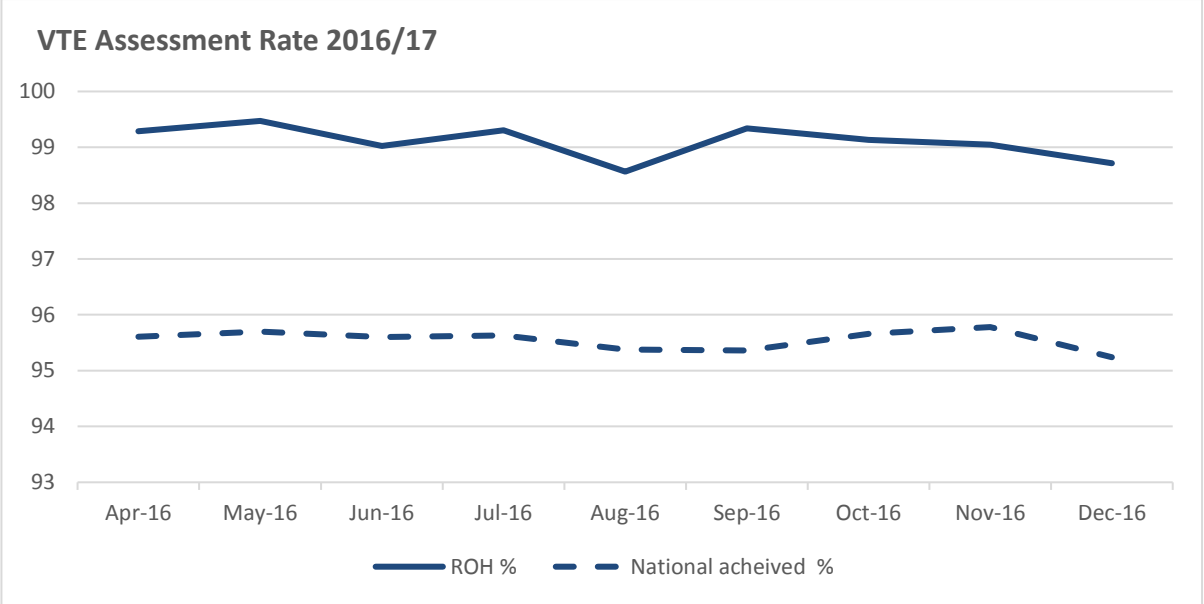
- VTE risk assessment (minimum requirement 95%) has been consistently achieved throughout 16/17.
- Compliance with thromboprophylaxis prescribing requirements (minimum requirement 95%) has been consistently achieved throughout 16/17.
- RCA's completed for all reported positive hospital acquired VTE's – 100 % requirement met.
- 2016/17 CQUIN: To identify lessons learnt and improve prevention strategies associated with VTE. All requirements met to date, we are on target to achieve exemplar centre status by the end of Q4 (March 17).

VTE's are deemed avoidable when there is any evidence of non-compliance with ROH or NICE requirements and there is no documentation to identify reasons for deviation. The data below demonstrates not only that the overall number of VTE's compared to 15/16 have reduced but of those identified 61% were recorded as unavoidable. This demonstrates that all measures had been taken to reduce the risk of a VTE occurring.

Year	Total no. reported	Recorded avoidable	% avoidable
15/16	35	18	51%
16/17	18	7	39%

TABLE 23: COMPLIANCE WITH VTE ASSESSMENT 2016/17

Month	No. Assessed	No. Admitted	ROH %	National Achieved %
Apr-16	975	982	99.29	95.61
May-16	943	948	99.47	95.70
Jun-16	911	920	99.02	95.60
Jul-16	1004	1011	99.31	95.63
Aug-16	824	836	98.56	95.38
Sep-16	1057	1064	99.34	95.36
Oct-16	1026	1035	99.13	95.66
Nov-16	1146	1157	99.05	95.78
Dec-16	923	935	98.72	95.24
Jan-17	1006	1019	98.72	Not Published at Present
Feb-17	996	998	99.80	Not Published at Present
Mar-17	1078	1097	98.27	Not Published at Present



Work will continue through 2016/17 to ensure that this standard is maintained and delivered in order to ensure the best outcome for our patients. On the basis of the evidence presented, the Trust considers that this priority is met for 2015/16.

3.2.4 Ensuring that learning identified from serious incidents and complaints are embedded in practice

In 2016/17 Currently, trustwide information relating to governance and patient experience activity is contained within the quality report that is presented monthly at the Clinical Quality Meeting, The Quality and Safety Committee and TMC.

The Trust now has established weekly Clinical Governance meetings that include any incidents that are graded by the reporter as moderate harm or above, any complaints and any other risk or issues. These are chaired by the Associate Medical Director for Division 2 and The Head of nursing for Division 1. Also on the agenda of these meeting, is the review of closed serious incidents action plans and dissemination of learning.

In addition, much work has been completed during 2016/17 on the sharing of learning from Serious Incident. RCA's from serious incidents are anonymised and sent to all clinicians trust wide and are discussed at local and trust wide committees. Serious incident are also presented in Clinical Audit. There is planned improvement work on the Ulysses system that will allow better triangulation of data between complaints and Incidents.

Whilst recognising that improvement has been made, this will be continuous and must be maintained. The Trust also recognises there are improvements needed to the incident system, therefore work is still ongoing to ensure the Trust learn from Incidents and Complaints.

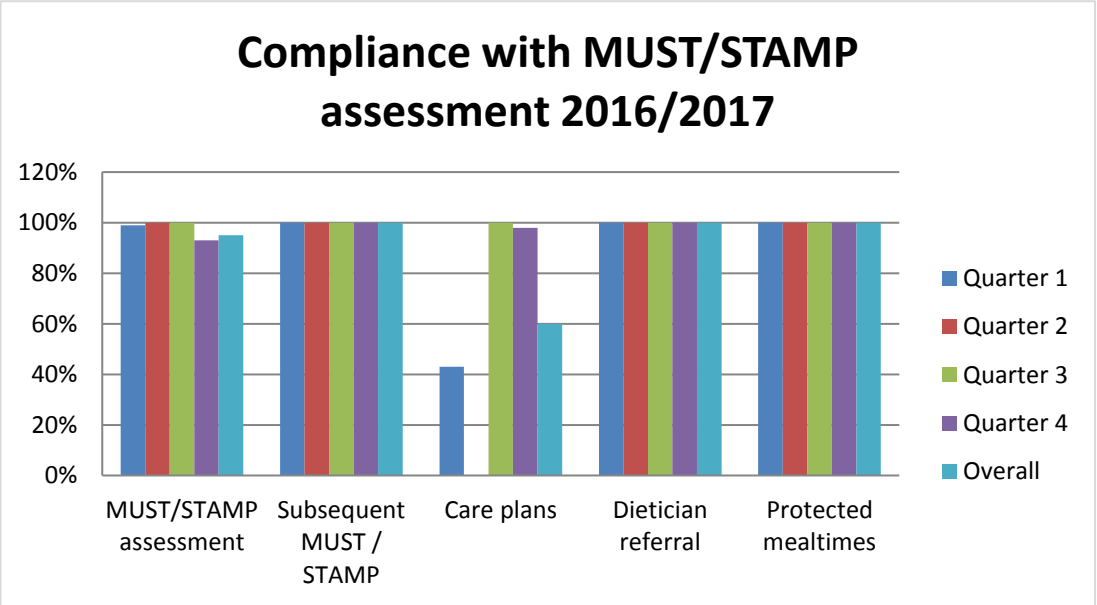
3.2.5 NUTRITION ASSESSMENTS

Nutritional assessments are used to monitor for the risk of malnutrition, in this case as defined by the NICE Quality Standard 24 'Quality Standard for Nutritional Support in Adults'. At ROH, we use the nationally recognised Malnutrition Universal Screening Tool (MUST) and the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to undertake these assessments. The Royal Orthopaedic Hospital NHS Foundation Trust uses the nutritional assessments as described in Standard 24 (as above) to determine compliance against this standard. The questions used in assessment are:

1. Are all patients screened within 6 hours of admission to identify the patients who are malnourished or at risk of becoming malnourished?
2. Are all patients re-screened weekly?
3. Do all patients have a care plan which identifies their nutritional care needs and how they are to be met?
4. If identified, do all patients who require a referral to the dietician have a referral?
5. Are patients interrupted at mealtimes?

- The completion of this assessment is audited on all wards by their nutrition link nurses on a quarterly basis, below is the compliance data from the ROH over the last year (Table 24)

TABLE 24: COMPLIANCE WITH MUST / STAMP ASSESSMENT 2016/2017



The percentage of compliance with the initial MUST/STAMP nutritional assessments were: Quarter 1 99%, Quarter 2 100%, Quarter 3 100% & Quarter 4 93%.

Therefore the overall data for 2016/17 shows an average of MUST/STAMP initial assessment and completion within 6 hours of admission at 98%. This is an increase in compliance.

There had been new training emphasis on MUST/STAMP assessments with the Train the Trainer training completed at end of Q4 of 2015/2016 with the availability of the Nutritional Assessment Policy. This has shown to be effective with the increase in completion of the initial assessments.

The percentage of patients who needed and received a subsequent assessment after 7 days was 100% overall throughout all 4 quarters.

All the patients who were identified from the assessment as needing a dietician referral were referred appropriately. This was shown as 100% compliant across all the 4 quarters.

Of the patients who required care plans to be in place, compliance was at 43% in Quarter 1, there was 0% compliance in Quarter 2, 100% compliance in Quarter 3 and 98% compliance in Quarter 4. There has been continual improvement since Quarter 2 and this will be continued to be monitored.

Good practice has continued with the use of care-plans and dietetic referrals based on clinical judgment for patients that are not assessed as nutritionally at risk from the MUST tool but put in place for other concerns, for example; patients with wound healing requirements, dementia.

The 'protected mealtimes' initiative has been embedded into practice across all the wards and inpatient departments as the compliance audit shows 100% of patients are not disturbed at mealtimes consistently across all 4 Quarters.

The Royal Orthopaedic Hospital NHS Trust has taken the following actions in order to improve compliance with nutritional risk assessment and so the quality of its services:

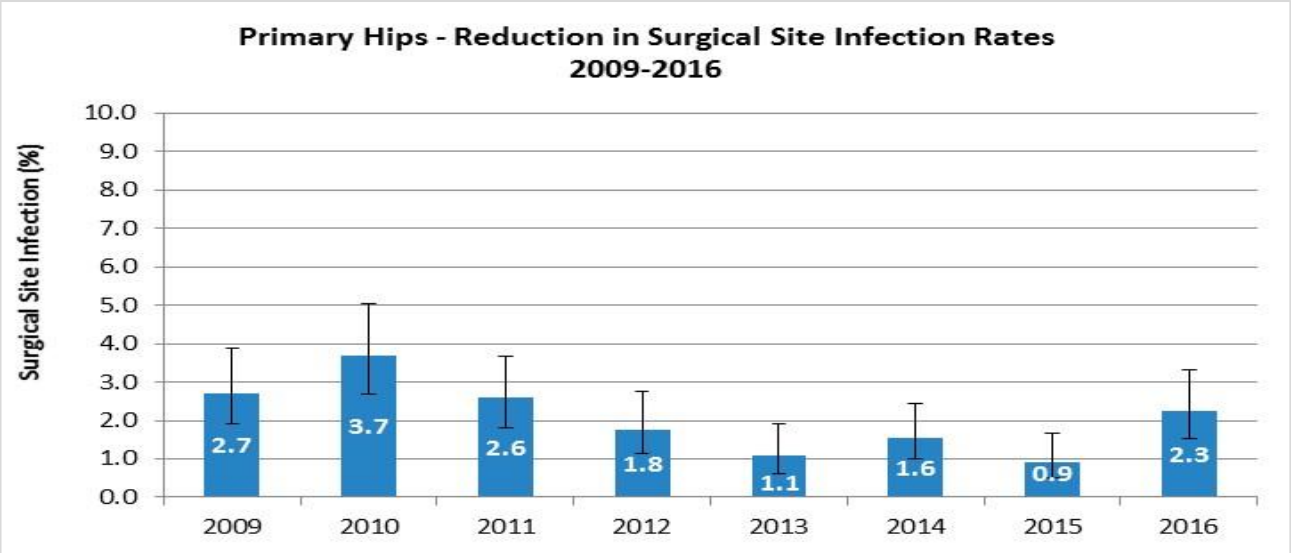
- The quarterly audit of compliance with the MUST risk assessment tool has moved to monthly for inclusion in the Ward Quality Dashboards to highlight any poor compliance for timely rectification by the Ward Managers and Matrons.
- The 'Red Tray' policy has been written in conjunction with the dietetic and Speech and language services and is currently going through the ratification process in the Trust.
- Red mats have been designed, financed and ordered for use with all patients identified with nutritional needs, on all the in-patient areas.
- The red tray policy and red mats will have a formal 'launch' in the Trust.

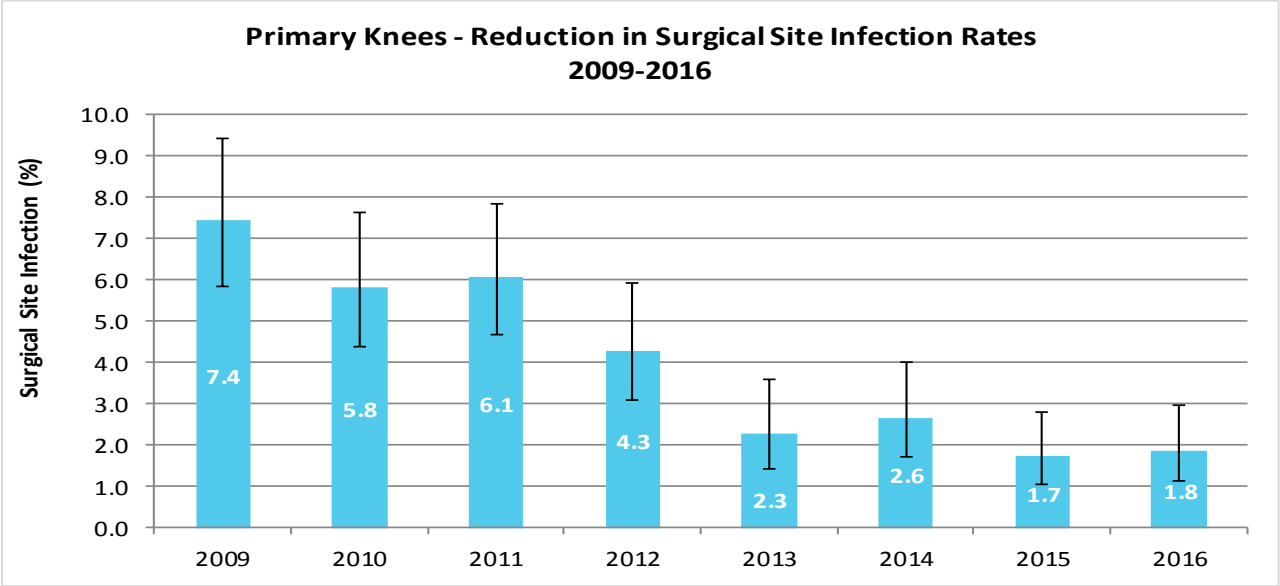
3.2.6 SURGICAL SITE INFECTION

The Royal Orthopaedic Hospital considers that the number of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or patient death are as described for the following reasons:

- In 2016, a total of 41 Surgical Site Infections for Primary Hip and Knee replacements were reported. 2015 saw the lowest rates of infections in Primary Hip and Knee Replacements at 30 days since surveillance began in 2009. In 2016, the rate of Surgical Site Infections for Primary Knee replacements remained relatively steady at 1.8%, compared to 1.7% reported in 2015. The rate of Surgical Site Infections for Primary Hip Replacements was 2.3%, which was up significantly from 2015 where the rate was 0.9%. This is due to a cluster of infections identified, primarily in Hip Replacement surgery and which led to a closedown of theatre for a period of 5 days to carry out a deep-clean.

TABLE 25: ROH SURGICAL SITE INFECTION: PRIMARY HIP AND KNEE REPLACEMENTS ONLY – 30 DAY RATE





There has been a significant reduction in Surgical Site Infection rates for Primary Knee Replacements where rates have fallen from 7.4% (CI: 5.8 – 9.4) in 2009 to 1.8% (CI: 1.1 – 3.0) in 2015, which equates to a reduction of 74.2% over an eight year period. Disappointingly, the cluster of infections identified by the team in the beginning of the financial year means that rates for 2016 are higher than for previous years. However, the benefits of performing the deep clean of theatres has already shown real term benefits in the form of a reduction in infections overall and in particular a reduction in the number of drug-resistant microorganisms identified in patients developing an infection post-operatively.

In line with NICE and DH guidance a range of measures were introduced at different times over the past 5 years to reduce the rate of SSI at the ROHFT. This included the introduction of antimicrobial sutures, 2% chlorhexidine, antimicrobial ioban incise drapes and Aquacell dressings. introduction of the Wound Care Helpline, and improving training and education to all clinical staff to raise awareness of SSI prevention, in conjunction with an expansion of monitoring and surveillance of SSIs would have contributed towards the reduction in SSI rates. Active surveillance is undertaken for all primary arthroplasty patients for a period of 12 months post operatively, with the data being reported to Public Health England according to their protocol.

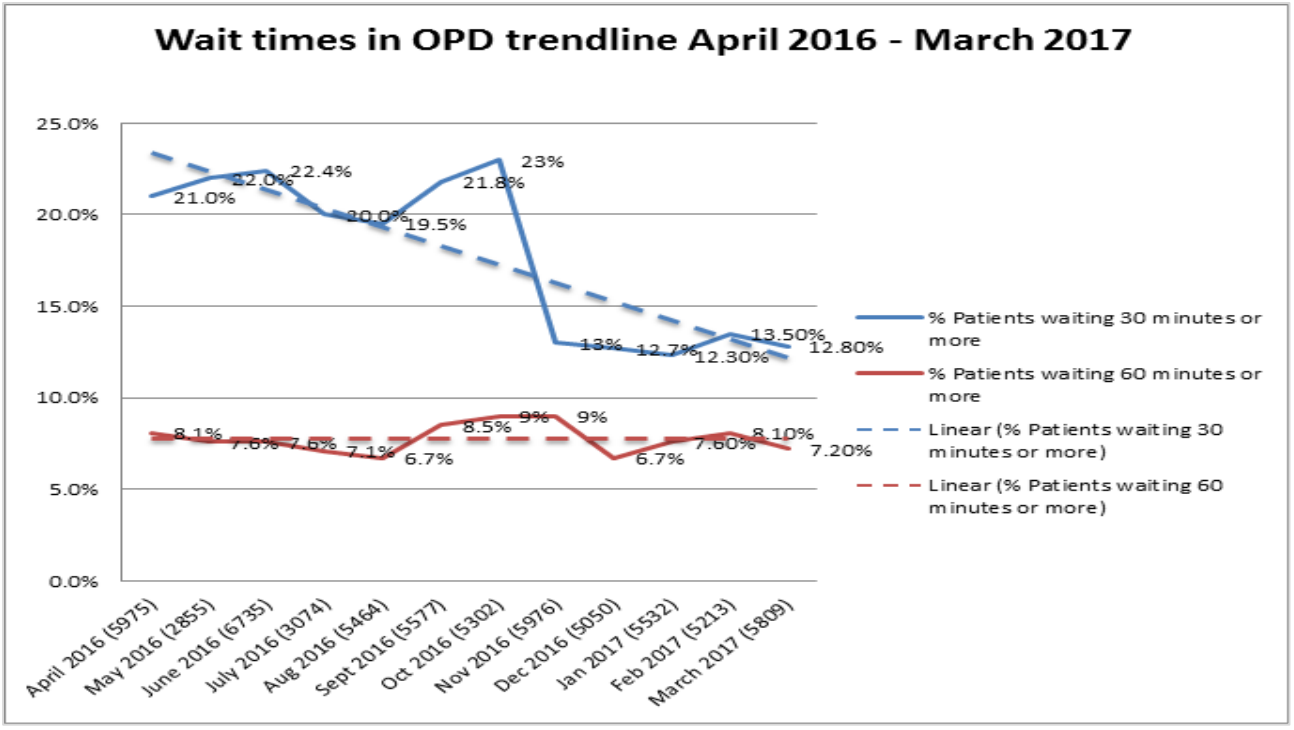
- The team feel that the reduction in SSIs is reaching an irreducible minimum based on the multitude of interventions that have been put in place as recommended in national guidance.
- The focus this financial year is to look to continue improving standards in Theatres and to review practice to improve SSI rates further.
- Implement recommendations from latest WHO Global guidelines for the prevention of Surgical Site Infection and the One Together Assessment Toolkit.

3.3 CLINICAL EFFECTIVENESS OBJECTIVES

3.3.1 To reduce OPD waiting times to less than 60 minutes

The chart below shows performance by month over the last 12 months together with the trend lines.

TABLE 26:



There have been measurable improvements in the numbers of patients waiting for 30 minutes or more for their appointment, however there is still further improvement work underway to reduce the number of patients who wait for longer than 60 minutes for their appointment.

3.3.2 Reduce cancellations on the day of surgery

As noted earlier in this report, there have been several actions taken in quarters 3 and 4 of 2016/17 which have helped to reduce cancellations on the day of surgery.

