RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST QUALITY ACCOUNT 2019/20

CONTENTS

PART ONE

1.0 STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE OFFICER

The delivery of high quality services, both in terms of clinical outcomes and patient experience, is the key priority for this hospital in delivering our vision to be the 'First Choice for Orthopaedic Care'. I am proud of the progress that the Trust has made in 2019/20. Feedback from our CQC inspection in autumn 2019 highlights these improvements and once again our Quality Accounts for 2019/20 further evidences this positive shift.

As noted above, 2019 ended with the publication of our CQC Inspection Report which consolidated the Trust's overall rating of 'Good', across all 5 domains (Safe, Effective, Caring, Responsive and Well-Led) and notably lifted the previous rating of 'Inadequate' for 'Safe' in our High Dependency Unit (classed as Critical Care for the purposes of the CQC) to 'Good', this also being extended across all other domains for this area. The outcome of the inspection represented a significant achievement for the Trust and one that represented the hard-work and commitment of staff from all areas of the hospital in ensuring that high standards of patient care were achieved at all times.

The CQC noted positive progress and performance in a number of important quality areas including:

- The reporting and learning from incidents and subsequent dissemination of key messages;
- The completion of the World Health Organisation (WHO) checklists;
- The multi-disciplinary team approach to the management of patients' care;
- The caring approach and values-driven culture of staff;
- The Handling of complaints and concerns;
- A robust approach to discharging Duty of Candour regulations;

- The learning from Deaths process and policy was embedded.

As a learning organisation, we have been focused throughout 2019/20 on the areas of practice that the CQC highlighted from both the 2018 and 2019 inspections where improvement would benefit the hospital. This Quality Account provides details about how these, and other, quality priorities have been addressed. In addition to the areas of focus identified by the CQC, the Trust also set its own quality priorities for 2019/20, as described in last year's Quality Accounts. Four of these have been fully achieved during the year:

- Reduce the number of incidents of consent on the day, improving the quality of consent.
- Staggered admission times for all patients attending ADCU, including those attending for diagnostics.
- Improvement in acute pain management.
- Embedding learning and improvements made relating to sepsis.

Progress has been made against the other two priorities, however as work is still ongoing in these areas, they have been rolled forwards and added into our 2020/21 quality priorities which are listed below, and described in more detail later in these Accounts:

- Ensure that all clinical and corporate policies are in date and have an appropriate audit plan (from 2019/20);
- Reduce the number of times patients Outpatient clinic appointments are rescheduled (from 2019/20);
- Reduce Patient Harms in the Trust – Falls (new for 2020/21; proposed to be the indicator to be sponsored by the Council of Governors);
- Improving Experience for Patients, Carers and Service Users (new for 2020/21);
- Patient Wellbeing (including Spiritual Health) (new for 2020/21)

The Trust places significant emphasis on the importance of every patient's experience at the Royal Orthopaedic Hospital. We continued to receive positive feedback from our patients through the Friends and Family test, with c. 96% of patients stating that they would recommend the hospital as a place to receive treatment. One important test of a hospital's commitment to patient care is whether staff would recommend the hospital if one of their friends or family required treatment. We were therefore very pleased to see that this measure increased to 92% in the 2019 national staff survey for the element where staff are asked to comment on whether they would recommend the standard of care provided by this organisation. Equally pleasingly was the 89% recommendation

when staff were asked to comment on whether care of patients was the organisation's top priority, this again being an increase from the previous year's position.

The role of healthcare providers in delivering and developing high quality healthcare extends beyond the physical boundaries of the hospital and, as a specialist orthopaedic provider, it is important that we provide leadership and drive to system-wide improvements in orthopaedic and musculoskeletal (MSK) health. 2019/20 has continued to be a busy year in this respect, with work ongoing to standardise and improve orthopaedic services across Birmingham and Solihull, such that any patient requiring care can be confident that they will receive the same outcome and experience wherever they are treated. As such, we are working closely with our partners at University Hospitals Birmingham NHSFT to make this a reality. Progress was impacted towards the end of the year as the Trust, along with every other healthcare organisation in the country, was affected by the global Coronavirus pandemic. However, looking forward to the restoration and recovery phase of the response, the focus is again on standardising pathways and creating excellent service provision for our elective patients.

During the year, I also took on the role of Chair of the National Orthopaedic Alliance, a role which will position the ROH as lead player in the work to reduce variation in orthopaedic practice and set standards across the specialty.

A particular success for this year has been the development of the JointCare service, a standardised way of performing routine joint replacement with a focus on enhanced recovery. The feedback on this new pathway from patients has been very positive, particularly in terms of the shorter length of time that they are needing to spend in hospital and the 'reunion' events where patients are able to reacquaint themselves with individuals who were treated as part of their cohort and share their experiences of the process.

The ROH has continued to lead the way on the development of the Bone Infection pathway for patients across the city, meaning that in future more patients will be treated in the right location at the right time to ensure improved outcomes for these complex conditions.

In addition to our collaborations with other hospitals, we have also been continuing to work closely with our GP and commissioning colleagues to support the development of MSK and triage services in primary care, enabling patients to access the specialist skills of our clinicians closer to their own homes. This work will continue into 2020/21.

2019/20 has been an exciting year for the ROH, but the task of ensuring that our services continue to be high quality and sustainable remains. We enter 2020/21 with the mission to continue to deliver excellent care while responding to the challenges of responding to the global pandemic and remaining focused on our ultimate ambition to the be "First Choice for Orthopaedic 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 Williams

Chief Executive

The Royal Orthopaedic Hospital

19 June 2020

ABOUT THE QUALITY ACCOUNT 2019/20

1.1 WHAT IS A QUALITY ACCOUNT?

Patients want to know they are receiving the very best quality of care. Providers of NHS healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the quality accounts regulations'). Information on quality accounts can be found on the NHS website (formerly 'NHS choices') at http://www..nhs.uk/quality-accounts.

NHS England and NHS Improvement also require all NHS Foundation trusts to produce quality reports as part of their annual reports. Quality reports help trusts to improve public accountability for the quality of care they provide.

A Quality Account is a report about the quality of services provided by an NHS provider. The report is an important way for providers 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.

The Royal Orthopaedic Hospital NHS Foundation Trust is committed to continuously improving 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 2020/21.
- Our progress against delivery of the Quality Priorities we outlined in 2019/20.
- 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 The Royal Orthopaedic NHS Foundation Trust maintains continuous quality improvement.

1.2 WHO HAS BEEN INVOLVED IN PRODUCING THE QUALITY ACCOUNT?

The Quality Account has been developed by The Royal Orthopaedic Hospital NHS Foundation Trust with input and assistance from a range of stakeholders, including;

- The Royal Orthopaedic NHS Foundation Trust Council of Governors.
- The Royal Orthopaedic NHS Foundation Trust Quality and Safety Committee.
- The Royal Orthopaedic NHS Foundation Trust Clinical Quality Group.
- The Royal Orthopaedic NHS Foundation Trust Patient and Carers Forum.

PART TWO

2.0 ABOUT THE TRUST

The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) is a single speciality orthopaedic hospital offering elective and specialist services at a local and regional level. Our vision is 'to be the first choice for orthopaedic care' and we are committed to delivering world leading outcomes and excellent patient experience in line with our values: respect, openness, compassion, excellence, pride and innovation.

We work closely with our partners across the Birmingham and Solihull Sustainability & Transformation Partnership (STP) to ensure that the best orthopaedic practice is developed and shared across the local health community. Our patients benefit from a team of highly specialist clinicians, many of whom are nationally and internationally recognised for their expertise.

Throughout 2019/20, the Trust has worked with partners at University Hospitals Birmingham (UHB) to streamline & improve elective orthopaedic services for patients across Birmingham & Solihull as part of the Orthopaedic Provider Alliance. This work will continue into 2020/21 as we collaborate closely with UHBNHSFT to develop a consistently high standard of orthopaedic care across the region.

We are proud of the research and innovation led by teams at The Royal Orthopaedic Hospital NHS Foundation Trust, including the expansion of robotic-arm assisted surgery (first NHS organisation in the UK), our JointCare programme which reduces length of stay for hip & knee replacement patients and focuses on patient 'wellness', and being a major research partner in the national 100,000 Genomes project. We are committed to updating our systems and processes so that we are able to offer the most efficient services to patients, and have seen the expansion of a new electronic prescribing and patient record system (PICS) in 2019/20.

In 2019 we continued the expansion of facilities at the ROH with the implementation of the Phase 1 of the new modular build complex of 4 state of the art theatres and a new inpatient ward, this work will be complete with Phase 2 expected to be commissioned in December 2020.

As part of the Trust's ambition to become a centre of excellence, we have focused on broadening access to our services. This has included the delivery of Musculoskeletal (MSK) clinics in the community, hosting GP out of hour's clinics in the Trust's Outpatients department, and implementing our MSK triage services in primary care through the role of First Contact Practitioner.

We are committed to tracking our progress against each of these goals. We have defined what success looks like (2017-2022):

- **Exceptional patient outcomes:** We will continue to be in the top 10% for positive Patient Reported Outcome Measures (PROMs).
- **Increased activity:** We will treat enough patients each year to reach our 50% growth target by 2022.
- **Improved Referral To Treatment compliance**: 92% target achieved in all sub-specialties.
- **Increased theatre productivity**: A 20% increase in cases per theatre session*
- **Reduced length of stay:** A 30% reduction in overall average length of stay.* Primary hip and knee length of stay in top 10% of peer benchmarking.
- **Highly recommended:** Positive 'Friends & Family Test' scores in the top 10%.
- **Engaged workforce:** Improvement in staff survey responses.
- **Financial stability**: Breakeven by 2020/21, Surplus by 2021/22.
- **Positive regulatory position:** Rated 'Outstanding' by the CQC & NHS Improvement will class us as 'Segment 1' in their Single Oversight Framework, a rating which assures that we require minimal oversight.

*Case mix adjusted

2.1 TRUST VALUES

The Royal Orthopaedic Hospital NHS Foundation Trust values define what is important in the way we deliver our vision.

Our key behaviours set out how we work, irrespective of the role we have in the Trust. These behaviours consistently carried out, will embed The Royal Orthopaedic Hospital NHS Foundation Trust values in our everyday working lives, and support the delivery of our vision 'to be the first choice in orthopaedic care'.

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Excellence

Work **TOGETHER** and deliver **EXCELLENCE**

Behaviours we are looking for	Behaviours we will not accept
• **Collaborates with colleagues, patients and other care providers to deliver high quality care for patients.** • **Accepts responsibility and critically reviews own performance; delivers improvement and fulfils promises made to others.** • **Values the contribution of all colleagues, irrespective of their role** • **Delivers consistently at or above required standards**	• Works in isolation from colleagues/other teams • Places own or team priorities above those of the Trust • Does not share good practice or learn from others/other teams • Refuses to accept feedback from colleagues • Inconsistent delivery of care/achievement of objectives

Innovation

Learn, **INNOVATE** and improve to continually develop orthopaedic care

Behaviours we are looking for	Behaviours we will not accept
• **Embraces new ideas and challenges self and others to adopt new ways of working/alternative approaches.** • **Networks with others to keep updated; leads on developing best practice.** • **Seeks new and better ways of caring for patients for today and in the future**	• Does not challenge self , nor change working or clinical practice • Does not network with others, fails to innovate/develop good practice • Prefers to maintain status quo and relies on existing skills and knowledge • Does not learn from experience or feedback, mistakes are repeated

Compassion

Have **COMPASSION** for all

Behaviours we are looking for	Behaviours we will not accept
• **Acts to support the health and well-being of own team.** • **Carries out genuine acts of kindness for others.** • **'Reads' others and acts with empathy, especially with different personalities.** • **Helps colleagues make the connection between their feelings and values and the quality of the service they provide.**	• Shows no understanding of others' perspective • Avoids responsibility for the well-being of colleagues. • Does not understand the impact of emotions and behaviour on colleagues

Openness

Be **OPEN**, **HONEST** and **CHALLENGE** ourselves to deliver the best

Behaviours we are looking for	Behaviours we will not accept
• **Truthful and transparent with patients and colleagues when makes mistakes** • **Supports colleagues who make mistakes or behave inappropriately by giving balanced, honest feedback.** • **Communicates in a way that is clear, concise and honest.** • **Is courageous in challenging unsafe practice and inappropriate behaviour; raises concerns about things they don't believe to be right**	• Inconsistent in messages to patients and colleagues, not forthcoming when mistakes have been made, fails to accept own responsibility • Feedback is either withheld or provided ineffectively/aggressively, rather than constructively • Does not communicate clearly, provides ambiguous responses • Does not challenge unsafe practice or inappropriate behaviour. • Raises concerns through inappropriate channels, or without respect for Trust process.`

Pride

Have **PRIDE** in and contribute fully to patient care

Behaviours we are looking for	Behaviours we will not accept
• **Shows pride in their work and strives to deliver the best within available resources** • **Utilises all knowledge, skills and experience for the benefit of patients and the Trust** • **Takes responsibility to overcome obstacles and adopts a 'can do' approach**	• Accepts and/or delivers work which is less than their best. • Is unable to explain how their role helps the Trust to deliver excellent patient care • Low resilience to disappointment, allows patient experience to suffer because of personal disappointments

Respect

RESPECT & listen to everyone

Behaviours we are looking for	Behaviours we will not accept
• **Listens without interrupting, is sensitive to others and shows patience** • **Acknowledges and empathises with others, irrespective of their needs, views and beliefs** • **Is always polite, in person, by email or telephone** • **Says 'hello my name is..' to every patient and where care is to be provided, explains this clearly in advance**	• Does not listen to others views, interrupts inappropriately • Disregards the contribution that others can make • Abrupt/discourteous in their communication (e.g. emails without salutation, unaware of their personal impact • Does not introduce self to patients/colleagues, does not explain care to be provided.

2.2 EQUALITY AND DIVERSITY

Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential.

We recognise the right of all our patients, visitors and employees to be treated fairly and considerably irrespective of age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability and social status.

2.3 QUALITY PRIORITIES FOR IMPROVEMENT 2019/20.

The Trust's 2018/19 Quality Account set out seven priorities for improvement during 2019/20; these were confirmed following consideration of performance in relation to patient safety, patient experience and effectiveness of care:

- Priority 1: Reduce the number of incidents of consent on the day, improving the quality of consent.
- Priority 2: Ensure that no more than 5% of clinical and corporate policies are beyond their review date at any period in time and have an appropriate audit plan
- Priority 3: Reduce the number of times patients Outpatient clinic appointments are rescheduled.
- Priority 4: Staggered admission times for all patients attending ADCU, including those attending for diagnostics.
- Priority 5: Improvement in acute pain management.
- Priority 6: Embedding learning and improvements made relating to sepsis.

The quality improvement priorities have been part of the Clinical Quality Group work plan and have been individually scrutinised within the Clinical Quality Group chaired by the Deputy Director of Nursing and Clinical Governance. The Clinical Quality Group took the decision based on delivery and ongoing scrutiny within a governance forum within the Trust to close four of the seven priorities. This decision was supported by the Trust's Quality and Safety Committee and further accepted by the Audit Committee.

Table 1 below provides a summary of the Trust's progress in the quality improvement priorities during 2019/20;

TABLE 1: ACHIEVEMENT OF QUALITY PRIORITIES 2019/20.

Priority 1: Reduce the number of incidents of consent on the day, improving the quality of consent.	This priority has been achieved. Review completed of consent policy Agreed consent KPI's Consent form reviewed, providing a range of speciality specific consent forms, standardising required consent issues. Consent audit completed, registered and reporting to Quality and Safety Committee.
Priority 2: Ensure that no more than 5% of clinical and corporate policies are beyond their review date at any period in time and have an appropriate audit plan	To be carried forward to 2020/21 as a Quality Priority Was previously rolled over from 2018/19 due to being incomplete and with additional actions. Review of policies undertaken with review dates and authors/executive leads has been completed, alongside appropriate allocation and review by groups and committees. Allocate Assure Policy Module to be utilised to support regular review and notification to authors around policy maintenance (from March 2020), reporting of policy metrics to appropriate forums (SG, IPPC, CYP, CQG, Execs, DTC). Partially successful with initiatives completed but greater compliance needed by allocated authors. Allocate Module being introduced this month and expected to contribute to better compliance. New Initiatives: New Divisional Lead (Stuart Lovack) to support policy authors to review/complete policies using Div 4 Estates Board meetings to review outstanding policies. Reporting from Allocate Policy Module into relevant groups and committees.

	Timetable to be created with RAG rating to schedule and review policies currently outstanding.
Priority 3: Reduce the number of times patients Outpatient clinic appointments are rescheduled.	To be carried forward to 2020/21 as a Quality Priority The appointments team are now using the Top Desk system to authorise and process requests for clinic reduction or cancellations. This ensures that all clinic requests are seen and authorised by the operational management team. There is to be an additional level of authorisation added shortly for any request under 6 weeks and this will be at deputy Chief Operating Officer or Associate Medical Director Level. Further strengthening the process. There is also now escalation from the appointments team if patients are being rescheduled more than twice or beyond 36 weeks on an advancing RTT clock. This escalation goes to the Clinical Service Manager and Clinical Service Support manager who are asked for instructions where to book these patients and to arrange additional capacity if needed In order to try and ensure patients are being chronologically booked and to avoid patients being rescheduled the Trust is introducing a partial booking process. Patients will only be booked 6 weeks in advance and therefore will not need to be moved due to consultant / clinician leave. This has been implemented in Pain Management, Back Pain, Spinal Degeneration and Deformity, and Young Adult Hips for new patients. There is an implementation and evaluation group set up, as part of the wider outpatient modernisation project, that is overseeing this. Currently there is an evaluation of resource requirements currently being carried out after which there will be a plan to roll this out across all specialties and eventually for follow up patients. There has been a reduction in rescheduling and improvement in chronological booking in the specialties live so far. DNA rates have also been reduced by the introduction of the interactive text messaging system, DrDoctor. Making it easier for patients to reschedule appointments means that capacity is reused for other patients and it also reduced the number of Was Not Brought appointments in vulnerable patient groups.

	Partially completed with more progress to be made on using partial booking in more specialities. Where utilised thus far very successful. New Initiatives: To continue rollout of Partial Booking to all specialities and follow up appointments.
Priority 4: Staggered admission times for all patients attending ADCU, including those attending for diagnostics.	This priority has been achieved. Waiting times between arriving into ADCU and being sent into theatres – data collected and reviewed. Previously no diagnostic lists were being staggered in CT, 3 out of 4 lists now use a two-admission time approach to ensure not all patients are arriving at the same time. Individual meetings held with clinical service managers, encouraging them to review individual speciality booking rules with the view of reducing waiting times for patients. PALS have been unable to provide specific data in relation to PALS complaints and waiting times, however through ADCU there has been a reduction in the number of complaints seen. All Theatre lists are using staggering admission times – reviewed and monitored via 642 meeting. A monthly dash board broken down by speciality showing average wait times for patients is shared via joint divisional ops meeting – this will remain as an ongoing agenda item in joint divisional meetings. To date CT patients on average waiting time has reduced by 7%, however it is likely this figure will only increase, as staggered admissions were only implemented in December. Overall there has been a reduction in the average waiting times for patients going to theatre from ADCU (excludes CT) by 3% below is all of the averages broken down by speciality:

	<table><tr><th></th><th colspan="3">2018/19</th><th colspan="3">2019/20</th><th colspan="2"></th></tr><tr><th>Team</th><th>Average Mins</th><th>No of Patients</th><th>10% Reduction Target (Mins)</th><th>Average Mins</th><th>No of Patients</th><th>10% Reduction Target (Mins)</th><th>Average Mins Variation 18/19 - 19/20</th><th>% Increase /Decrease 18/19 - 19/20</th></tr><tr><td>Large Joints</td><td>198.3</td><td>3923</td><td>19.83</td><td>198.6</td><td>4077</td><td>19.86</td><td>0.3</td><td>0.17%</td></tr><tr><td>Oncology/Histopathology</td><td>252.7</td><td>1338</td><td>25.27</td><td>241.7</td><td>1071</td><td>24.17</td><td>-11.0</td><td>-4.35%</td></tr><tr><td>Paediatrics</td><td>232.4</td><td>73</td><td>23.24</td><td>198.5</td><td>75</td><td>19.85</td><td>-33.9</td><td>-14.58%</td></tr><tr><td>Small Joints</td><td>200.4</td><td>1515</td><td>20.04</td><td>187.3</td><td>1455</td><td>18.73</td><td>-13.1</td><td>-7.02%</td></tr><tr><td>Spinal</td><td>233.8</td><td>788</td><td>23.38</td><td>238.8</td><td>639</td><td>23.88</td><td>5.0</td><td>2.09%</td></tr><tr><td>Grand Total</td><td>212.2</td><td>7637</td><td>21.22</td><td>206.2</td><td>7317</td><td>20.62</td><td>-6.1</td><td>-2.94%</td></tr></table> All initiatives completed or on track to complete shortly.
Priority 5: Improvement in acute pain management.	This priority has been achieved. Acute Pain Guidelines now drafted and awaiting ratification at Drugs and Therapeutics Committee, providing a Trust approved and agreed analgesic ladder for prescribers. Phase 2 PICS incorporates a range of pain tools to support management and monitoring of pain scores. Audit completed of Jointcare dataset. PgCert level education on pain management commissioned for Rapid Response Team (RRT). Senior Sisters completed work with nursing staff to adjust response/urgency of staff to managing pain as a medical emergency. Patient Education Literature provided to patients explaining analgesia available and our expectations for their pain management. Pain is no longer a theme noted in complaints and PALS concerns.
Priority 6: Embedding learning and improvements made relating to sepsis.	This priority has been achieved. Review and Launch of Adult Deteriorating Patient Policy, NEWS2 training and sepsis training completed for medical and nursing staff, KPI's agreed and reporting into Sepsis Group (and now resuscitation group), Incident Reporting was reviewed quarterly at Clinical Quality Group.

2.4 QUALITY PRIORITIES FOR IMPROVEMENT 2020/21.

The quality improvement priorities for 2020/21 were agreed following a review of the quality priorities from 2019/20, a review of our patient complaint and PALs themes and following a review from our Trust data on quality performance.

The quality improvement priorities for 2020/21 were agreed at the Trust's Executive Team in March 2020, and the Clinical Quality Group in April 2020. The priorities were shared and agreed with the Trust's governors in May 2020 including their sponsored quality priority. The quality improvement priorities will be cascaded to all staff via team brief in May 2020.

Priority 1: Reduce Patient Harms in the Trust – Falls.

Rationale: Falls in 2019/20 (94 predicted from YTD) will exceed 2018/19 figure (88), persistent and significant cause of low harm 36 (YTD) and medium harm 3 (YTD). During the year we did not have any severe harm or deaths relating to falls, however we note that each fall is serious in itself and has the potential for severe harm and therefore should be reduced in number. Quality Priority status would help to push forward the actions already underway from the falls group and monitor outcomes and set appropriate targets.

Initiatives to be implemented in 2020/21

- Thematic Review of Falls (past 12 months data).
- Frame data in reports to allow useful comparison (falls per 1000 bed days).
- Review Trust Falls Assessment
- Review Staff and Patient Information and Education
- Review and progress the Throne Project (the redesign of bathrooms to improve navigation, falls risk and suitability for dementia patients)
- Review deconditioning and PJ Paralysis to support mobility.
- Report in CQG with new revised dataset.
- Review dataset and benchmark against comparable Trusts.

How progress will be monitored, measured and reported.

Monitored and measured by the Falls Group via the Falls data via incident reporting and where relevant RCA.; reported to the Clinical Quality Group meetings and Quality and Safety Committee.

Priority 2: Improving Experience for Patients, Carers and Service Users (PCSU)

Rationale: Patient Experience Agenda not imbedded into the Trust, with limited attendance, membership and engagement by patient representatives. In Jointcare patient engagement has been very successful and excellent levels of engagement post-surgery. The Trust Patient Experience Team needs to utilise this learning to progress both Patient and Carers Forum and Patient Engagement and Experience Group. KPIs for complaints are not being met. A recent review found that action plans whilst created are not being completed, progress needed therefore on utilisation of Ulysses system to progress sight of action plans at Divisional Level for monitoring closure. Strengthen the Patient and Carers Forum membership.

Initiatives to be implemented in 2020/21:

- Publish and Roll Out Patient Experience Strategy
- Review Patient Complaints and Concern to theme, identifying areas of concern and negative experience for PCSU's.
- Create Action Plan with key leads responsible for areas identified.
- Review Complaints Procedure so that it best serves both complainant and service to improve
- Confirm all complaints action plans created in 2018/19 and 2019/20 are completed and closed.
- Review Patient and Carers Forum looking to try and increase attendance and full representation of our patient group (with particular note (but not exclusively) to ethnic minority representation).

How progress will be monitored, measured and reported.

Progress with initiatives will be reviewed at Patient and Carers Forum and Patient Engagement and Experience Group (PEEG).

Priority 3: Ensure that no more than 5% of clinical and corporate policies are beyond their review date at any period in time and have an appropriate audit plan

Rationale: Was previously rolled over from 2018/19 with additional actions (noted below).

- Review of policies undertaken with review dates and authors/executive leads has been completed, alongside appropriate allocation and review by groups and committees.
- Allocate Assure Policy Module to be utilised to support regular review and notification to authors around policy maintenance (from March 2020), reporting of policy metrics to appropriate forums (Safeguarding, Infection Prevention Control Committee, Children and Young Person, Clinical Quality Group, Executive Committee, Drugs and Therapies Committee).
- Partially successful with initiatives completed but greater compliance needed by allocated authors. Allocate Module being introduced this month and expected to contribute to better compliance.

New Initiatives:

- Divisional Lead (Stuart Lovack) identified to support policy authors to review/complete policies using Div 4 Estates Board meetings to review outstanding policies.
- Reporting from Allocate Policy Module into relevant groups and committees.
- Timetable to be created with RAG rating to schedule and review policies currently outstanding.

How progress will be monitored, measured and reported.

This priority will be monitored via the relevant Divisions Divisional Management Board and in speciality group meetings (CYP Board, Cancer Board, Clinical Quality Group).

Priority 4: Reduce the number of times patients Outpatient clinic appointments are rescheduled.

Background: Was previously rolled over from 2018/19 with additional actions (noted below).

- The appointments team are now using the Top Desk system to authorise and process requests for clinic reduction or cancellations. This ensures that all clinic requests are seen

and authorised by the operational management team. There is to be an additional level of authorisation added shortly for any request under 6 weeks and this will be at deputy Chief Operating Officer of Associate Medical Director Level. Further strengthening the process.

- There is also now escalation from the appointments team if patients are being rescheduled more than twice or beyond 36 weeks on a ticking RTT clock. This escalation goes to the Clinical Service and Clinical Service Support manager who are asked for instructions where to book these patients and to arrange additional capacity if needed
- In order to try and ensure patients are being chronologically booked and to avoid patients being rescheduled the Trust is introducing a partial booking process. Patients will only be booked 6 weeks in advance and therefore will not need to be moved due to consultant / clinician leave. This has been implemented in Pain Management, Back Pain, Spinal Degeneration and Deformity, and Young Adult Hips for new patients. There is an implementation and evaluation group set up, as part of the wider outpatient modernisation project, that is overseeing this. Currently there is an evaluation of resource requirements currently being carried out after which there will be a plan to roll this out across all specialties and eventually for follow up patients. There has been a reduction in rescheduling and improvement in chronological booking in the specialties live so far.
- DNA rates have also been reduced by the introduction of the interactive text messaging system, DrDoctor. Making it easier for patients to reschedule appointments means that capacity is reused for other patients and it also reduced the number of Was Not Brought appointments.
- Partially completed with more progress to be made on using partial booking in more specialities. Where utilised thus far very successful.

Initiatives to be implemented in 2020/21

- To continue rollout of Partial Booking to all specialities and follow up appointments

How progress will be monitored, measured and reported.

Progress will be monitored through data and KPIs, monitored via Clinical Quality Group and Operational Management Board.

Priority 5: Patient Wellbeing (inc Spiritual Health)

Rationale: : October 2019 CQC inspection outcome noted that we should provide Breaking Bad News training to more staff. Our Policy in the Event of a Patient Death Policy needs review and needs to incorporate changes to our processes. This Quality Priority supports Trust's 5 P's Patient Strategy and can prioritise time and focus on developing a GAP analysis against NHS Chaplaincy Guidelines. In early 2020 we reviewed at Senior Nurses the need for a Patient Admission Care Pack needed to provide standard information about trust, services available and wellbeing items (currently provide to oncology patients only).

Initiatives to be implemented in 2020/21

- Form a working group covering patient wellbeing.
- Review Chaplaincy Service – to support multifaith chaplaincy provision.
- Develop Patient Care Pack following review of documentation and demand for personal care items.
- Review End of Life care and Breaking Bad News Training arrangements.
- Review Care of the Dying Patient Policy (including review in light of new mortuary arrangements.
- Report workstream into CQG and Patient & Carers Forum.
- Review NHS Chaplaincy Guidance

How progress will be monitored, measured and reported.

Progress will be monitored through data and KPIs, monitored via Clinical Quality Group, Patient Experience and Engagement Group and Patient and Carers Forum.

2.5 STATEMENT OF ASSURANCE FROM THE TRUST BOARD.

2.5.1 PROVISION OF SERVICES BY THE TRUST

During 2019/20, The Royal Orthopaedic Hospital NHS Foundation Trust provided 14 relevant health services. The Royal Orthopaedic Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 14 of these relevant health services.

The 14 services provided by the Trust are:

- Anaesthesia
- Bone Infection Services
- Functional Restoration
- Imaging
- Large Joints
- Small Joints
- Spinal Surgery
- Paediatric Orthopaedics
- Pain Management
- Orthopaedic Oncology
- Orthotics
- Podiatry
- Royal Orthopaedic Community Scheme (ROCs)
- Therapy Services

2.5.2 PERCENTAGE OF INCOME GENERATED BY TRUST SERVICES

The income generated by the relevant health services planned in 2020/21 represents 89.46% of the total income generated from the provision of relevant health services by The Royal Orthopaedic Hospital NHS Foundation Trust for 2019/20.

2.5.3 PARTICIPATION IN CLINICAL AUDIT

During 2019/20, seven national clinical audits covered relevant health services that The Royal Orthopaedic Hospital NHS Foundation Trust provides.