The major contribution to the reduction of on the day cancellations is the proactive recording and clinical review, since November 2016, of the reasons why patients are medically unfit on the day of surgery, and the subsequent changes that have been made to the POAC process, the booking form used to record the surgery and anaesthetic plan, and the content and range of questions asked of patients at the 72 hour (pre date of surgery) phone call to ascertain their current state of health.

Proactive bed management approaches have led to reduced lengths of stay for patients, which has helped to improve patient flows and ensure that cancellations due to bed unavailability are rare. The filling of lists and the scrutiny of lists in advance of the date of surgery have also helped to ensure that equipment needed is available as required, which has also had the effect of reducing the number of cancellations caused by equipment failures.

All of these actions continue, as there is further work required to reduce the level of on the day cancellations even further over the coming year.

3.3.3 Delivering the commitments outlined in the first year of the Dementia Strategy

The Trust achieved its priority set out in 2016/17 to deliver the commitments of the first year of the dementia strategy, building the foundations to improve the care and experience of patients with dementia and their carers and families.

Key achievements in year one:

- All ROH staff now receive tier 1 face to face dementia awareness training.
- Each ward and department has a dedicated dementia champion.
- The Trust's environment has been reviewed and assessed using a recognised tool, to ensure it meets the needs of our patients with dementia; with a prioritised improvement work plan.
- Use and roll out of 'This is me' from our Pre-Operative Assessment Unit.
- We now screen all our patients over the age of 65 for dementia, with a process for positive results.
- Carer presence and input into the Dementia Steering Group.
- Assessment of carer involvement in our wards and department.

Building on the successful work in year one, the Trust has a clear set of commitments for year two of our strategy, these commitments will be monitored via the Clinical Quality Group via a bi-monthly report and presence of the Trust Dementia lead.

3.4 PATIENT EXPERIENCE OBJECTIVES

3.4.1. IMPROVING PATIENT REPORTED EXPERIENCE OF PAIN

The Acute Pain CQUIN was implemented for 2016/17 in response to increased patient complaints relating to pain and an increased incidence of VTE's in 2015/16. 'Improve patient reported experience of pain' was a Quality Improvement for 2016/17.

The results of the acute pain CQUIN audits have shown a positive improvement in both patient satisfaction and experience of post-operative pain.

Audits conducted in Q1 and Q3 showed that patient satisfaction with regards to pain has increased from 80-90% to over 90%.

In 2015/16 it was stated that 14% of patients had inadequate pain control post op.

Audit in Q4 showed that 11.7% of patients felt that on day 1 their pain was not well managed. However by day 14 post op 100% of patients felt their pain was well managed.

100% of patients reported that there had been a decrease in their pre-operative pain.

The audit in Q4 showed that 100% of patients received Clexane, TEDS and Flotrons boots where clinically indicated. This is a marked improvement from Q1 audit.

There has been a significant decrease in complaints relating to post op pain. There was 14 complaints in 2015/16 and this has dropped to 1 in 2016/17.

The number of VTE's has reduced to 27 in 2016/17 from 45 in 2015/16. This is a 40% reduction in incidence.

An Acute Pain guideline has been developed by Dr Rea and approved by Executive Director of Patient Services. Roadshows have been planned for launch.

Following local audit, benchmarking with specialist providers and National research based evidence new pain tools will be utilised across the Trust. These are 0-10 for adults, Wong Baker 0-10 for children, FLACC for children and adults with learning difficulties and Abbey for patients with dementia or delirium.

Post-operative pain management will continue to be monitored monthly through ward key performance indicators with oversight by Clinical Quality Group.

3.4.2 COMPLAINTS AND PALS

During 2016/17 the Trust has received 170 formal complaints. This is a significant increase compared with 2015/16 and reflects both the national and local trends in NHS Complaint Management. In 2016/17, the Trust has continued to review and refine its processes for responding to complaints and continues to work within the procedures developed in the Complaints and Pals Policy created in February 2016. This ensures that we continue to adhere to all of the recommendations of the Clywd/Hart Review (2013) and Francis (2013) report.

The Trust took the decision to make the PALS and Complaints team highly visible to all patients and from the beginning of April 2016, the contact number was included on all patient correspondence

including appointment letters. This is reflected in the considerable increase of use of the PALS and Complaints Services and supports strand 2 of our five year strategic to deliver exceptional patient experience every step of the way.

The Complaints department continues to manage incoming complaints in a pro-active manner. Time scales for investigations vary depending on the complexity of the complaint. We continue to aim for resolution in 25 working days and local resolution meetings are increasingly being used to facilitate improved communication and successful resolution for complainants. The Trust follows the PHSO Principles of Remedy when responding to formal complaints

- Gettingitright
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

TABLE 27: COMPLAINTS AND PALS 2013-2017

	PALS	Complaints
2013/2014	1016	146
2014/2015	1621	105
2015/2016	1094	113
2016/2017	4136	170

Top three categories for Complaints through 2016/17 were:

- Communication (including values & behaviours)
- Access to Treatment (including delays to surgery)
- Appointment delay/cancellation

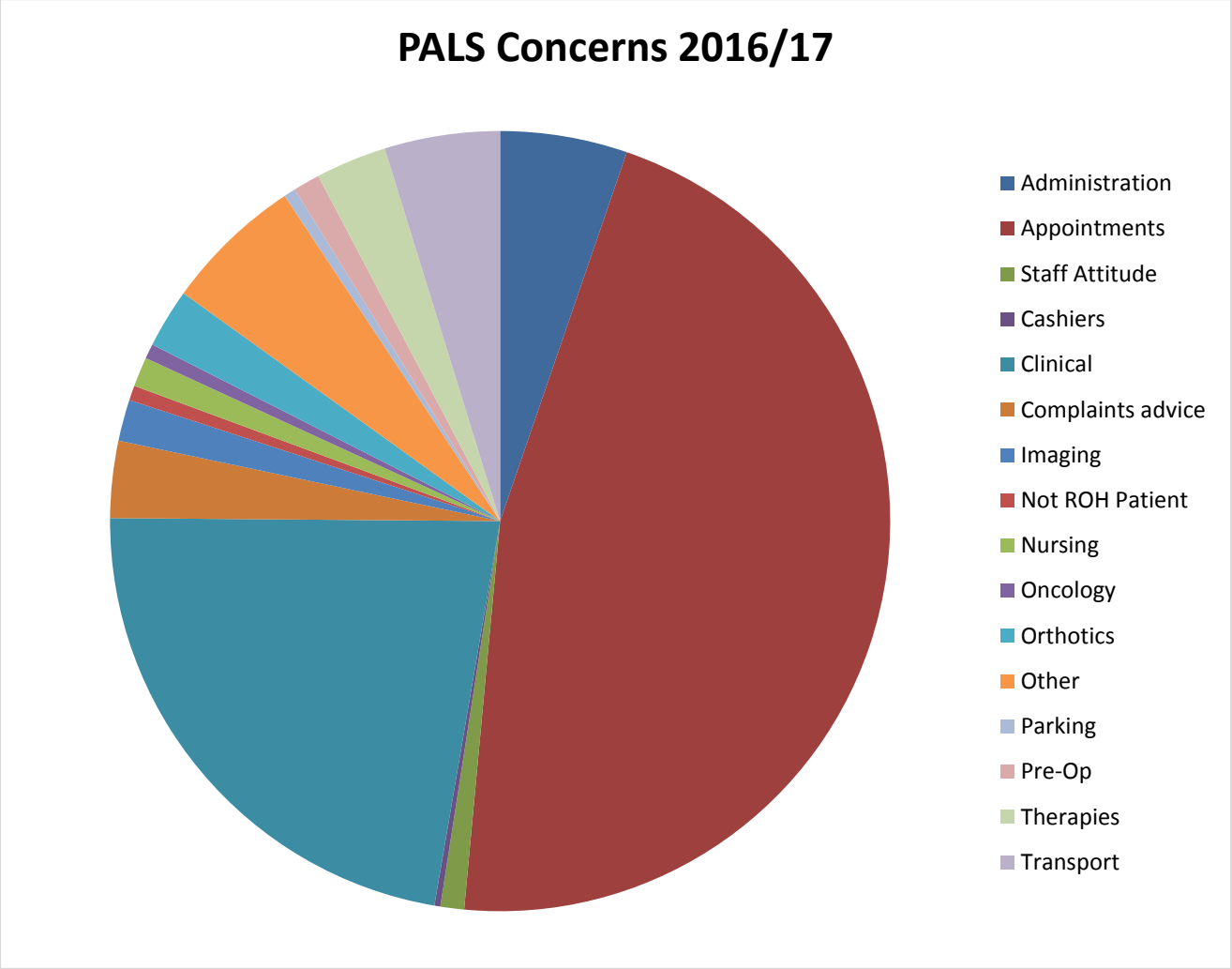
The themes have been shared with Divisional teams and action plans developed to respond to the issues raised. The action plans are monitored through weekly Divisional Governance meetings.