During that period, The Royal Orthopaedic Hospital NHS Foundation Trust participated in all national clinical audits that it was eligible to participate in.

The national clinical audits that The Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2019/20 are as follows:

- National PROMS Programme – Elective Surgery (PROMS)
- British Spine Registry (BSR)
- Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
- Child Health Clinical Outcome Review Programme - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
- National Joint Registry (NJR) – (Healthcare Quality Improvement Partnership)
- Surgical Site Infection Surveillance Service – (Public Health England)
- Case Mix Programme - (ICNARC)

Table 2 below gives the national clinical audits that The Royal Orthopaedic Hospital NHS Foundation Trust participated in during 2019/20. The national clinical audits that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2019/20 are also listed within table 2, alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

TABLE 2: NATIONAL CLINICAL AUDIT OUTCOMES

NATIONAL CLINICAL AUDIT	% CASES SUBMITTED
National PROMS Programme – Elective Surgery	100%
National Comparative Audit of Blood Transfusion Programme	100% (1/1 case eligible)
National Joint Registry (NJR)	Compliance number of hip and knee procedures =2,378. Hips = 102% Knees – 101%
Public Health England Surgical Site Infection Surveillance (Hip and Knee)	Quarter 2 and 3 = 100% (618/717) Quarter 1 – No participation Quarter 4 – Data reconciliation in progress.
Case Mix Programme (ICNARC)	Quarters 1-3 = 100% (345/345) – Quarter 4 results not available until May 2020.

The reports of seven national clinical audits were reviewed by The Royal Orthopaedic Hospital NHS Foundation Trust in 2019/20 and intends to take the following actions to improve the quality of healthcare provided:

- The level of compliance with 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 is reviewed at both the Clinical Audit and Effectiveness Committee and Quality and Safety Committee and has provided assurances regarding the quality of outcomes in both hip and knee replacement surgery.

The reports of 25 completed local clinical audits were reviewed by the provider in 2019/20 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in table 3 below.

TABLE 3: LOCAL CLINICAL AUDIT OUTCOMES

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
Hip Arthroscopies - Review of single surgeon outcomes	The Hip Arthroscopy is a specialised procedure that can be involved with a steep learning curve. Most surgeons will perform most of their procedures after reaching Consultant level. In order to see patient outcomes and to assess their satisfaction with the procedure we will review a single surgeon's data throughout different points of his career.	Expand service evaluation to include all of the CM procedures +/- another young adult hip department Have more robust recording of pre/post of proms and incorporate into findings Have a more robust mechanism of recording operative time Centralised database to ensure any young adult undergoing hip arthroscopy is recorded and updated if seen by another consultant/trust.
Does infiltration with high volume ropivacaine provide adequate post-operative analgesia following single level, lumbar decompression / discectomy.	Having recently switched from using low volume bupivacaine to high volume ropivacaine for local anaesthetic infiltration after lumbar decompression / discectomy, we want to evaluate the analgesic effect this is having and ensure that our patients are being analgised better than (or at least as well as) before the change in practice.	Difficult to review pain scores after Jan 2019 as new nursing document doesn't include this in observation assessment. suggest team recording data to review patients on a regular basis to achieve appropriate data.
Review of Scoliosis Bracing	A need to establish if the most effective methods of treating scoliosis are being used and if there is a need for further training in this specialist area	The lack of x-rays following brace removal appears to reflect the nature of bracing in general. Bracing is used in the most part as a maintenance device to prevent curve progression until surgical intervention is deemed appropriate. There were only 3 cases where an x-ray following removal of brace was carried out of those included. Further consideration to alternative evidence based bracing types, and measuring techniques, including comfort and compliance should be included in future

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
		reviews. With the aim of further showing the achievable results with increased clarity.
Emergency Spinal Transfers to a Regional Spinal Hub	Delays to emergency transfers in an out of the department have led to this area needing further investigation to see if these delays have a cause that we can address	•Add a 'reason for delay' section to the admission/discharge sheet for further audit. •Encourage proper documentation of timings of admission on the PAS system –potentially hire a ward clerk. •Enforce RSN policy on transfers IN and OUT •Consider financial penalties both ways for failure of compliance.
Is crossmatch required for AIS(Adolescent Idiopathic Scoliosis) posterior only surgery?	Patients posted for posterior AIS surgery rarely need blood transfusion.	We have now decided to modify our blood ordering practice for adolescent posterior scoliosis surgery. All patients will be grouped and saved at the pre-op visit. Pre-operative crossmatch will not be routinely done except for patients with antibodies in blood, patients with known factor deficiencies and bleeding diatheses and pre-operative anaemia. All patients will have monitored hypotensive anaesthesia, intra-operative cell savage and tranexamic acid to reduce blood loss. Post-operative transfusion triggers will be revised and use of intravenous iron supplementation will be promoted to further reduce transfusions.
Is radiation dose relevant in CT lower limbs for assessment of lower limb version.	CT of the lower limbs is often performed in patients with patellofemoral instability. These patients are often young and we would like to evaluate whether radiation dose is justified in these patients.	It has been suggested that torsional malalignment may be an underestimated primary risk factor for patellofemoral instability. Our study demonstrates a significant relationship between tibial torsion and qualitative measurements of trochlear dysplasia and our results support our hypothesis that altered biomechanics in the presence of torsional malalignment can result in anatomical abnormalities within

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
		the patellofemoral joint, which may contribute to patellofemoral instability.
Patients' communication preferences in orthopaedic oncology	There is no evidence to indicate how cancer patients wish to receive their diagnosis and no standards/guidelines to guide how this process should be managed. Furthermore, equally limited evidence exists regarding patient satisfaction.	Our practice appears to be acceptable with patients and hence no action or change in practice is proposed as a consequence of this audit. A re-audit after an appropriate period of time to ensure quality/standards are being maintained, with a strong focus on prospective follow-up (as discussed in the observations section) would be advantageous in ongoing service appraisal.
Intradural Tumour Resections at The Royal Orthopaedic Hospital NHS Foundation Trust: Service Evaluation	The aim of this audit is to assess current practice of intradural tumour resection at the Royal Orthopaedic Hospital and compare this to national guidelines. This will identify areas of improvement as well as equipping the ROH spinal team, allowing their practice to be altered if appropriate.	The service evaluation found that not all patients were reviewed by MDT before undergoing intradural spinal tumour resection from January 2017 to December 2018. The service evaluation found that quality of life scores EQ-5D and Oswestry Disability Index (ODI) were not calculated or recorded for patients undergoing intradural spinal tumour resections from January 2017 to December 2018. The service evaluation found that outcomes for spinal patients were not uploaded to the British Spine Registry for any patient undergoing intradural spinal tumour resection from January 2017 to December 2018. By 31st December 2020, all patients will be reviewed by the spinal oncology MDT pre-operatively and neuro-oncology MDT following histopathology results. This will be co-ordinated by the three consultants undertaking intradural resections at this hospital. This will be coordinated by the lead consultant for each patient. Learning points

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
		Extensive range of variables make data collection difficult, so ensure adequate time to do this effectively and accurately.
Accessing blood loss and amount of re-transfusion with autologous blood transfusion drain in total knee arthroplasty	Patients frequently need blood transfusion postoperatively after a total knee replacement. Different types of drains are used intraoperatively, such as the CELLTRANS drain which is used for autologous blood re-transfusion.	We recommend stopping the use of ABT drains in patients undergoing primary TKA to reduce unnecessary expense. We recommend that when using the REDIVAC drain, it will be advisable to keep it on free drainage rather than suction. We recommend improving the documentation of blood loss on the fluid balance chart when a drain is used. We recommend further investigation into risk stratification in order to guide the use of ABT drains in high-risk patient groups in terms of blood loss/blood transfusion.
A retrospective audit to assess the clinical effectiveness and safety profile of Linezolid in the management of Prosthetic Joint infections at The Royal Orthopaedics Hospital	Linezolid is indicated for multi drug resistant gram-positive bacteria where other antibiotics are resistant. Although, Linezolid is a very effective antibiotic, it can cause serious side effects including blood disorders and optic neuropathy, particularly if treatment duration exceeds 28 days.	All patients prescribed Linezolid from August 2019 onwards should be documented on the BIU database due to the restrictions on the drug and can only be prescribed by a specialist microbiologist. All side effects caused by Linezolid from August 2019 onwards should be reported to the MHRA via yellow card reporting system to increase awareness of side effects.
Audit on Provision of Patient Information leaflet During the Consenting Process for foot and ankle patients. (re-audit)	Accurate and timely informed surgical consent is the first essential safety process element for any surgical procedure. The consent process has several important components, one of which is providing the patient with information regarding the procedure.	Providing patient information leaflets for every foot and ankle procedure and making sure that we have created bespoke information leaflets. To comply 100% in achieving the above 2 standards Re audit again in one years' time to seek our compliance with these standards. It is difficult to create Patient information leaflets for all foot and ankle procedures as there are various procedures.

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
Audit of incidental thoracic spinal canal stenosis in patients undergoing lumbar spine MRI	It has been observed that thoracic canal stenosis is not an infrequent incidental finding in patients undergoing lumbar spine MRI. Routine lumbar spine MRI series does not typically include above T12 and therefore we aim to evaluate whether the mid to lower thoracic spine should be included routinely in lumbar spine MRI.	1. to include lower thoracic spine (T10/11) in MR of lumbar spine - Inform MR radiographers 2. to report disc degeneration and analyse this while reporting - Presented in radiology clinical governance meeting.
To Tilt or not to tilt for cervical nerve root injections	To assess the effect of tilting the neck during cervical nerve root injections has on the cross-sectional diameter of the vertebral artery. There is some evidence that it can cause vasovagal.	One can safely tilt the head during cervical nerve root injections - Presented at Radiology Clinical governance meeting and disseminated the knowledge among the radiologists.
Audit of ultrasound availability for 2 weeks wait nurse led clinic	The oncology 2ww nurse led clinic runs weekly all day on a Thursday and patients are GP referrals on a 2 week wait cancer pathway often requiring an ultra sound\MRI scan in order to determine diagnosis and further management plan. The radiology department run an ultrasound service on Thursday am and pm and we want to aim for a one stop visit so that the patient pathway is managed effectively and that he patient experience is exceptional	Recommendations 1. US slots are available so that 100% of patients needing US have scans on the day of clinic 2. MRI slots are available so that 100% of patients requiring MRI scans have them on the day of the 2ww clinic. 3. Patient referrals are triaged to ensure that any inappropriate referrals are forwarded to the appropriate team e.g. MARSU Learning points Update audit proforma to clarify what imaging has been done by the GP and if US has been done on the day of clinic
Assessing the microbiological and histological investigations performed for patient with PJI of the hip following hip arthroplasty in the context of their follow up.	Around 1% of patients receiving a hip replacement develop a periprosthetic joint infection (PJI) in the UK.1 It is a devasting complication following a hip arthroplasty and causes tremendous burden on patients though increased morbidity, mortality and length of stay.	Recommendations The sample size of infected patients is small in this study. As out of 150 patients, only 4-8 patients were found to be infected in microbiology/histology. Hence, a greater number of patients is required to obtain a clinically useful result.

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
		Most patients had 6 weeks and 1 year follow up. However, this was not consistent as some patients had at 2 years or 6 months. Hence, more consistent record keeping is required and the next study should look at a wider follow-up timeframe.
ROHOS Counselling Service Audit & Patient Feedback Survey	To give a rounded picture of the counselling service by collect quantitative data which will describe the activity of the counselling service and qualitative data which will reflect the experience of patients using the Royal Orthopaedic Counselling Service (not captured in the annual patient survey)	To improve the amount of the auditable data collected. From August 2019 Macmillan activity data will be more comprehensive and allow a more complete picture of activity, including whereabout patients are on their individual "cancer journey" and how many sessions each patient has had. Learning points Difficulty in abstracting data for the counselling service is being addressed. To allow more time for administration of the survey in future.
Flexor Hallucia Longus - The Unsung Hero of the Foot and Ankle	The FHL is an important review area for the musculoskeletal radiologist on MRI imaging particularly in patients with chronic Achilles tendon rupture as the FHL is regularly used in tendon transfer surgery.	We suggest preoperative radiological assessment of the FHL to establish that the FHL muscle and tendon are normal and intact and suitable for transfer surgery. We also discuss the spectrum of pathologies affecting FHL. - Presented at Radiology clinical governance meeting and disseminated the findings amongst the radiologists
Prophylactic antibiotic prescribing in primary total hip and knee arthroplasty	Surgical site infection (SSI) accounts for almost 20% of hospital acquired infections. They increase patients' morbidity and mortality and increase risk of secondary complications.	Educate medical staff on the appropriate use of electronic prescribing and encourage drugs given in the peri-operative period to be prescribed on PICS. This recommendation could be brought up at the anaesthetist's clinical governance meeting. Continue good adherence to antibiotic prophylaxis guidelines in total hip and knee arthroplasty.

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
The use of the "flow-void" sign on MRI in the evaluation of malignant bone lesions	The "flow void" sign is an important imaging sign in bone metastases from renal cell carcinoma but little emphasis is placed on this sign when evaluating solitary bone lesions.	Look for flow voids in malignant bone lesion - Presented in radiology governance meeting to disseminate the findings amongst the radiologists.
Audit on compliance of NICE guidelines for the indication of Caudal epidural Injections.	The current standards of NICE guidelines have given acute and sever sciatica as the indications for caudal epidural. None of the patients with spinal canal stenosis should be offered the same. We intend to look at the compliance with these guidelines among the patients selected for the caudal epidural in out trust.	To circulate the guidance for epidural injection in clinics. Give a time span for three months. Re-audit the practice Adherence to NICE guidance is not 100% indicating room for improvement. Improve compliance with NICE - Recirculation of NICE guidance for caudal epidural injections Re-audit practice - After 3 months of reminders and circulation of NICE guidance we would re-audit the practice in August 2020.
Arthroscopic Meniscectomy and Meniscal Repair at ROH – Does it conform to BASK Meniscal Surgery Guidelines?	Knee pain with meniscal damage is a very common presentation to the ROH Arthroscopy service. There are a range of aetiologies that underlie this presentation and management strategies differ accordingly. Selecting the appropriate management strategy is important to optimise patient outcomes and ensure that surgery is performed in line with current evidence and guidance.	All arthroscopic meniscal surgery at Royal Orthopaedic Hospital should be carried out according to BASK guidelines as a minimum standard. Ideally there should be formal categorisation of patients according to the BASK guidelines recorded in the clinic letter. In the absence of this all patients listed for arthroscopic meniscal surgery should have the indications for surgery clearly recorded in their clinic letter.
Greater Trochanteric Pain Syndrome: A multi-centre service evaluation	This service evaluation has been undertaken as part of preparation for fellowship application in April 2020, for an intervention study to be carried out at the ROH for patients with Greater Trochanteric Pain Syndrome.	Patients presenting to the NHS with GTPS appear to have complex, multi-factorial issues with high levels of pain and disability and are often medicated for multiple co-existing conditions. Importantly, they have characteristics which differentiate them from patients recruited to the LEAP trial, Hence, it is unclear whether the findings of the LEAP

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
		trial are applicable to patients with GTPS consulting physiotherapy services in the NHS. Further research is warranted to evaluate this.
To evaluate the use of the BACTIP classification in the management of central cartilage tumours around the proximal humerus and knee. A service evaluation.	To see if the implementation of the Birmingham Atypical Cartilage Tumour Imaging Protocol (BACTIP) resulted in a delay in diagnosis of an enchondroma converting to a chondrosarcoma.	BACTIP is a useful tool in the initial assessment of CCT's around the proximal humerus and knee. In only 1 case was there a 5m potential delay in the diagnosis of a CS. It determines which cases need prompt referral to a specialist orthopaedic oncology unit for further assessment.
Incidence of Post-Operative Nausea and Vomiting in Recovery	To identify current practice and compare with national standard	Dual anti-emetic prophylaxis – only for high risk (Apfel 3 and 4) Re-audit with new prophylactic regime. Use of dexamethasone – reserved for high risk patients, can cause difficulty with BM control in diabetics.
Are we recharging for implants correctly?	Previously in 2016, implants used where there was bone loss for infection, fracture and metastasis were not being recharged for by the Trust. An audit in 2017/2018 showed that a number of implants were not being charged for and sometimes patients were completely missed from being recharged for at all. The reason for re-auditing, is to assess whether anything has changed since this initial audit and if not, what we can recommend to improve things.	We recommend that it is a personal job role to identify patients who are eligible for recharging. All patients should be picked up at the time of operation and review with Consultant's should be undertaken on a monthly/quarterly basis. Barcode system should be utilised to ensure all implants are correctly recharged for. We recommend re-audit in 6-12 months.
Retrospective review of RTB consent form completion quality.	To provide due diligence for the delivery of the trusts standard operating procedures regarding informed consent documentation for the storage and use of human tissues held within the ROH Research Tissue Bank.	Agree minimum standard for consent documentation for tissue/data only studies which fall outside the clinical trials regulations. Update research consent SOP to reflect minimum requirements for valid consent documentation.

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS/ACTIONS
		Review consent documentation prior to release of any future samples from the RTB released under the current version RTB protocol. Complete review of the RTB protocol and submission of substantial amendment Renaming of the biobank from 'Research Tissue Bank' to 'ROH Tissue Bank.'
Audit on wearing of Disposable surgical face masks in operating theatre	The British Orthopaedic Association holds the following views on operating theatre practice: The level of sterile precautions required to perform orthopaedic surgery safely is higher than that for surgery involving the bowel, infected body cavities, contaminated wounds and other soft tissue surgery. All staff in the operating theatre suite, including the anaesthetic room and corridor, must adhere to existing high standards of theatre discipline and follow established procedures that include Masks, which cover both the nose and mouth, to be worn at all times within the operating theatre and any lay-up room.	Suggest Team leader in theatre and lead consultants reminds team about need to wear masks during the team brief as the beginning of the day. This can be recorded as a tick box on the day brief checklist. Secondary check could be made as part of WHO checklist during 'time out'. This will act as another check prior to 'knife to skin'. Posters in the theatres to remind staff about the need to wear masks throughout. SMART principles. Re-audit in 3 months' time.
Audit of an Individual Radiologists Accuracy Reporting Chest X-rays on Orthopaedic Oncology Outpatients	Audit results required for appraisal purposes. Part of last year's PDP	No change to the individual's current practice is required.

2.5.4 PARTICIPATION IN CLINICAL RESEARCH

At The Royal Orthopaedic Hospital NHS Foundation Trust we believe that every patient has the right to be given the chance to participate in clinical research and to contribute to the generation of new knowledge which can lead to improvements in their health and care or that of future generations. The Trust has a vibrant research portfolio of clinical trials, observational studies and biological studies which underpin our delivery of evidence-based care. We are working with world leading academic and industry partners to ensure that our patients have access to the latest innovations in orthopaedic care whether that is a new approach to physiotherapy rehabilitation, advanced therapies to regenerate diseased bone tissue or pharmaceutical treatments which aim to reduce the need for invasive surgery and speed up recovery.

Over the last year we have demonstrated a continued growth and diversity of our research portfolio, enhanced our research facilities and developed our research capabilities. We have invested in the professional training and development of our workforce and established the foundations within the Trust to nurture the next generation of orthopaedic researchers.

Particular achievements include:

- **CULTIVATING A HOME-GROWN RESEARCH PORTFOLIO BASED ON LOCAL PRIORITIES AND OUR PATIENT'S NEEDS**

  We are in the process of recruiting to newly created Clinical Research Fellowships which will promote the development of orthopaedic clinical academic careers. These posts will encourage the development of locally initiated research programmes, enhance research skills and training and will increase research capacity within the Trust. This builds on the successful clinical academic career pathways established by our research physiotherapists who continue to act as role models for other clinical professionals in the forging of roles which combine clinical practice with research leadership and delivery.

- **DEVELOPING ACADEMIC CLINICAL AND BASIC SCIENCE STUDIES IN COLLABORATION WITH LOCAL UNIVERSITIES AND OTHER NHS PROVIDERS**

  We have established strong collaborations with local universities including Aston University and University of Birmingham to support the development of orthopaedic research programmes which will run through the Dubrowsky laboratory

- **INCREASING THE NUMBER OF INTERVENTIONAL STUDIES IN OUR PORTFOLIO WHICH WILL VALIDATE AND EVALUATE NEW AND EXISTING MEDICINES, MEDICAL DEVICES AND ORTHOPAEDIC THERAPIES**
  For the second year running we have achieved our goal of increasing the opportunities for our patients to take part in clinical trials, with such studies representing over half of our research portfolio. Such trials evaluate new orthopaedic treatments or compare different available treatments to confirm which approach offers our patients the best possible outcomes.

- **BUILDING THE DUBROWSKY REGENERATIVE MEDICINE LABORTORY**

  Building of a new state of the art regenerative medicine laboratory onsite at the Trust which opened in summer 2019. Funded by a charitable legacy gift from a former ROH patient, Mr Dubrowsky, The lab, will provide translational research facilities for developing new orthopaedic therapies which use the body's own cells to restore function.

The total number of projects taking place within the Trust continues to steadily increase year on year, with 83 studies actively recruiting or in follow-up during the 2019/20 year to date, compared with 71 studies during 18/19 **(Figure 1)**.

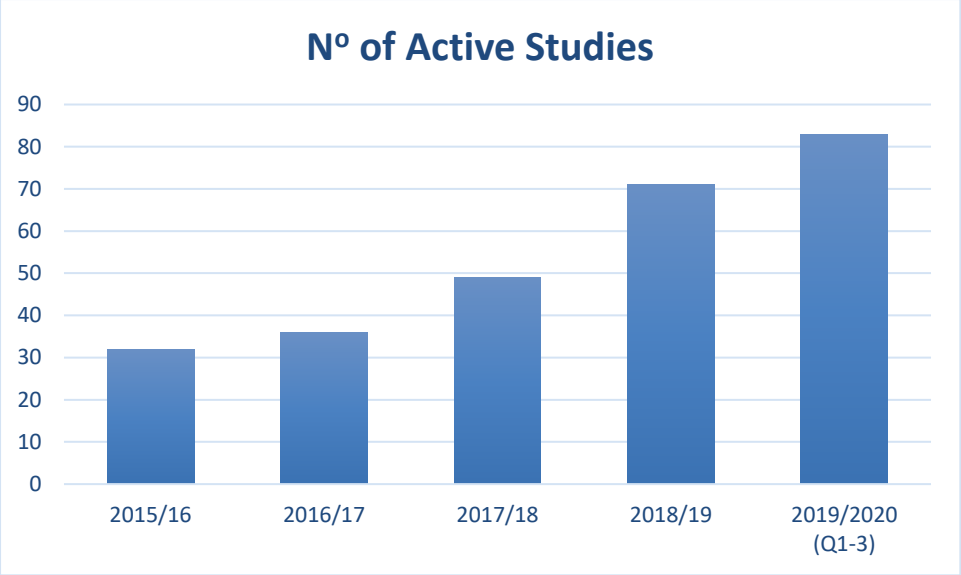


FIG 1: NUMBER OF ACTIVE STUDIES

Of the 83 active studies - 30 are open, 34 are in follow-up, 15 are in set-up and 4 were suspended or withdrawn. Reasons for suspension or withdrawing include research pathways not being compatible with current ROH clinical pathways.

Whilst increasing our overall activity, a continued drive to deliver a balanced project portfolio has maintained our increased involvement in interventional trials. The proportion of interventional studies increased dramatically as a result of this strategic plan in 2018/19 to result in more than half of our studies involving new treatments for our patients. We have continued to sustain this balance achieving 55% of the portfolio for 19/20 **(Figure 2)**.

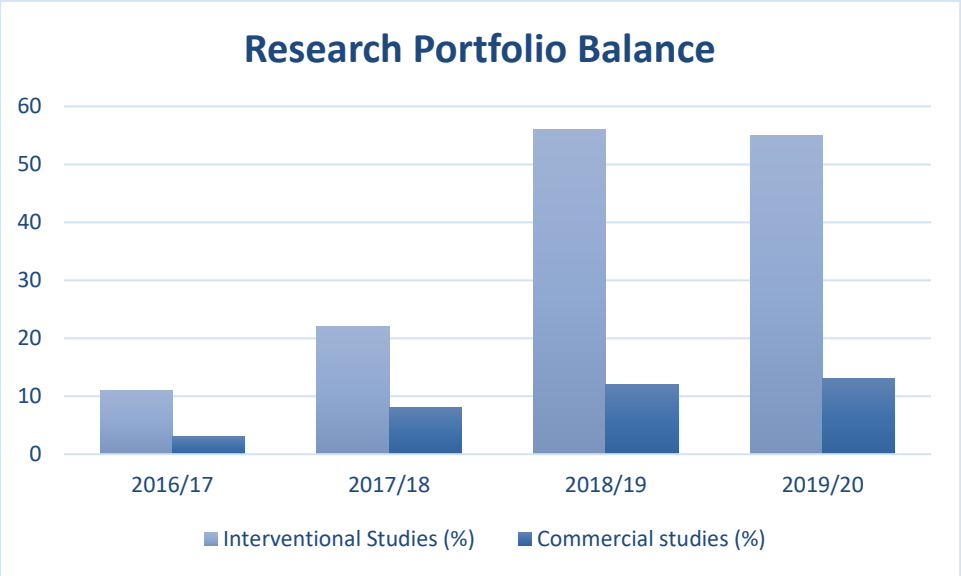


FIG 2: RESEARCH PORTFOLIO BALANCE

Interventional trials are inherently more complex, involving fewer patients and requiring a longer, more intensive follow-up period when compared to observational studies. Our increased involvement in these types of studies has correlated with our current recruitment total for the year to date being slightly lower than the same period in previous years where the interventional portfolio was significantly smaller and the research team were mainly deployed on large observational studies. However, increasing the number of active interventional studies is important for enabling patients to have access to the most advanced methods and treatments available.

The ROH is amongst the top five NHS Trusts in the UK for recruitment into NIHR adopted orthopaedic research programmes. In parallel with this, we have also increased our involvement in commercially sponsored studies to the highest number in recent years (11 for 19/20 to date, compared with 9 for 18/19, 8 for 17/18 and 3 in 16/17), and this has allowed us to continue to deliver our strategic intention to provide patients with access to the latest pharmaceutical and technological innovations developed within the commercial and academic sectors. The proportion of active studies registered on the NIHR portfolio has increased slightly to 67%, however participants recruited into portfolio studies account for 97% of our total recruitment for the year to date. This is because a higher number of our active non-portfolio studies are in the follow up phase and are not actively recruiting, while nearly all of our studies in the recruitment phase are NIHR portfolio adopted.

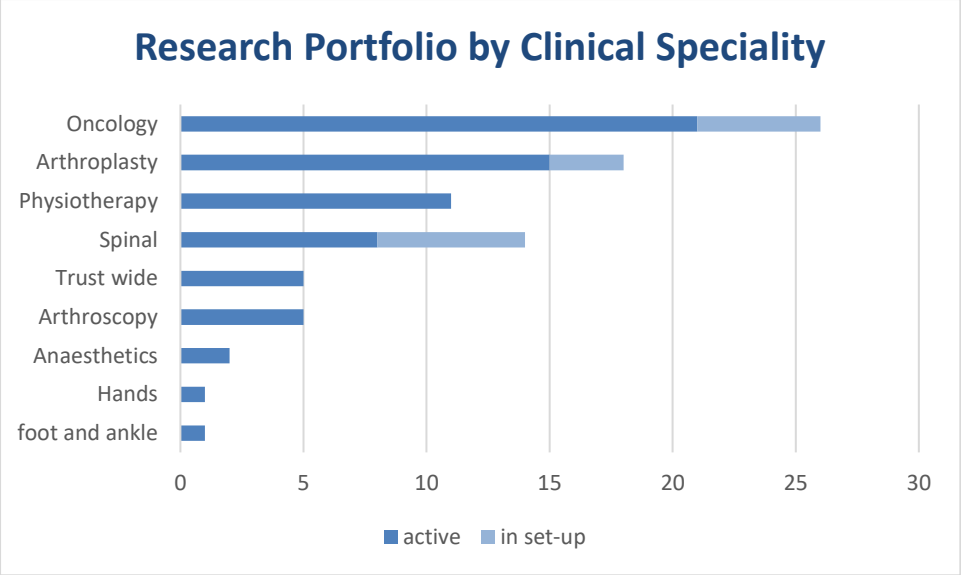


FIG 3: RESEARCH PORTFOLIO BY ORTHOPAEDIC SPECIALITY

As with previous years, the most research active clinical specialties continue to be Arthroplasty, Oncology and Spinal services, and we have maintained a level of research activity in a majority of clinical areas across the Trust **(Figure 3).**

2.5.5 CQUIN PAYMENT FRAMEWORK

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree on payments to NHS Trusts based on delivery of improvement work.

A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust income in 2019/20 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 2019/20 this figure was £746,345 (2018/19 - £1.64M).

CQUIN	Commissioner	100% financial value	19/20 ROH achievement (%)	19/20 ROH achievement (£)	Comments
Alcohol & Tobacco Screening	Birmingham and Solihull CCG	£59,631	100%	£59,631	
Alcohol & Tobacco Brief Advice	Birmingham and Solihull CCG	£59,631	100%	£59,631	
Alcohol & Tobacco Brief Intervention	Birmingham and Solihull CCG	£59,631	100%	£59,631	
Influenza Vaccination	Birmingham and Solihull CCG	£29,815	62.67%	£4,472.25	ROH hit the 60% milestone and therefore was awarded 15% of the total CQUIN value
Bone Infection	Birmingham and Solihull CCG	£387,602	100%	£387,602	
Spinal	NHS England	£150,035	100%	£150,033	

During March 2020 changes were made to final payments as a result of Covid Pandemic and a the fixed sum was paid after negotiation without reference to CQUIN results.

Further details of the agreed goals for 2020/21 and for the following 12-month period are available on request from Julie Gardner, Assistant Director of Finance – julie.gardner14@nhs.net

2.5.6 CARE QUALITY COMMISSION (CQC) REGISTRATION AND COMPLIANCE

The Royal Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'without conditions'.

The Care Quality Commission has not taken enforcement action against The Royal Orthopaedic Hospital NHS Foundation Trust during 2019/20.

The Royal Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In October/November 2019 the Trust received a formal CQC assessment against the CQC assessment framework. The Trust's report from this visit was published in December 2019 and has seen the Trust retain an overall rating for the Trust of 'good'.