3.4.3 PALS 2016/2017

The PALS department has continued to work towards delivery of a responsive PALS service through 2016/17. Contacts are made through a range of sources including face to face, telephone and email. Contacts through PALS are not necessarily a concern or problem but can be an enquiry. Each contact is assessed individually and proactive measures are taken to assist as efficiently and effectively as possible. Due to the large increase in volume of calls, the department changed the reporting mechanism to departments so that each received information about concerns only, in to focus on trends and issues that need to be managed.

The top 3 categories for PALS contacts continue to be Appointment Queries, Clinical Queries and Administration Queries respectively with a detailed breakdown of activity shown in table 28 below.

TABLE 28: CATEGORIES OF PALS CONTACTS 2016/17



3.4.4 THE FRIENDS AND FAMILY TEST AT ROH

The Friends and Family question is a single question used across the NHS to establish whether patients and service users are happy with the standard of care that they receive.

In 2016/17 we worked with an external provider called 'I Want Great Care' to support our delivery of the Friends and Family test. This new system was introduced on 1 February 2017.

The Friends and Family test has now been rolled out to all inpatient, outpatient and paediatric areas. A total, 2,437 pieces of patient feedback were received in February 2017, as opposed to 898 in January 2017. This is an improvement of 171%.

The tables below show the results of the FFT across all inpatient, outpatient and paediatric areas for the year 2016/17.