The CQC reported noted the following improvements

- The trust should consider the way in which challenge is documented within minutes to be reflective of the discussions taken place.
- The trust should consider a review of the corporate risk register to include date of entry to the register, frequency of update and a review of the control measures in place.
- The trust should review the systems in place to manage staff anxieties regarding the future of the trust and potentially losing its identity as an orthopaedic specialist trust.
- The trust should ensure all staff complete their safeguarding training. (Regulation 12.2 (c) Safe care and treatment).
- The trust should ensure that staff understand its policies on locking medical records and resuscitation trolleys. (Regulation 17.2 (d) Good governance).
- The trust should ensure staff complete patient records fully including fluid charts and malnutrition universal screening tools. (Regulation17.2 (d) Good governance).
- The trust should ensure staff respond to patient call bells promptly. (Regulation 10.2 (b) Dignity and respect).
- The trust should ensure wards are adapted to the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3.(b) Person-centred care).
- The trust should ensure patients are not moved at night. (Regulation 10.2. (a) Dignity and respect)

- The trust should remind staff to record cleaning jobs done and action taken on fridge temperature variation.
- The trust should share its surgery safety thermometer performance with patients and visitors.
- The trust should provide formal training on breaking bad news.
- The trust should minimise in-clinic wait time for day surgery patients.
- The trust should continue to develop solutions to overcome its fragmented information systems.
- The trust should maintain the pace of its engagement work and develop an approach to consulting spinal patients.
- The trust should continue to develop its management information to monitor pre-assessment recalls, surgical site infections for spinal or other complex surgery.
- The service should ensure staff are up-to-date with all mandatory and safeguarding training. (Regulation 12.2 (c) Safe care and treatment).
- The service should ensure consultant reviews are appropriately recorded to show they have been conducted within 12 hours of patient admission. (Regulation 12. 2 (a) (b) Safe care and treatment).
- The service should ensure they implement local Safety Standards for Invasive Procedures (LocSSIPs) and assess the need for these against all invasive procedures carried out. (Regulation 12. 2 (a) (b) Safe care and treatment).
- The service should ensure they conduct regular simulation and emergency drills for the unit to be able to assess what went well and where improvements were needed. (Regulation 17. 2 (a) (b) Good Governance).
- The service should ensure all policies and procedures are up-to-date to accurately reflect the types of patients admitted to the unit. (Regulation 17 (1) Good Governance).

- The service should ensure the design of the unit meets the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3. (b) Person-centred care).
- The service should ensure all current risks for the service are recorded on the local risk register. (Regulation 17.2 (b) Good Governance).
- The service should consider displaying the results of the safety thermometer, so they are visible to patients and visitors.
- The service should consider providing access to a speech and language therapist during weekends.
- The service should consider clearly displaying in the unit that information and leaflets are available in other languages.

Table 4 sets out the rating by each domain and area with note as to when last assessed by the CQC.

TABLE 4: CQC RATING FOR THE ROYAL ORTHOPAEDIC NHS FOUNDATION TRUST

Ratings for The Royal Orthopaedic Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Surgery	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019
Critical care	Good ↑↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Good ↑ Dec 2019	Good ↑ Dec 2019	Good ↑ Dec 2019
Services for children and young people	Good Oct 2014	Outstanding Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Outpatients	Good May 2018	Not rated	Good May 2018	Good May 2018	Requires improvement May 2018	Good May 2018
Overall*	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

2.5.7 INFORMATION ON THE QUALITY OF DATA

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:*

- 99.86% for admitted patient care.
- 99.94% for outpatient care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:*

- 99.93% for admitted patient care.
- 99.79% for outpatient care.

*Figures cover the latest available period: April 2019 – January 2020.

2.5.8 INFORMATON GOVERNANCE ASSESSMENT REPORT

Information Governance (IG) is the way in which an organisation protects and processes the information it holds, uses and shares. It covers both personal (e.g. patient records, complaints) and corporate (e.g. staff personal records, financial records) information. The organisation is assessed using the Data Security and Protection (DSP) toolkit which has 10 data security standards with a 116 mandatory evidence items prescribed by the National Data Guardian. The Trust meets 98 of these but cannot currently meet some of the challenging cyber security requirements. There is a robust action plan in place and the Trust is doing everything reasonable to address the gaps which gives it the status of 'Standards not fully met (plan agreed)' status for 2020/21 with the intention of attaining standards met status by the end of the year. This will not impact on the Trust's ability to protect, use and share information safely.

2.5.9 PAYMENT BY RESULTS CLINICAL CODING AUDITS

The Royal Orthopaedic Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

2.5.10 IMPROVEMENTS IN DATA QUALITY

The Royal Orthopaedic Hospital NHS Foundation Trust will be taking the following actions to improve data quality;

- The establishment of a Data Quality Group.
- The implementation of an in-house RTT training programme for all administrative staff.
- Continuing RTT external training for Operational Service managers and the Revalidation team, with an assessment prior to completion.

2.5.11 LEARNING FROM DEATHS

Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. The Royal Orthopaedic Hospital NHS Foundation Trust have been required to publish all patient deaths since September 2017. Our policy is available for download at https://www.roh.nhs.uk/about-us/publications/reporting-investigation-and-learning-from-deaths-in-care

During 2019/20 the following number of deaths which occurred and were captured on the Learning from deaths process;

- 2 Deaths were reported as in-hospital deaths at the ROH
- 20 deaths within 30 days of being discharged from the ROH
- A total 22 deaths that was identified by the Learning From Deaths criteria
- All cases were initially screened by the named consultant from the 22 deaths

- 2 cases were referred to the coroner and a full investigation was carried out and findings shared among the trust and presented at clinical audit day
- 4 cases had complete SJR investigation
    - All of these deaths were deemed unavoidable (score 6 on the RCP guidelines)
- 12 cases after initial review did not warrant further SJR investigation.
- 2 cases are still currently in progress awaiting outcomes of SJR investigation
- 2 cases are still currently in the initial screening process

- There were no deaths associated to Mental Health or Learning Disabilities Patients
- Feedback was provided to next of kin where concerns were discovered.

The following actions and the learning in 2019/20 are;

- The ROH has reviewed the process for review and sign off of VTE risk assessments and recommended prophylaxis to ensure compliance with Trust VTE Guidelines and WHO sign-in.
- ADCU post- operative documentation was reviewed and updated to ensure it enables compliance with Trust Clinical Record Keeping Policy and professional standards
- ADCU have all Blood pressure machines in the department checked by Medical Engineering to ensure timings recorded are correct
- ADCU are using NEWS2 observation charts on all patients to ensure accurate documentation of observations and early recognition of a warning signs in line with national mandate.

The Royal Orthopaedic Hospital NHS Foundation Trust will assess the impact of these actions via its Clinical Audit and Effectiveness Committee and Divisional Board meetings. If the desired output is not achieved, these actions are reviewed and amended to ensure change and improvements are implemented and sustained.

2.6 REPORTING AGAINST CORE INDICATORS.

2.6.1 SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The standardised mortality rates for hospitals, produced nationally are not applicable to The Royal Orthopaedic Hospital NHS Foundation Trust, because the number of deaths that occur are too small for change to be statistically significant.

However, all deaths that occur at The Royal Orthopaedic Hospital NHS Foundation Trust are reviewed in line with the Trust's Learning from Deaths policy following the National Quality Board (NQB) 2017 guidance.

2.6.2 PATIENT REPORTED OUTCOME MEASURES

The Royal Orthopaedic Hospital NHS Trust considers that this data is as described for the following reasons, Patient Reported Outcome Measures (PROMs) provides information on the effectiveness of care delivered to NHS patients as perceived by our patients themselves. Patients complete a questionnaire before, and six months after their surgery.

TABLE 5: PROMS FINAL DATA APRIL 2018 – MARCH 2019 (PUBLISHED FEBRUARY 2020)

Procedure Type	Measure	England Average	England Highest	England Lowest	ROH	Position
Hip Replacement Primary	EQ-5D Index	0.465	0.557	0.348	0.470	Above National Average
Hip Replacement Primary	Oxford Hip Score	22.68	25.38	18.75	22.91	Above National Average
Hip Replacement Revision	EQ-5D Index	0.287	0.396	0.206	0.302	Above National Average
Hip Replacement Revision	Oxford Hip Score	13.86	18.96	7.85	13.75	Below National Average
Knee Replacement Primary	EQ-5D Index	0.338	0.405	0.266	0.339	Above National Average
Knee Replacement Primary	Oxford Knee Score	17.33	20.01	13.77	17.39	Above National Average
Knee Replacement Revision	EQ-5D Index	There are too few revision knee replacements with completed data in 2017/18 for comparison with the England average.				

*Data source: Informatics

The Trust continues to accept the most complex arthroplasty revision cases.

Individual surgeon performance for revision hip arthroplasty is now peer reviewed annually both in terms of patient reported outcome data and implant survival. Surgeons also receive regular individual feedback on their data with regular reports from informatics which are included in their annual appraisal.

The Trust continues to develop the Amplitude surgical outcomes database with the aim of facilitating better real time monitoring to support both patients and surgeons monitoring their recovery. This continues to be the preferred option to further drive continuous improvement and quality as the reporting / business intelligence aspect of outcomes continues to mature and develop.

The Royal Orthopaedic Hospital NHS Foundation Trust has taken the action above to improve this score, and so the quality of its services by, maintaining a high focus on submitted cases and continued monitoring of submitted case totals, EQ-5D and Oxford score data through the Clinical Audit and Effectiveness Committee and Quality and Safety Committee.

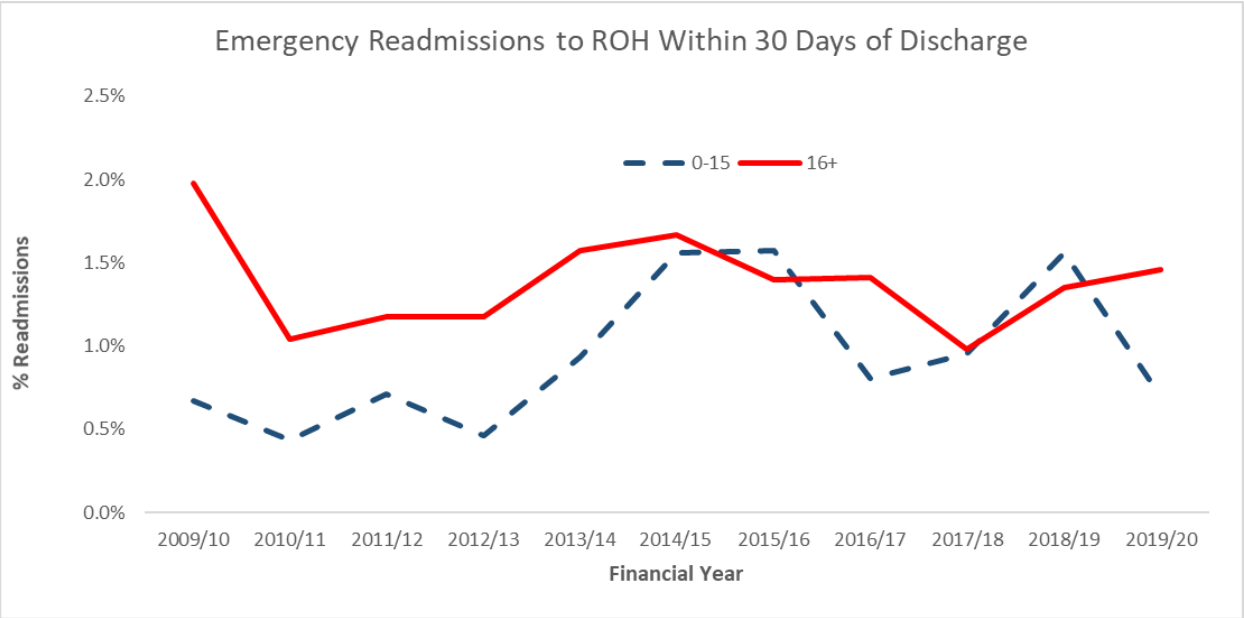
2.6.3 READMISSIONS WITHIN 28 DAYS OF DISCHARGE

The percentage of patients aged 0-15 and 16 or over, who were readmitted to The Royal Orthopaedic Hospital NHS Foundation Trust within 28 days of being discharged are shown in table 6 and graph 1 below.

TABLE 6: READMISSION RATES WITHIN 28 DAYS

Readmission Rate	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
0-15	0.7%	0.4%	0.7%	0.5%	0.9%	1.6%	1.6%	0.8%	1.0%	1.6%	0.7%
16+	2.0%	1.0%	1.2%	1.2%	1.6%	1.7%	1.4%	1.4%	1.0%	1.4%	1.5%
All	1.8%	1.0%	1.1%	1.1%	1.5%	1.7%	1.4%	1.3%	1.0%	1.4%	1.4%

GRAPH 2: READMISSION RATES WITHIN 28 DAYS



The Royal Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reason; the data is submitted and quality checked on a monthly basis as part of regular reporting.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by including this core quality indicator within the Trust's Quality report for further oversight and scrutiny.

2.6.4 RESPONSIVENESS TO PERSONAL NEEDS

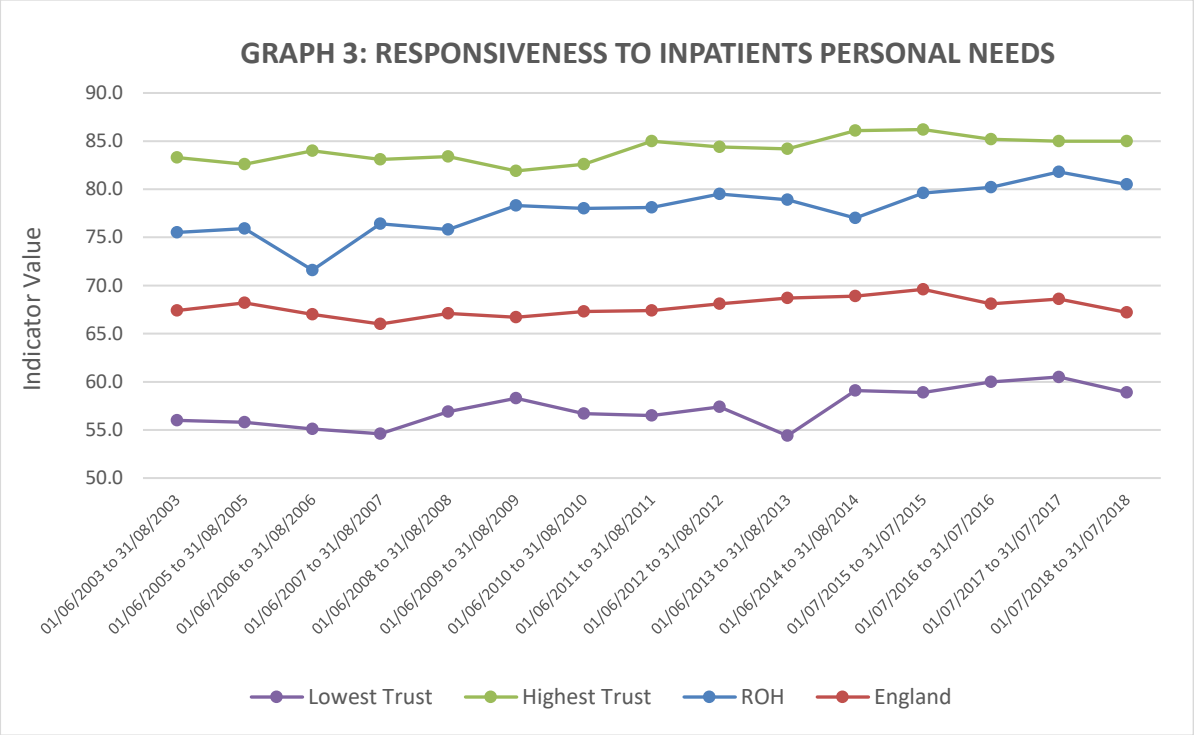
The responsiveness to personal needs data is taken from five questions within the National Inpatient Survey. These questions are:

- Were you as involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about the medication side effects to watch for when you went home?

- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?

The Royal Orthopaedic Hospital NHS Foundation Trust considers this data is as described for the following reasons; The Trust collects the data anonymously and sends it to be independently reviewed and scored by an external provider (Iwantgreatcare).

GRAPH 3: RESPONSIVENESS TO INPATIENTS PERSONAL NEEDS



Comments made using this collection method are moderated and published external to the Trust. Scoring remains consistently high and feedback is monitored to ensure that any trends or issues are addressed promptly.

The Royal Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by;

- Monitoring in real-time and taking corrective actions where necessary.
- Roundtable discussions with regards to concerns in an individual ward, resulting in an action plan and close monitoring.
- Providing a departmental manager with immediate feedback to allow prompt action.
- Review of the PALS service to provide greater availability of support and advocacy to patients, visitors and carers.

TABLE 7: RESPONSIVENESS TO INPATIENTS PERSONAL NEEDS

Inpatient Stay	The Royal Orthopaedic NHS Foundation Trust	England	Highest Trust	Lowest Trust
01/06/2003 to 31/08/2003	75.5	67.4	83.3	56.0
01/06/2005 to 31/08/2005	75.9	68.2	82.6	55.8
01/06/2006 to 31/08/2006	71.6	67.0	84.0	55.1
01/06/2007 to 31/08/2007	76.4	66.0	83.1	54.6
01/06/2008 to 31/08/2008	75.8	67.1	83.4	56.9
01/06/2009 to 31/08/2009	78.3	66.7	81.9	58.3
01/06/2010 to 31/08/2010	78.0	67.3	82.6	56.7
01/06/2011 to 31/08/2011	78.1	67.4	85.0	56.5
01/06/2012 to 31/08/2012	79.5	68.1	84.4	57.4
01/06/2013 to 31/08/2013	78.9	68.7	84.2	54.4
01/06/2014 to 31/08/2014	77.0	68.9	86.1	59.1
01/07/2015 to 31/07/2015	79.6	69.6	86.2	58.9
01/07/2016 to 31/07/2016	80.2	68.1	85.2	60.0
01/07/2017 to 31/07/2017	81.8	68.6	85.0	60.5
01/07/2018 to 31/07/2018	80.5	67.2	85.0	58.9

Data source: Informatics

2.6.5 FINDINGS FROM THE STAFF SURVEY/STAFF FRIENDS AND FAMILY TEST 2019/20

This section presents the findings from the 2019 annual NHS Staff Survey and the Staff Friends and Family Test.

NHS STAFF SURVEY (NSS)

Each year The Royal Orthopaedic Hospital NHS Foundation Trust participates in the annual NHS Staff Survey and staff who are employed by or under contract to the Trust are asked to complete the survey. The findings are shared with staff members through communication channels and team meetings as well as the range of management meetings including Executive Directors, Trust Board and other committees. Managers are also given departmental information (where numbers of responses allow) and this detail is used in ongoing staff Performance Development reviews (PDRs) and to support the Business Planning process.

In 2019, 1014 staff were asked to take part in the National Staff Survey with 51% (n=524) of staff responded using a mix mode of online and paper copy completions. The Trust is in the benchmarking group with 14 other Specialist Acute Trusts

The overall staff engagement score in the NHS Staff Survey saw another improvement from 7.4 to 7.6 (7.1 in 2018).

In addition, question 21d 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' increased from 90.7% to 92.4%.

Question 21c 'I would recommend my organisation as a place to work' saw an improvement from 72.9% to 77.2%.

STAFF FRIENDS AND FAMILY TEST (FFT)

The Royal Orthopaedic Hospital NHS Foundation Trust also takes part in Staff Friends and Family Test (FFT) which asks the question 'How likely are you to recommend The Royal Orthopaedic Hospital

NHS Foundation Trust as a place to work?' All staff are invited once a year to take part with survey being run three times a year in Quarter 1 (May), 2 (July) and 4 (February).

In 2019/20, 275 staff members responded to the survey across the three quarters using a mixed mode of online and paper copy completions. The completion rate was higher than 2018/19 with 235 respondents.

The completion rates for each quarter are:

Quarter	Completion rate 2019	Completion rate 20 18
1	24% (=)	24%
2	25% (+)	26%
4	27% (-)	23%

In 2019/20, overall there was a slight improvement in staff saying they would 'recommend the Trust to friends and family if they needed care or treatment.

Quarter	Recommend for treatment 2019	Recommend for treatment 2018
1	95.0% (-)	96%
2	94.4% (-)	96%
4	96.6% (+)	93%

There was also an overall percentage increase in Staff who said that they would 'recommend the Trust to friends and family as a place to work'.

Quarter	Recommend as place to work 2019	Recommend as place to work 2018
1	73.7% (-)	81%
2	74.4% (+)	73%
4	81.1% (+)	70%

ACCOMPLISHMENT

The Trust is encouraged by the positive scores Christian, is this still the correct wording as some scores have declined and The Royal Orthopaedic Hospital NHS Foundation The Trust considers that this data is as described for the following reasons;

- The Trust has continued to make positive progress with patient outcomes
- The Trust has increased its focus on performance management across all teams.
- The Trust has received positive feedback from the latest CQC inspection and report
- The Trust was shortlisted for a HSJ award in 2019 for Acute or Specialist Trust of the Year.
- The Trust continues to look for ways to improve the RTT target for the Trust which has been seen as positive with staff and patients.
- The Health and Wellbeing approach is now well embedded in the Trust with additional dedicated resource since November 2019.
- The Trust runs regular Inclusion and Wellbeing events to support staff members, patients and visitors. These include Equality and Diversity and Disability Network meetings
- The Trust has undertaken expansion plans in Theatres and wards to increase capacity and secure the future of the Trust.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the response to the annual NHS Staff Survey indicator, and the Staff Friends and Family Test results, and so the quality of its services, by;

- Continue to ensure facilities are of a high standard for staff and patients
- Continue to embed a culture of continuous improvement through QSIR (quality) training
- Continue to embed a coaching style of leadership and management supported by a programmes such as the accredited Management Skills programme (MSP)
- Further improve staff communication with improvements to all staff briefings providing greater opportunity for staff feedback, enhancing the perceived value of the staff voice.
- Incorporate staff survey information into the business planning process (started in 2019)
- Continue to implement the staff wellbeing approach and actions
- Achieve the **Thrive at Work** Bronze level through accredited by West Midlands Combined Authority (WMCA).

- Inclusion Group to develop and lead on Trust Agenda for greater inclusion.

2.6.6 VENOUS THROMBOEMBOLISM (VTE)

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

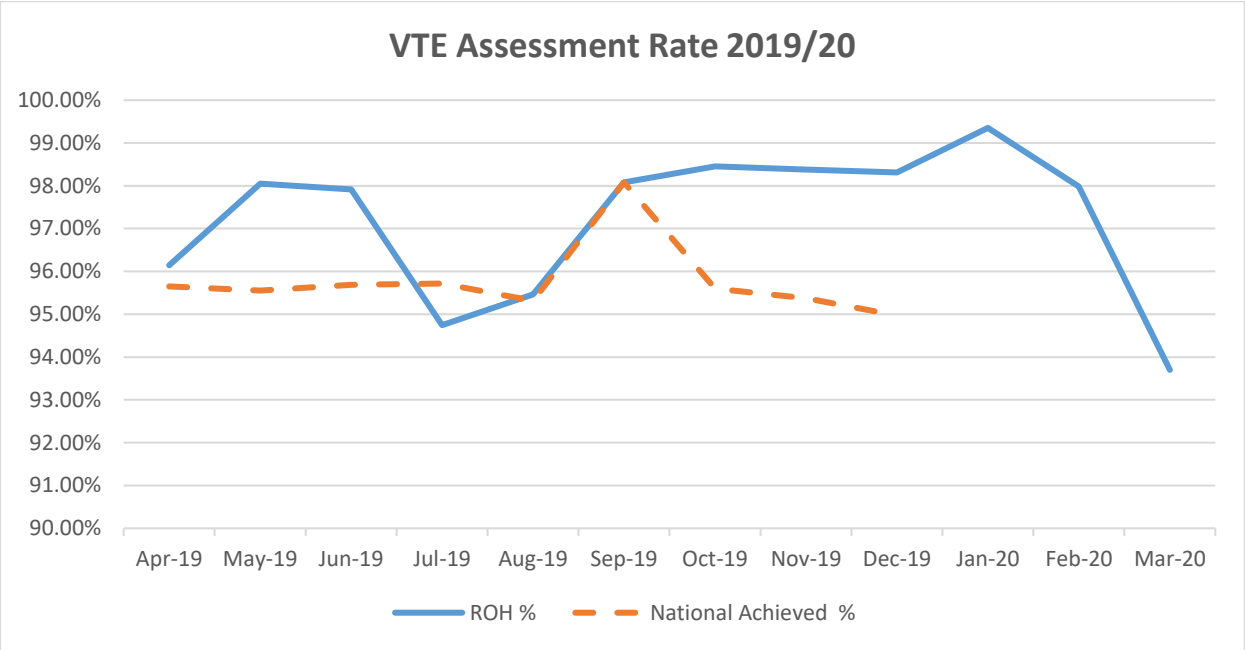
- Monitoring and compliance against the national standard continues and is reported monthly to ensure that >95% of all patients admitted to the Trust are risk assessed for VTE.

TABLE 8: VTE RISK ASSESSMENTS BY MONTH 2019/20

Month	No. Assessed	No. Admitted	ROH %	National Achieved %
Apr-19	898	934	96.15%	95.65%
May-19	955	974	98.05%	95.55%
Jun-19	986	1007	97.91%	95.69%
Jul-19	1064	1123	94.75%	95.72%
Aug-19	884	926	95.46%	95.31%
Sep-19	1074	1095	98.08%	98.08%
Oct-19	1212	1231	98.46%	95.60%
Nov-19	1095	1113	98.38%	95.37%
Dec-19	988	1005	98.31%	94.97%
Jan-20	1228	1236	99.35%	Not Published at Present
Feb-20	1216	1241	97.99%	Not Published at Present
Mar-20	833	889	93.70%	Not Published at Present

*Data source: Informatics

GRAPH 4: VTE RISK ASSESSMENT VS NATIONAL AVERAGE



The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromboembolism (VTE) on admission using the PICS electronic system.

2.6.7 CLOSTRIDIUM DIFFICILE INFECTION (CDI)

The Royal Orthopaedic NHS Foundation Trust considers that this data is as described for the following reasons; Clostridium Difficile infections are monitored and reported on a monthly basis, with Root Cause Analysis (RCA) conducted on every positive case.

The control of infection is of paramount importance for our patients; during 2019/20, there have been zero cases of CDI.

The Trust is compliant with Department of Health Guidance against which CDI is reported and is subject to the external scrutiny of its data for audit purposes.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to maintain this indicator, and so improve the quality of its services:

- Maintain our focus on the application and implementation of infection prevention and control principles to ensure that they are embedded in daily practice.

- Staff training and awareness in understanding the WHO 5 Moments hand hygiene principles will continue, and we will ensure application of the principles of bare below the elbow.
- Continue with bespoke Ward and Department level training.
- We will continue to maximise the effectiveness of ward rounds and ensure that best practice is upheld in respect of the antimicrobial strategy.
- Support environmental cleaning processes to minimise the risk of potential cross contamination.
- Continue to carry out enhanced cleaning with Chlorclean throughout Wards and Departments in autumn and winter.
- We will continue to monitor appropriate isolation room utilisation in order to maintain safety and facilitate effect bed flow.

2.6.8 PATIENT SAFETY INCIDENTS

The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

TABLE 9: PATIENT SAFETY INCIDENT DATA

	Number of Patient safety Incidents reported*	Number of patient Safety Incidents with Severe harm/ death*	% of patient safety incidences that resulted in severe harm/ death	The rate of Patient safety Incident per 1000 bed days (NB this indicator changed in 2014/15 from the rate of incidences per 100 admissions**	National Rate (Best)	National Rate (Worse)
2019/20	2953	4	0.14%	49.24	18.7	107.0
2018/19	2202	1	0.20%	75.9	26.3	184
2017/18	1530	7	0.5%	45.38	19.1	142.0

*Source – Ulysses Incident System
**Source – NRLS

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

- 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 Trust categorises incidence from no harm to severe harm and uses the definitions provided by the National Reporting and Learning System (NRLS) and the Duty of Candour Regulation 20 to categorise the level of harm.
- All reported incidents are subject to review by a member of the governance team at the Royal Orthopaedic Hospital NHS Foundation Trust who will seek clarity on the level of harm at the weekly Divisional Governance meetings from clinical staff where necessary and amend the initial categorisation if required.
- The Trust actively promotes a culture of incident reporting so that issues can be identified, actions initiated and lessons learned.

The Royal Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve the number of incidents reported and so the quality of its services by ensuring learning from incidences is shared and embedded across the Trust, by;

- Trust wide information relating to patient safety and patient experience activity is contained within the Trust Quality report that is presented monthly at the Clinical Quality Group and Quality and Safety Committee.
- Improvement work on the Ulysses system that will allow better triangulation of data between complaints and patient safety incidents.
- The Trust weekly Divisional Governance meetings that include any incidents that are graded by the reporter as moderate harm or above, any complaints and local and divisional risks.
- A review of the way actions from incidents are tracked and shared across the Trust, including the development of action trackers that are used to monitor progress and provide oversight at Divisional Governance meetings.
- Actively encourage the reporting of incidents by reviewing our feedback mechanism through our incident reporting system, Ulysses.
- Final Root Cause Analysis reports are anonymised and sent to all clinicians, these are discussed at local level and at Trust wide forums.
- Continue to deliver Root Cause Analysis Training to members of staff who undertake investigations.
- Both the CCG and CQC reviewed the governance processes for reporting and investigating incidents – both found no issues and described the improvements in Duty of Candour, Serious Incidents, Internal Root Cause Analysis, Learning from Deaths process and Governance Structure.

PART 3

3.0 REVIEW OF QUALITY PERFORMANCE 2019/20

3.1 REVIEW OF QUALITY PRIORITIES 2019/20

The Trust's 2018/19 Quality Account set out six priorities for improvement during 2019/20; these were confirmed following consideration of performance in relation to patient safety, patient experience and effectiveness of care:

- Priority 1: Reduce the number of incidents of consent on the day, improving the quality of consent.
- Priority 2: Ensure that no more than 5% of clinical and corporate policies are beyond their review date at any period in time and have an appropriate audit plan
- Priority 3: Reduce the number of times patients Outpatient clinic appointments are rescheduled.
- Priority 4: Staggered admission times for all patients attending ADCU, including those attending for diagnostics.
- Priority 5: Improvement in acute pain management.
- Priority 6: Embedding learning and improvements made relating to sepsis.

The quality improvement priorities have been part of the Clinical Quality Group work plan and have been individually scrutinised within the Clinical Quality Group chaired by the Deputy Director of Nursing and Clinical Governance. The Clinical Quality Group took the decision based on delivery and ongoing scrutiny within a governance forum within the Trust to close four of the six priorities. This decision was supported by the Trust's Quality and Safety Committee.

Table 10 below provides a summary of the Trust's progress in the quality improvement priorities during 2019/20;

TABLE 10: ACHIEVEMENT OF QUALITY PRIORITIES 2019/20.

Priority 1: Reduce the number of incidents of consent on the day, improving the quality of consent.	This priority has been achieved. Review completed of consent policy Agreed consent KPI's Consent form reviewed Consent audit completed, registered and reporting to Quality and Safety Committee.
Priority 2: Ensure that no more than 5% of clinical and corporate policies are beyond their review date at any period in time and have an appropriate audit plan	To be carried forward to 2020/21 as a Quality Priority Was previously rolled over from 2018/19 with additional actions. Review of policies undertaken with review dates and authors/executive leads has been completed, alongside appropriate allocation and review by groups and committees. Allocate Assure Policy Module to be utilised to support regular review and notification to authors around policy maintenance (due from March 2020, held back due to Level 4 emergency), reporting of policy metrics to appropriate forums (SG, IPCC, CYP, CQG, Execs, DTC). Partially successful with initiatives completed but greater compliance needed by allocated authors, Allocate Module being introduced this month and expected to contribute to better compliance. New Initiatives: Divisional Lead (Stuart Lovack) to support policy authors to review/complete policies using Div 4 Estates Board meetings to review outstanding policies. Reporting from Allocate Policy Module into relevant groups and committees. Timetable to be created with RAG rating to schedule and review policies currently outstanding.
Priority 3: Reduce the number of times patients Outpatient clinic appointments are rescheduled.	To be carried forward to 2020/21 as a Quality Priority The appointments team are now using the Top Desk system to authorise and process requests for clinic reduction or cancellations. This ensures that all clinic requests are seen and authorised by the operational management team. There is to be an additional level of authorisation added shortly for any request under 6 weeks and this will be at deputy Chief Operating Officer of Associate Medical Director Level. Further strengthening the process. There is also now escalation from the appointments team if patients are being rescheduled more than twice or beyond 36 weeks on a ticking RTT clock. This escalation goes to the Clinical Service and Clinical Service Support manager who are asked for instructions where to book these patients and to arrange additional capacity if needed In order to try and ensure patients are being chronologically booked and to avoid patients being rescheduled the Trust is introducing a partial booking process. Patients will only be booked 6 weeks in advance and therefore will not need to be moved due to consultant / clinician leave. This has been

	implemented in Pain Management, Back Pain, Spinal Degeneration and Deformity, and Young Adult Hips for new patients. There is an implementation and evaluation group set up, as part of the wider outpatient modernisation project, that is overseeing this. Currently there is an evaluation of resource requirements currently being carried out after which there will be a plan to roll this out across all specialties and eventually for follow up patients. There has been a reduction in rescheduling and improvement in chronological booking in the specialties live so far. DNA rates have also been reduced by the introduction of the interactive text messaging system, DrDoctor. Making it easier for patients to reschedule appointments means that capacity is reused for other patients and it also reduced the number of Was Not Brought appointments. Partially completed with more progress to be made on using partial booking in more specialities. Where utilised thus far very successful. New Initiatives: To continue rollout of Partial Booking to all specialities and follow up appointments.
Priority 4: Staggered admission times for all patients attending ADCU, including those attending for diagnostics.	This priority has been achieved. Waiting times between arriving into ADCU and being sent into theatres – data collected and reviewed. Previously no diagnostic lists were being staggered in CT, 3 out of 4 lists now use a two-admission time approach to ensure not all patients are arriving at the same time. Individual meetings held with clinical service managers, encouraging them to review individual speciality booking rules with the view of reducing waiting times for patients. PALS have been unable to provide specific data in relation to PALS complaints and waiting times, however through ADCU there has been a reduction in the number of complaints seen. All Theatre lists are using staggering admission times – reviewed and monitored via 642. A monthly dash board broken down by speciality showing average wait times for patients is shared via joint divisional ops meeting – this will remain as an ongoing agenda item. To date CT patients on average waiting time has reduced by 7%, however it is likely this figure will only increase, as staggered admissions were only implemented in December. Overall there has been a reduction in the average waiting times for patients going to theatre from ADCU (excludes CT) by 3% below is all of the averages broken down by speciality:

	2018/19			2019/20				
Team	Average Mins	No of Patients	10% Reduction Target (Mins)	Average Mins	No of Patients	10% Reduction Target (Mins)	Average Mins Variation 18/19 - 19/20	% Increase /Decrease 18/19 - 19/20
Large Joints	198.3	3923	19.83	198.6	4077	19.86	0.3	0.17%
Oncology/Histopathology	252.7	1338	25.27	241.7	1071	24.17	-11.0	-4.35%
Paediatrics	232.4	73	23.24	198.5	75	19.85	-33.9	-14.58%
Small Joints	200.4	1515	20.04	187.3	1455	18.73	-13.1	-7.02%
Spinal	233.8	788	23.38	238.8	639	23.88	5.0	2.09%
Grand Total	**212.2**	**7637**	**21.22**	**206.2**	**7317**	**20.62**	**-6.1**	**-2.94%**

	All initiatives completed or on track to complete shortly.
Priority 5: Improvement in acute pain management.	This priority has been achieved. Acute Pain Guidelines now drafted and awaiting ratification at Drugs and Therapeutics Committee, providing a Trust approved and agreed analgesic ladder for prescribers. Phase 2 PICS incorporates a range of pain tools to support management and monitoring of pain scores. Audit completed of Jointcare dataset. PgCert level education on pain management commissioned for Rapid Response Team (RRT). Senior Sisters completed work with nursing staff to adjust response/urgency of staff to managing pain as a medical emergency. Patient Education Literature provided to patients explaining analgesia available and our expectations for their pain management. Pain is no longer a theme noted in complaints and PALS concerns.
Priority 6: Embedding learning and improvements made relating to sepsis.	This priority has been achieved. Review and Launch of Adult Deteriorating Patient Policy, NEWS2 training and sepsis training completed for medical and nursing staff, KPI's agreed and reporting into Sepsis Group (and now resuscitation group), Incident Reporting reviewed quarterly at Quality and Safety Group.

3.1.1 PATIENT EXPERIENCE – COMPLAINTS AND PALS

During 2019/20, the Trust has received 142 formal complaints. This is a 3.5% increase compared with 2018/19. This year, the Trust has continued to strive to improve the service offered to patients to resolve their concerns at the most appropriate level. This ensures that we continue to adhere to all of the recommendations of the Clywd/Hart Review (2013) and Francis (2013) report.

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

- Getting it right
- Being customer focused
- Being open and accountable

- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

TABLE 11: NUMBER OF COMPLAINTS AND PALS CONTACTS 2018-2019

	PALS	COMPLAINTS
2015/2016	**1094**	**113**
2016/2017	**4136**	**170**
2017/2018	**5094**	**148**
2018/2019	**1531**	**137**
2019/2020	**770**	**142**

*Data source: Complaints department

Top three categories for Complaints through 2019/20 were:

- Appointments, including delay failure to provide, letter not issues, cancellation and booked incorrectly.
- Waiting for surgery date, including waiting times for surgery.
- Complications during surgery

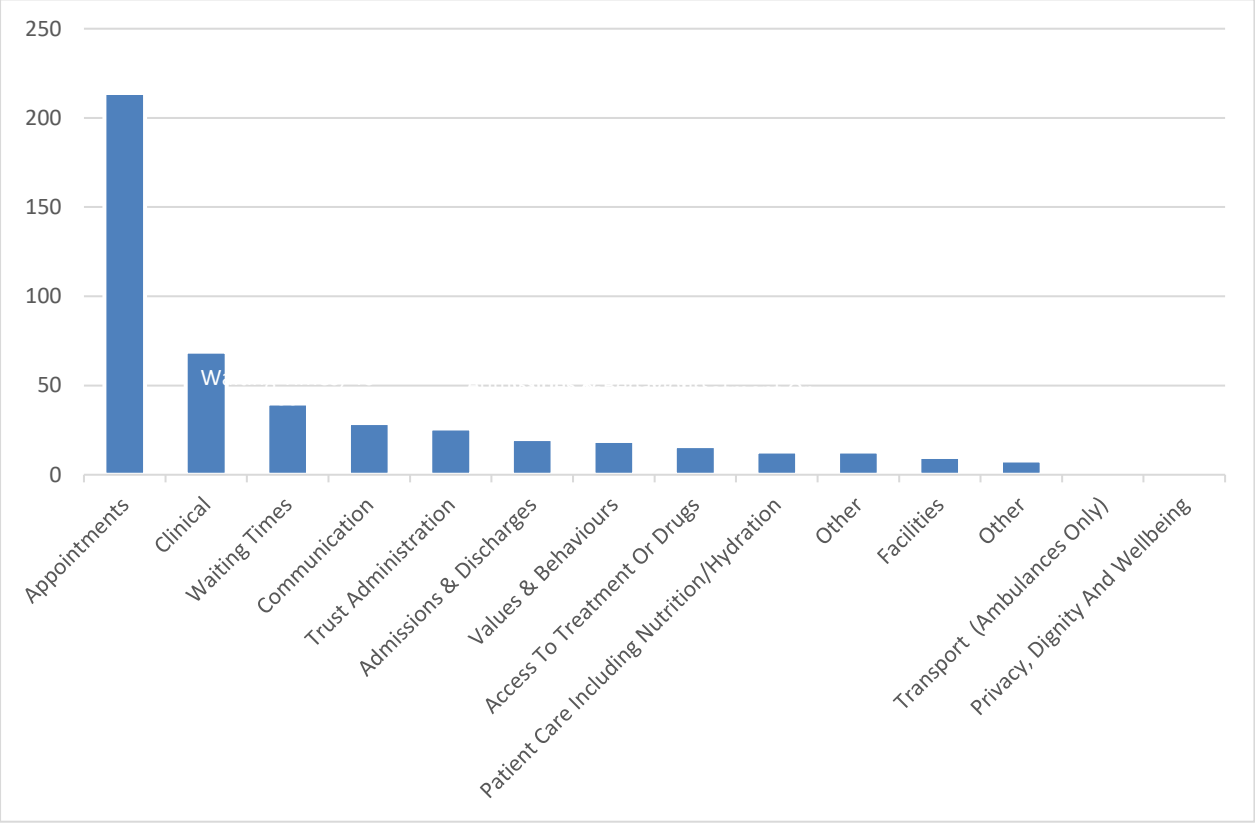
Where actions have been identified as specific to a complaint, an individual action plan is created, which is monitored though the Divisional Governance structure. Complainants are informed of the completion of these actions. All complainants are offered the opportunity to provide feedback on the outcome of the process.

The PALS department has continued to deliver a responsive PALS service through 2019/20, with a focus on providing support where concerns are identified. 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. During the year, the coding of the PALS concerns was aligned to complaints to allow comparison and to identify trends. Any trends identified are also compared to other sources of patient data and discussed at Divisional Governance meetings and wider forums where appropriate.

The PALS department has handled 770 individual contacts in the last twelve months, which has greatly reduced as planned from last year (due to a full year effect of removing the telephone number from general correspondence), 67% of PALS calls this year where concerns that required more assistance, compared with 41% the previous year.

TABLE 12: PALS CONCERNS BY TREND 2019/20



*Data source: Complaints department

The top 3 categories for PALS contacts continue to be Appointment Queries, Clinical Queries and waiting times respectively with a detailed breakdown of activity shown in table 12 above.

3.1.2 FRIENDS AND FAMILY TEST

The Friends and Family Test (FFT) is the mandated patient tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The Friends and Family question is a single question with a choice of answers used across the NHS to establish whether patients and service users are happy with the standard of care that they receive. Patients who indicate that they are extremely likely or likely to recommend the service they have used are considered to have provided positive feedback. Similarly, patients who indicate that they are unlikely or extremely unlikely to recommend the service they have used are considered to have provided negative feedback. Any neither likely nor unlikely or don't know feedback is considered neutral.

NHS England set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for out-patient and community services.

In 2019/20, we have continued to work with an external provider called 'I Want Great Care' to support our delivery of the Friends and Family test. The Trust has received 6420 individual pieces of feedback from the Friends and Family Test in the last year across all areas and departments. Compliments from these are also now recorded and shared with individuals and teams. The Trust has maintained a 96.1% positive score meaning that 6169 times, patients have indicated that they are happy with and would recommend the care that they have received here in the last twelve months.

TABLE 13: 2018/19 FRIENDS AND FAMILY TEST

Service	Number of individual feedback forms received		% of positive reviews		% of negative reviews	
	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20
Adult Inpatient Services	1761	1202	95.7	96.7	1.1	0.7
Adult Outpatient Services	9151	3879	97.3	97.1	0.54	0.9
Community Services	436	270	98.4	96.9	0.23	0.7
Children and Young People Outpatient Services	1065	402	88.9	85.1	1.5	1.3

*Data source: Iwantgreatcare

3.1.3 TRUST QUALITY METRICS

The Royal Orthopaedic Hospital NHS Foundation Trust's integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Foundation Trust. The report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

The data is validated by the relevant Trust Leads and the Governance Department.

The Trust's Quality Report is produced monthly and presented at the Clinical Quality Group and for assurance at the Quality and Safety Committee.

Table 14 below outlines the key quality metrics; a sustained or significant improvement has been demonstrated across all the quality metrics in 2019/20

TABLE 14: TRUST QUALITY METRICS 18/19 AND 19/20

QUALITY METRIC	NUMBER OF 18/19	NUMBER OF 19/20
Pressure Ulcers – Category 3 Avoidable	2	1
Pressure Ulcers – Category 2 Avoidable	7	7
Patient Falls All harms	88	93
VTE Avoidable	4	3
VTE Serious Incidents	4 (Avoidable)	3(Avoidable)
Never Events	0	3
Serious Incidents Non VTE Related	9	7
MRSA	0	0
Clostridium Difficile Infection (CDI) Avoidable	0	0

*Data source: Ulysses Incident Reporting System

Developments within the Tissue Viability service:

- The Tissue Viability team are now part of the Documentation Task and Finish Group; a review of the associated nursing documentation took place in October 2019
- Following 2 incidents and subsequent investigations and action plans the Plaster cast and Epidural care plan has been amended
- The patient information leaflet regarding pressure ulcer prevention has been amended
- The 'React to Red' Skin Strategy has been enhanced and #itsmorethanabruise strategy using apples as a teaching tool has been introduced
- Wound management guidelines, and a review of wound dressings was amended
- NHSI 2018 Recommendation Pressure Ulcers: Revised Definition and Measurement fully implemented
- Core Competencies for registered nurses amended to align with National guidance and recommendations

- Tissue Viability Lead Nurse elected chairperson of the West Midlands Tissue Viability Nurses Association.
- All HCA's are to undertake formal skin assessment and First Aid dressings competency
- Pressure Ulcer Policy amended to align with National guidance and recommendations
- Negative Pressure Wound Therapy (NPWT) guidelines update to include a flowchart agreed by all Consultants to sign post appropriate incisional/negative wound care therapy
- Enhanced training for NPWT – increasing awareness re application, management, removal and maintaining patient safety whilst maintaining patient safety
- Closer liaison and working with Plastics service
- Closer working clinically and from a Procurement perspective with UHB
- Complex COW rounds on Ward 3 have been audited, the results recognised the need for specialist TV input who are now involved, and all patients' wounds are now reviewed on an individual basis
- There is a published referral guidance to TV team
- All wards now stock negative pressure therapy and formulary approved dressings
- Increase partnership and closer working with ROCS and BIS
- Integral members of the task and finish group to formalise the process around the wound care help line in order to develop an approved process. This ensures patient safety as staff can follow a flow chart to ensure patients are seen if needed in a timely manner

Developments in the prevention and management of falls:

- Falls training reviewed and reinstated into the Clinical update day in 2018.
- Falls documentation and risk assessments reviewed; including implementation of a document to support medical staff in post fall management.
- Benchmarking against the West Midlands Quality Review Service (WMQRS) for falls has been undertaken, and gaps in compliance addressed.