TABLE 29: PERCENTAGE LIKELY TO RECOMMEND - INPATIENTS 2016/17

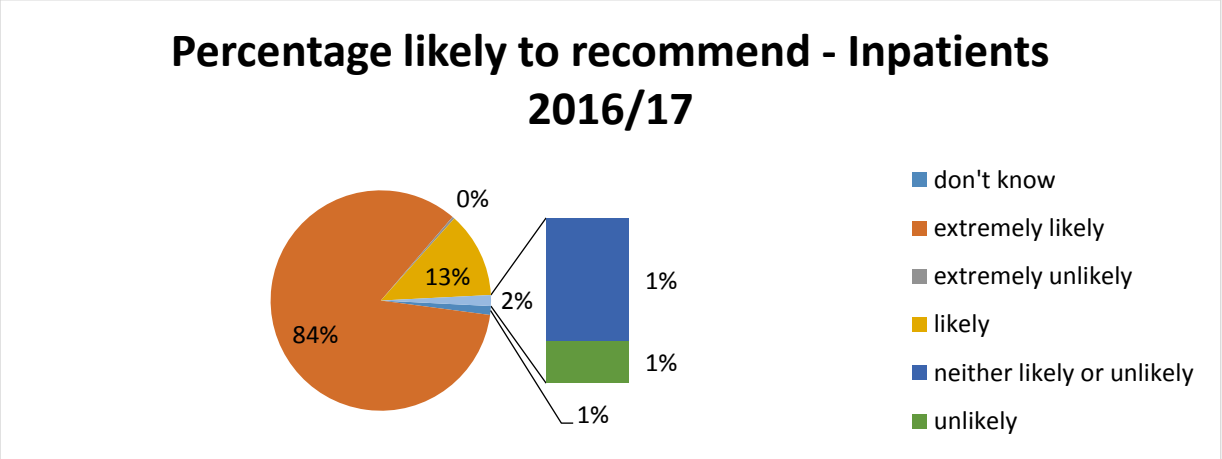


TABLE 30: PERCENTAGE LIKELY TO RECOMMEND - OUTPATIENTS 2016/17

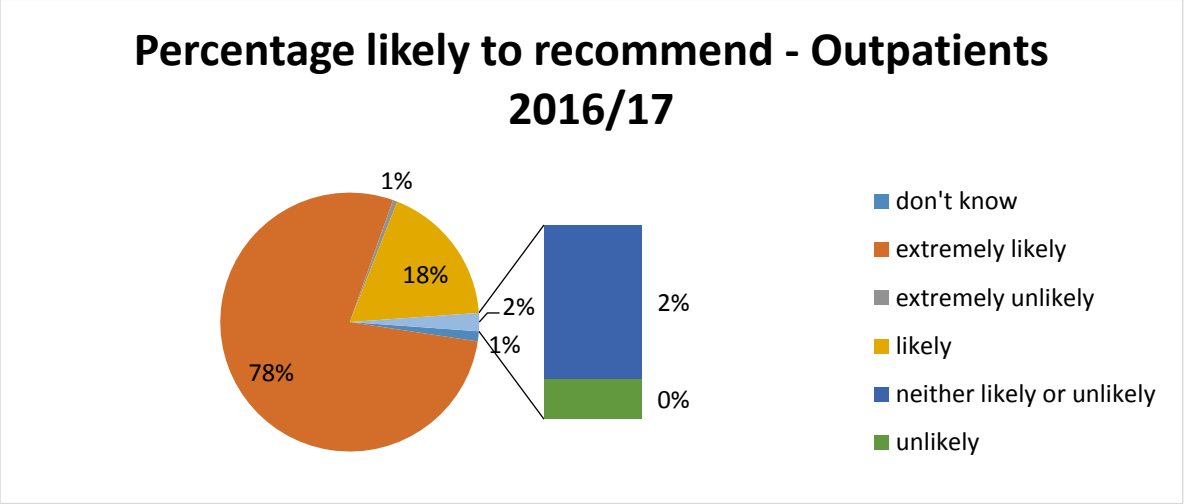


TABLE 31: PERCENTAGE LIKELY TO RECOMMEND ROCS 2016/17

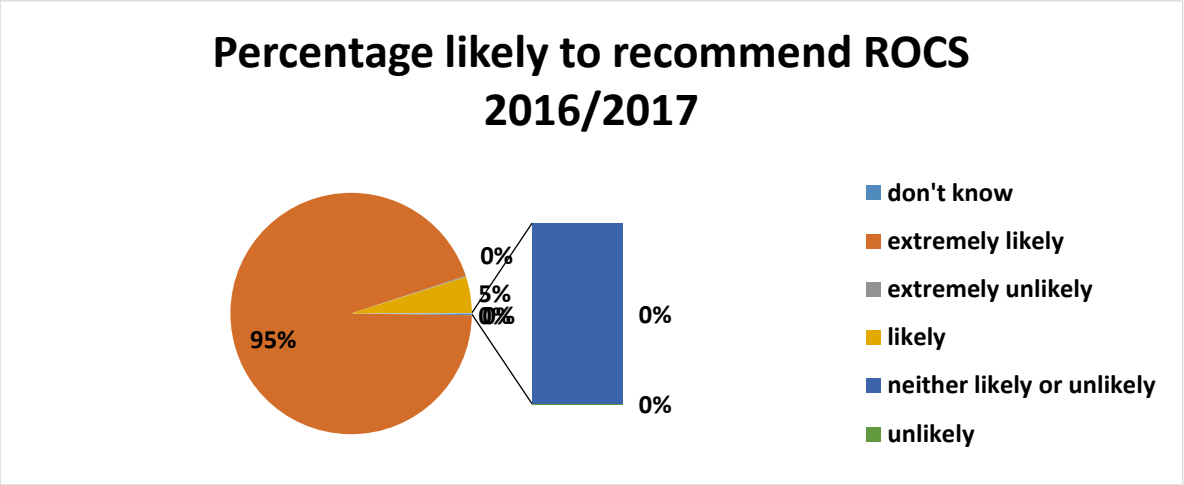
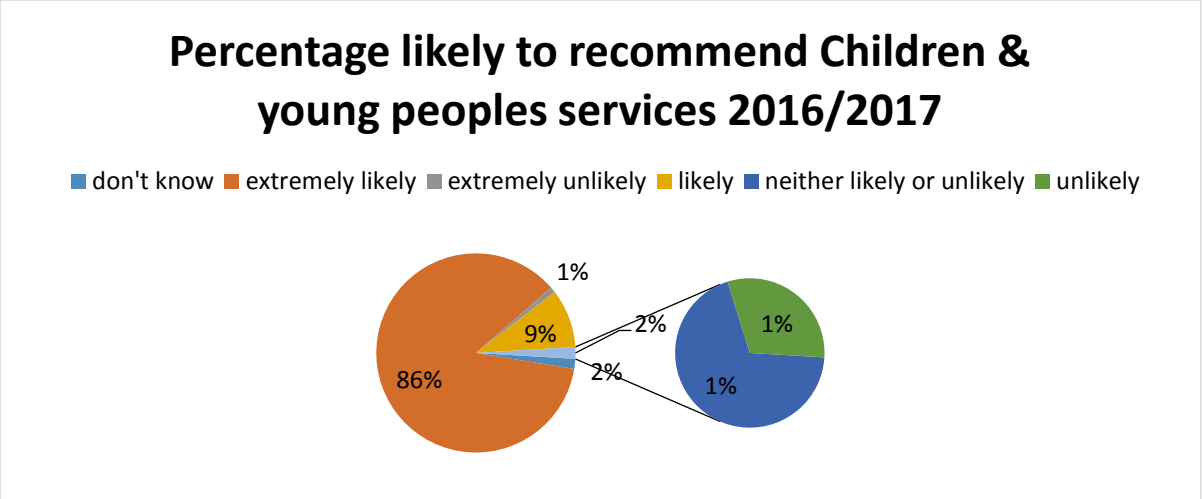


TABLE 32: PERCENTAGE LIKELY TO RECOMMEND CHILDREN & YOUNG PEOPLES SERVICES 2016/17



The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 February - 28 February

Your average score for all questions this period

★1 ★2 ★3 ★4 ★5 **4.83**

Reviews this period

2437

Your recommend scores

5 Star Score

4.80

% Likely to recommend

95.0%

% Unlikely to recommend

1.1%

Adult Services

	This period		Last 6 months		Questions					
Name	Responses	Score	Score	Trend	Recommend	Dignity/Respect	Involvement	Information	Cleanliness	Staff
Admissions and day case unit[1]	– (155)	4.89	4.89		↑	↑	↑	↑	↑	↑
Arthroplasty[1]	– (307)	4.86	4.86		↑	↑	↑	↑	↑	↑
Arthroscopy[1]	– (286)	4.80	4.80		↑	↑	↑	↑	↑	↑
Back pain, MSK & Pain[1]	– (263)	4.81	4.81		↑	↑	↑	↑	↑	↑
CT[1]	– (38)	4.82	4.82		↑	↑	↑	↑	↑	↑
High Dependency Unit[1]	– (2)	5.00	5.00		↑	↑	↑	↑	↑	↑
Hydrotherapy[1]	– (19)	4.92	4.92		↑	↑	↑	↑	↑	↑
MRI[1]	– (125)	4.93	4.93		↑	↑	↑	↑	↑	↑
Occupational Therapy[1]	– (0)	-	-		→	→	→	→	→	→
Oncology[1]	– (38)	4.84	4.84		↑	↑	↑	↑	↑	↑
Orthotics [1]	– (3)	4.78	4.78		↑	↑	↑	↑	↑	↑
Pain Team[1]	– (0)	-	-		→	→	→	→	→	→
Physiotherapy [1]	– (51)	4.87	4.87		↑	↑	↑	↑	↑	↑
Podiatry[1]	– (0)	-	-		→	→	→	→	→	→

A word cloud of comments from February 2017 are included here:

A sample of comments from FFT is included below in Table 33 below:

TABLE 33: COMMENTS

From welcome at reception, introduction on ward and theatre staff, everyone was extremely friendly and helpful and put me at ease. I was told exactly what would happen throughout my short stay.
Everyone was concerned, listened and explained everything well. They were very polite and courteous to both myself and my husband.
Consultant was very friendly, as were the check-in staff. The clinic was running late so if would be nice to be kept informed with more detail.
Surgery and aftercare in the hospital was good. After returning home I feel that more could have been done to support rehabilitation. At two follow-up appointments I saw registrars who joined to look at my condition holistically although my hip was OK, the difference in leg length was causing muscle spasm in my back, and making a difference to daily activities.
Staff always pleasant and informative and the hospital clean and tidy. It would be nice post-op to see the main consultant or at least the same junior, rather than a different person each time.

In the 2015/16 Quality Account, a series of actions that was due to be taken to improve the way in which the FFT was operated and responded to was reported. Please find below a table which details progress against each one.

Action detailed in 2015/16 Quality Report	Progress in March 2017
A Task and Finish Group has been set up with specific remit to review the way Friends and Family data is collected and shared across the organisation.	This group met successfully once a fortnight for nine months to establish a strong basis across departments for the collection and use of FFT data. This is now firmly embedded into departmental practice. In addition, this group helped with the procurement of the iWantGreatCare system.
The forms used to gather the response to the question have been revised to include more detailed demographic information to enable better monitoring and review of responses.	This additional data has been used to inform equality and diversity activities across ROH, and continues to be recorded.
The forms used for collecting data from Children's services will be revised so that they are more child-friendly and enable children to communicate in a range of ways.	This has now happened, and the response rate from the children's ward is increasing.
A review of the work undertaken by the Patient Experience volunteers at the Trust will be	Volunteers are now consistently supporting the delivery of FFT across all departments.

3.6 MAINTAINING STANDARDS ACROSS THE BOARD: COMPLIANCE WITH NATIONAL TARGETS AND THE REGULATORY REQUIREMENTS

Table 34 overleaf shows the key indicators used to assess the overall quality of our performance during the last year. Specifically, these highlight our performance against the relevant indicators and performance thresholds as set out in Appendix A of the Risk assessment Framework.

We remain challenged by the demand for spinal deformity services and collaborative work is underway between Specialist Commissioners, Birmingham Women's and Children's NHS Foundation Trust and ourselves to reach contract agreement as to how this service will be developed to meet demand.

TABLE 34:

National target	10/11	11/12	12/13	13/14	14/15	15/16	16/17	Target
		Achieved 6 cases	Achieved 1 case	Achieved 2 cases, both unavoidable	Achieved 0 Avoidable cases	Achieved 0 Avoidable cases		0 Avoidable cases
				Qtr1 90.5% Qtr2 82.5% Qtr3 89.5% Qtr4 100%	Q1 90.48% Q2 90% Q3 85.71% Q4 87.50%	Q1 77.8% Q2 100% Q3 86.4% Q4 87.5%	Failed Q1 64.3% Q2 80% Q3 75% Q4 76.2%*	85% standard

*Figures for year 2016-17. Please note Q4 for all targets are provisional on Open Exeter as uploads 2 months behind. ROH have uploaded all data although shared patients on a 62 day pathway may not be uploaded until May 2017

Referral to Treatment (RTT)

The Trust has not achieved delivery of the 18 week 'Referral to Treatment' target during 2017/18. All patients that have breached 52 weeks are undergoing a 'harm review' led by a primary consultant with oversight by the Medical Director at a corporate Harm Review.

The Trust has recognised that there are a number of data quality issues as well as service delivery issues in arriving at this position.

Issues were recognised by the Operations Team during early 2016/17, with the Director of Operations commissioning an audit into this area of delivery. In addressing the recommendations arising from this audit, the Informatics Team have been developing an improved business information system to track delivery. In parallel, a validation exercise was started in Quarter 3 2016/17 (which is continuing, with assistance and advice from NHS Improvement) to focus on the large number of open pathways. This area has received and continues to receive weekly Executive focus through a tracker. Regulators have been informed from the outset and have been involved in the design of the approach to restore delivery of the 18 week RTT target. The Trust continues to work with the Intensive Support Team to help to accelerate recovery of this position. Training and development of skills within the administration and clinical teams regarding RTT rules and their application on patient pathways has been implemented and will continue.

Trajectories are being finalised with subspecialty teams to map out the options for delivery of activity to bring performance back to target.

3.7 MAINTAINING CONTINUOUS QUALITY IMPROVEMENT AT ROH

3.7.1 CONTINUING FOCUS ON QUALITY IMPROVEMENT IN OPERATIONAL PERFORMANCE

In line with national guidance the Trust is committed to improving quality and to this end agreed a series of CQUIN schemes in conjunction with Commissioners during 2015/16.

Once agreed the schemes are cascaded down from Directors to operational and clinical leads who are responsible for the delivery of the CQUIN schemes. Progress towards achievement of the schemes is monitored quarterly at the appropriate subcommittee of the Trust Board and discussed and agreed with commissioners at monthly contract review meetings.

The Trust also has an agreed set of clinical performance indicators which form the basis of its contracts with commissioners and are monitored at monthly contract review meetings.

3.7.2 DEVELOPING A NURSING STRATEGY

The Trust has l develop a new nursing strategy in 2016/17 that outlines the Trusts ambitions for the profession through until 2019. We continue to progress our nursing strategy in relation to the five key areas listed below:

- A focus on improving safety and experience for patients through nursing practice
- A focus on the development of clinical leadership
- A focus on recruitment and retention of nursing staff
- A focus on training and development
- A focus on delivering the objectives outlined in the Dementia strategy

The Trust aims to launch the newly developed Nursing Strategy on the 12th May 17 in line with 'Nurses Day'.

3.7.3 VANGUARD

The Royal Orthopaedic Hospital's involvement in the National Orthopaedic Alliance (NOA) vanguard has given the Trust an opportunity to help shape how orthopaedic care will be delivered in the future.

The NOA aims to improve the services that its members provide and then create a framework that others can follow to improve their own care standards, leading to consistent high quality care across the country. The vanguard's framework is based on a quality standards membership model founded on evidence-based descriptors of 'what good looks like' in orthopaedic care. To help realise the project, ROH is joined by the founding members of the Specialist Orthopaedic Alliance (SOA) in leading NOA activity. They include:

- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust

All current members of the SOA have signed up to the principles of the vanguard.

For 2017/18, NOA's plans and priorities are:

- Continue to recruit new members
- Launching and promoting the NOA quality standards
- Replicating the NOA model across 2 other specialties

Work on writing the NOA quality standards has commenced and they are due to be launched during 2017. The NOA vanguard is also exploring opportunities to replicate its membership model across other specialties and have so far had interest from providers in the areas of ophthalmology, urology and cardiothoracic surgery.

For more information on the vanguard visit: www.england.nhs.uk/noa

4.0 STATEMENTS OF ASSURANCE:

4.1 STATEMENT OF DIRECTORS RESPONSIBILITY IN RESPECT OF THE QUALITY REPORT.

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2016 to March 2017
- Papers relating to quality reported to the board over the period April 2016 to March 2017
- Feedback from governors dated 15 March 2017 and 17 May 2017
- Feedback from local Healthwatch organisations dated 22 May 2017
- Feedback from Overview and Scrutiny Committee dated 25 May 2017 – Birmingham Health, Wellbeing & Environment Overview & Scrutiny Committee were offered the chance to comment but declined.
- Feedback from local commissioners – Birmingham Cross City CCG were provided with the Quality Account, but late provision has resulted in them not providing feedback in sufficient time for signing of the financial statements.
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 05 October 2016
- The latest national patient survey 08 June 2016
- The 2016 national staff survey opened to staff to complete during October 16 to November 2016, published 7 March 2017.
- The Head of Internal Audit's annual opinion of the trust's control environment dated 30 May 2017
- CQC inspection report dated July 2015
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The Trust has chosen not to report performance against the indicator 18wks RTT due to issues with data cleansing. The Trust is currently undergoing a validation programme to cleanse the data held on its patient administration system in respect of patient pathways. This is being completed with assistance from NHSI and oversight by the Commissioners and the Trust Board. The Directors have a plan in place to remedy this.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

30 May 2017. .....Chairman

30 May 2017 .....Designated Accounting Officer

4.2 Statement from Healthwatch Birmingham on the Royal Orthopaedic Hospital NHS Foundation Trust Quality Account 2016/2017

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for The Royal Orthopaedic Hospital NHS Foundation Trust 2016/17. In line with our role, we have focused on the following:

- The use of patient and public insight, experience and involvement in decision-making
- The quality of care patients, the public, service users and carers access and how this aligns with their needs
- Variability in the provision of care and the impact it has on patient outcomes

Patient experience and Feedback

The Trusts commitment to listening to patients in order to provide the best experience possible, is one that Healthwatch Birmingham supports. We are glad to see that 'fully engaged patients and staff' is one of the Trusts transactional change priorities. We believe that this is important as it will facilitate the attainment of the Trusts strategic objectives, namely;

- Delivering exceptional patient experiences and world class outcomes.
- Developing services to meet changing needs, through partnership where appropriate

Equally positive is that the Trust has involved staff, patients and the public in developing the 2017/18 quality priorities. Of further note is the Trusts plan to develop a new communication and engagement strategy that will aid engagement. Developing such a strategy would demonstrate that there is agreement and commitment across the Trust on how and why patient experience and feedback is used to inform decision-making. To be effective, the strategy needs to be understood by all staff, promoted, and arrangements for collating feedback and experience should be clearly outlined.

The report has outlined some work undertaken by the Trust, that we believe would serve as a foundation for developing a strategic approach to using patient and public insight, experience and involvement to drive improvements. We note that in the previous Quality Account the Trust reviewed the way the Friends and Family Test (FFT) data is collected and shared across the organisation. The outcome of this review has been used to establish a strong basis across departments for the collection and use of FFT data and the procurement of the 'Iwantgreatcare' system. This type of review helps the Trust to establish how and why patient feedback and experience is used to monitor quality and outcomes for patients. Furthermore, review the many methods that can be used to collect patient feedback, insight and experiences and triangulate data collected to inform The Trusts decision-making.

The Trust could also improve its use of patient feedback and experience by using it to identify, understand and address health inequality. This will help identify any gaps in service provision and the needs of different groups, particularly those that seldom give feedback. Since 2010/11 to 2016/17, the Trust has not achieved the national target for access to healthcare for people with learning difficulties. We therefore welcome the addition of demographic information to the FFT questionnaire. In particular, the use of this additional data to inform equality and diversity issues across the Trust. We look forward to seeing in the 2017/18 Quality Account evidence of the use of this strategy across the Trust and an evaluation of the usefulness of using patient experience and feedback.

The Family and Friends Test Score

We recognize the positive impact the use of an external provider to deliver the FFT in 2016/17 has had on the response rate. We note that the FFT has been rolled out to all inpatients, outpatients and paediatric areas. As a result the response rate has increased from 898 responses in January 2017 when the project started to 2,437 responses in February 2017. The positive recommender rate is high for all services provided with 95% likely to recommend the Trust. We ask the Trust to consider introducing qualitative questions to the survey that will complement the statistical data the Trust collects. This, like the demographic data, will offer greater insight to barriers patients face to receiving good quality of care. Healthwatch Birmingham would like to see the following in next year's report:

- A demonstration of how patient feedback and experiences have been used to develop priorities for the 2018/19 Quality Account in the 2017/18 Quality Account;
- Changes in practice or improvement to services that have been made as a result of patient feedback and experience in the 2017/18 Quality Account.
- A demonstration of how the Trust uses patient insight and experience to understand the barriers different groups face and the impact on health outcomes. Consequently, how this data is used to implement change or improvement that addresses the needs of these groups.

Complaints and PALS

The report states that during 2016/17, The Trust received 170 complaints and 4,136 people contacted PALS representing a 75% increase. The top three issue: communication (values and behaviour); access to treatment (delays in surgery); and appointment delay/cancellation. We note that action plans have been developed to address these issues. We hope to see the impact these actions have had on these issues in the 2017/18 Quality Account. We recognise the Trusts' efforts to learn from complaints to improve services. Namely, the implementation of the Acute Pain CQUIN in response to increased patient complaints relating to pain in 2016/17. We therefore welcome the Trust's inclusion of 'embedding learning identified from complaints' as a priority for the 2017/18 Quality Account. We would like to see more examples of learning and impact on services in the 2017/18 Quality Account.

According to the report, the Trust intends to reduce PALS complaints by 20% by introducing 'time to talk'. Whilst we welcome the Trusts' introduction of the 'time to talk' scheme at ward level to deal with concerns/issues in real time, we have concerns. Firstly, how will this work in practice, for instance who will patients talk to? Is it the same staff they are raising concerns about, if not will ward staff be present? We believe that service users and their families might find it difficult to raise concerns at ward level, especially when they are still receiving care. Secondly, how will you ensure that the patients and their families know that they still have access to PALS if they do want to make a formal complaint? Thirdly, we do recognise that resolving issues before a formal complaint can lead to better outcomes for patients. However, in meeting this target, the Trust should also monitor the increase in issues raised by patients through time-to-talk, alongside patient satisfaction of resolution.

Care Quality Commission

The Trusts response to the CQC rating of 'requires improvement' should be commended. We observe that the Trust has developed an action plan to address the concerns raised by CQC during their inspection. Whilst this is welcome, it is not clear how patients, carers and the public will be involved or engaged, especially on the Children's and the HDU Board. How will their insight and experience inform the development service improvements? In order to make improvements, the Trust needs to ensure that service users are involved from the point of identifying the barrier to improvement in health outcomes including increasing independence and preventing worsening ill-health; and mapping out possible solutions to evaluating options and selecting the optimum solution. To do this effectively, the Trust needs to increase the number and diversity of people it's hearing from.

Learning from Incidents and Complaints

Healthwatch Birmingham is concerned that the number of patient safety incidents has increased from 1113 in 2015/16 to 1530 in 2016/17. Equally, during 2016/17 the Trust reported three never events against 0 in 2015/16. An external review of these events has led to the implementation of several actions including reviewing feedback mechanism and plans to triangulate data between complaints and patient safety incidents. We look forward to reading how these actions have led to improvements in the 2017/18 Quality Account.

We welcome the Trusts' plans to build on last year's Quality Account priority on learning by adopting two priorities for 2017/18. Thereby, ensure that the Trust is learning from complaints and incidents in order to improve access to and the quality of services. We believe that this is beneficial to the Trust and to service users. The Trust should indicate in the 2017/18 Quality Account examples of how the Trust has learned from complaints/incidents and the improvements made as a result. This will make clear to service users that services are being improved as a result of learning.

Similarly, we would like to see in the 2017/18 Quality Account how families have been involved in reviews and investigations into death and the impact this has had on learning; how service users, carers and the public have been involved in the developing a Trust policy and approach for learning from deaths; and how patients, carers and service users have been involved in developing benchmarks for serious incidents to be used from March 2018.

Venous Thrombo-Embolism (VTE)

One of the recommendations following an Audit was to improve assessment of patients at admission & 24 hours for VTE risk. We are happy to see that the Trust is consistently performing above the National Average in terms of the number of risk assessments carried out. As this has an impact on health outcomes and potential to lead to variability in health care, we welcome the Trusts plans in 2017/18 to reduce the number of avoidable VTE's.

Nutritional assessments

Table 16 shows that compliance with nutritional assessments is at 98%, and 100% for percentage of patients that needed a further assessment after 7 days. Compliance with referral to dietician was at 100%. However, the compliance with care plans has been inconsistent although this has improved. This was 43% in quarter one; 100% in quarter 3; and 98% in quarter four. We welcome the use of care plans to identify non-nutrition related risks such as wound healing or dementia.

Thank you for giving us the opportunity to review the Trust's Quality Account.

Andy Cave

CEO
Healthwatch Birmingham