- Falls and Dementia Groups have amalgamated to form a vulnerable patient group to strengthen both groups and work to represent and change the experience for what is largely a single patient group.

Developments in the prevention and management of VTE:

- The Trust was awarded as a VTE exemplar site and a member of the National VTE Exemplar Centre Network in May 2018. The Trust continues to work closely with the Network to ensure the prevention and management of VTE's at ROH is in line with best and evidence based practice
- Mandated electronic VTE risk assessment through our prescribing system (PICS) is now embedded; We have consistently exceeded the minimum 95% risk assessment on admission requirement compliance.
- ROH VTE prevention guidelines were reviewed and updated to take into consideration the VTE NICE guidance released in March 2018 and August 2019.
- VTE awareness training both face to face and e-learning continues to be delivered to nursing and medical new starters
- The Trust signed up to the Getting it Right First Time (GIRFT) VTE survey launched in October 2019 (currently this is on hold due to COVID with a restart date yet to be established).

3.1.4 INVOLVEMENT, EXPERIENCE AND VOLUNTEERING STRATEGY

The Royal Orthopaedic Hospital NHS Foundation Trust has made significant progress in 2019/20 in formulating a patient experience strategy to provide a vision and ambition, ensuring we involve patients and their families, and use their feedback to ensure change, service improvements and redesign of pathways.

The strategy articulates our vision for the development of effective involvement strategies for patients, carers, families, partners and volunteers over the next three years (2019-2022).

Our aim is to develop a truly inclusive culture where patients become partners not only in their care, but in the development of services, pathways and facilities, with our ultimate aim being to further enhance and ensure a positive experience.

The strategy has been developed by:

- Guidance documents and requirements that as a NHS organisation we must consider and fulfil.
- The views and ideas from volunteers, patients and the public following an engagement event held in December 2018, seeking to understand 'what matters to them'.
- Our Patient and Carer Forum.
- Gaining the views from and involving our staff with consultation on the draft document.
- Undertaking and incorporating the findings from the NHS Improvement (2018) Patient Experience Improvement Self-assessment Tool
- Undertaking and incorporating the findings from Healthwatch Birmingham's Quality Standards for Public and Patient Involvement tool; with regular meetings with Healthwatch and their consultation of the draft document.
- JointCare patient engagement sessions providing feedback as to patient experience within one of our largest patient groups (joint replacement).
- Newly created Patient Engagement and Experience Group (PEEG) to connect the Patient and Carers Forum with hospital management teams to note and action changes agreed.

3.1.5 MENTAL HEALTH IMPROVEMENTS

Following the Trust's CQC inspection and subsequent report in May 2018, which identified that staff did not feel confident to care and support patients with mental health needs; a significant amount of improvement works have been carried out to rectify this. The Trust identified a lead to take this work forward and they have worked closely with our local mental health provider.

During 2019/20, the following improvements and actions have been implemented:

- Two Mental Health First Aid trainers who have completed accredited Mental Health First Aid training by Mental Health First Aid England.
- The Trust now has 112 staff members who have received Mental Health First Aid training, with further training sessions planned.
- A roll out of Tier 1 Mental Health awareness training for all staff as part of the Trust's Mandatory training day commenced in August 2019
- A review of the Trust's Service Level Agreement (SLA) with our local mental health provider to ensure it fulfils the needs of the Trust has been completed.
- A mental health intranet page and resource folders have been designed and launched, detailing common mental health conditions, signs and symptoms, specific care plans and risk assessments and information to signpost staff.
- Updated and relevant referral pathways for mental health support.
- Trust mental health boards, displayed in all wards and departments offering information for both staff and patients.
- Established 'working group' for Mental Health which meets quarterly
- Incident reporting, notification form and database set up to capture patient Mental Health issues.
- Staff contact form rolled out for Mental Health First Aiders to complete when they have provided Mental Health support to colleagues.

- Task and finish group established to review Mental Health provision on site for under 18-year olds.
- Business case submitted for training of 2 accredited youth Mental health First Aid Trainers submitted.

Posters for Children and young person's mental health displayed in all wards and departments offering information for both staff and patients.

3.1.6 ENGAGEMENT AND LEARNING FROM SERIOUS INCIDENTS

The Governance structure and processes have been strongly embedded within the Trust around serious incidents and complaints, with evidence of learning from incidents within the investigation reports. In the latest CQC inspection the CQC commented that the Trust had made improvements in the learning from incidents; The CQC found that the Trust managed safety incidents well and learned lessons from them. The CQC also described how;

- Staff recognised and reported incidents and near misses.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Managers ensured that actions from patient safety alerts were implemented and monitored.
- Patients and their families were included in the process.

The Trust in 2019/20 has had a reduction in serious incidents and has met most of the Clinical Commissioning Group key performance indicators. The Trust's most recent staff survey results relating to 'Safety Culture' has seen a positive increase (statistically significant) in all patient safety metrics. These metrics have increased in the previous 3 years.

3.2 COMPLIANCE WITH NATIONAL TARGETS AND REGULATORY REQUIREMENTS 2018/19

3.2.1 REFERRAL TO TREATMENT (RTT)

The Trust has been reviewed its demand and capacity, and patient tracking list management processes, to move the Trust's 18 week referral to treatment (RTT) position towards 92%. New key performance indicators have been developed which are monitored at weekly meetings in order to give full assurance that all inpatient and outpatient waiting lists are being actively managed, to reduce the number of patients over 18 and 52 weeks.

A major achievement of the Trust has been the total removal of all 52 week waits with no patients waiting over 52 weeks from March 2019, which in October 2017 was over 100 patients. Not only has this been achieved but the number of patients over 18 weeks has been significantly reduced with seven out of the thirteen specialities within the Trust achieving 92%.

The proactive management and tracking of all patients coupled with transformation of patient pathways has enabled this sustained achievement in access and performance to deliver an improved patient experience.

Table 15 below illustrates how the Trust has performed in 2019/20 against the national target of 92%.

TABLE 15: 18 WEEK REFFERAL TO TREATMENT 2019/20

TABLE 15: 18 WEEK REFFERAL TO TREATMENT 2019/20

18-Week Incomplete	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Waiting Under 18 Weeks	8047	8296	8015	7707	7436	7456	7585	7451	7452	7376	7169	5896
Waiting Over 18 Weeks	1092	1034	1063	1034	1279	1416	1579	1420	1398	1477	1379	1543
Total	9139	9330	9078	8741	8715	8872	9164	8871	8850	8853	8548	7439
% Waiting Under 18 Weeks	88.05%	88.92%	88.29%	88.17%	85.32%	84.04%	82.77%	83.99%	84.20%	83.32%	83.87%	79.26%
Longest Wait in Days	330	323	348	295	306	329	332	330	323	339	334	333
Longest Wait in Weeks	47	46	49	42	43	46	47	47	46	48	47	47
Average Days Wait	68.23	68.37	69.93	68.05	73.68	74.52	74.79	73.23	75.64	74.78	72.4	84.7
Average Weeks Wait	9.09	9.30	9.42	9.14	10.08	9.95	10.16	10.02	10.17	10.20	9.9	11.4

*Data source: Informatics

TABLE 16: 18 WEEK REFERRAL TO TREATMENT 2018/19 (COMPARISON)

TABLE 16: 18 WEEK REFERRAL TO TREATMENT 2018/19 (COMPARISON)

18-Week Incomplete	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Waiting Under 18 Weeks	6898	7097	7274	7495	7666	7727	7608	7426	7296	7552	7586	7903
Waiting Over 18 Weeks	1398	1314	1362	1277	1325	1331	1223	1086	1080	1186	1157	1146
Total	8296	8411	8636	8772	8991	9058	8831	8512	8376	8738	8743	9049
% Waiting Under 18 Weeks	83.15%	84.38%	84.23%	85.44%	85.26%	85.31%	86.15%	87.24%	87.11%	86.43%	86.77%	87.34%
Longest Wait in Days	895	926	956	733	764	549	527	556	567	518	399	344
Longest Wait in Weeks	127	132	136	104	109	78	75	79	80	73	56	49
Average Days Wait	75.9	75.7	74.7	72.0	72.2	73.1	69.7	68.3	73.6	70.4	67.9	67.4
Average Weeks Wait	10.1	10.3	10.2	9.6	9.8	9.9	9.4	9.3	9.8	9.5	9.2	9.1

*Data source: Informatics

TABLE 17: 52 WEEK WAITS 2019/20

TABLE 17: 52 WEEK WAITS 2019/20

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
52 Week Waiters	0	0	0	0	0	0	0	0	0	0	0	0

*Data source: Informatics

TABLE 18: 52 WEEK WAITS 2018/19 (COMPARISON)

TABLE 18: 52 WEEK WAITS 2018/98 (COMPARISON)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
52 Week Waiters	46	55	61	47	27	20	13	14	11	5	2	0

*Data source: Informatics

3.2.2 62 DAY CANCER TREATMENT TARGETS

The Trust is one of only five specialist bone sarcoma centres in the United Kingdom and often has referrals from a wide geographical spread. Some of the patients have been referred to us after a prolonged pathway which makes treatment within 62 days challenging. However, since autumn of 2018, new processes and more stringent tracking of patients to progress them effectively through their pathway has seen improved cancer performance. Individual timelines for any cancer breach are prepared and discussed at the Cancer Board, chaired by the Executive Medical Director and subsequently reviewed and discussed at Harm Review, chaired by the Deputy Medical Director, to see if any the patient has come to any form of harm and if lessons can be learned and changes in process adopted.

The Trust is also working on the new 28-day faster diagnosis standard (FDS), to ensure that the Oncology Service and our diagnostic partners are working collaboratively to improve results turnaround ready for April 2020 when this shadow target was to be officially monitored. However, this has not been implemented nationally, due to the Covid-19 outbreak.

TABLE 19: 62 DAY CANCER TREATMENT TARGETS 2019/20

Target Name	National Standard	Q1	Apr-19	May-19	Jun-19	Q2	Jul-19	Aug-19	Sep-19	Q3	Oct-19	Nov-19	Dec-19	Q4	Jan-20	Feb-20	Mar-20
62 day (traditional)	85%	80.8%	100%	72.7%	77.8%	93.8%	100.0%	100.0%	84.6%	72.2%	70.6%	66.7%	80.0%	66.7%	90.0%	20.0%	66.7%
Number in target		10.5	3	4	3.5	15	5	4.5	5.5	13	6	3	4	9	4.5	0.5	4
Number outside target		2.5	0	1.5	1	1	0	0	1	5	2.5	1.5	1	4.5	0.5	2	2

Data source: Somerset cancer registry (SCR) and National Cancer Waiting Times Database.

TABLE 20: 62 DAY CANCER TREATMENT TARGETS 2019/20 (COMPARSION)

Target Name	National Standard	Q1 (Apr, May, Jun)	Breach	Total	Q2 (Jul, Aug, Sep)	Breach	Total	Q3 (Oct, Nov, Dec)	Breach	Total	Q4 (Jan, Feb, Mar)	Breach	Total
2ww	93%	98.10%	3	159	96.40%	6	168	98.90%	2	179	98.40%	3	188
31 day first treatment	96%	94.30%	2	35	97.80%	1	46	100.00%	0	35	97.50%	1	40
31 day subsequent (surgery)	94%	100.00%	0	40	97.70%	1	44	100.00%	0	37	97.80%	1	45
62 day (traditional)	85%	80.80%	2.5	13	93.80%	1	16	72.20%	5	18	66.70%	4.5	13.5
62 day (Cons Upgrade)	n/a	97.10%	0.5	17	74.60%	8	31.5	100.00%	0	18	91.70%	2	24
31 day rare (test, ac leuk, child)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1			1			1			3		

*Data source: National Cancer Waiting Times Database and Somerset cancer registry (SCR)

3.2.3 6 WEEK WAIT – DIAGNOSTICS

Table 21 below illustrates how the Trust has performed in 2019/20 in relation to the diagnostic 6 week wait, against the national standard of 99%.

TABLE 21: DIAGNOSTIC 6 WEEK WAITS 2019/20

	ROH				National Position
Month	Over 6 Weeks	Under Six Weeks	Total	% Under Six Weeks	% Under Six Weeks
Apr-19	6	1322	1328	99.55%	96.42%
May-19	1	1230	1231	99.92%	95.92%
Jun-19	4	1341	1345	99.70%	96.24%
Jul-19	7	1220	1227	99.43%	96.48%
Aug-19	8	1260	1268	99.37%	95.69%
Sep-19	4	1406	1410	99.72%	96.21%
Oct-19	6	1566	1572	99.62%	96.92%
Nov-19	12	1562	1574	99.24%	97.06%
Dec-19	13	1346	1359	99.04%	95.83%
Jan-20	9	1419	1428	99.37%	95.58%
Feb-20	6	1580	1586	99.62%	97.24%
Mar-20	2	587	589	99.66%	Not published

*Data source: Informatics

TABLE 22: DIAGNOSTIC 6 WEEK WAITS 2018/19 (COMPARISON)

	ROH				National Position
Month	Over 6 Weeks	Under Six Weeks	Total	% Under Six Weeks	% Under Six Weeks
Apr-18	1569	8	1577	99.49%	97.53%
May-18	1487	1	1488	99.93%	97.28%
Jun-18	1250	5	1255	99.60%	97.13%
Jul-18	1164	8	1172	99.32%	97.17%
Aug-18	956	9	965	99.07%	96.94%
Sep-18	1102	4	1106	99.64%	97.33%
Oct-18	1240	7	1247	99.44%	97.67%
Nov-18	1236	7	1243	99.44%	97.60%
Dec-18	1140	11	1151	99.04%	96.71%
Jan-19	1256	3	1259	99.76%	96.41%
Feb-19	1339	3	1342	99.78%	97.70%
Mar-19	1364	1	1365	99.93%	97.53%

*Data source: Informatics

3.3 ADDITIONAL 2019/20 CONSIDERATIONS

3.3.1 SEVEN DAY HOSPITAL SERVICES

It is understood from NHS Improvement that the 7 day services work stream applies only to patients on an emergency pathway, and does not apply across elective services. Therefore, for The Royal Orthopaedic Hospital NHS Foundation Trust, the standard only applies to the spinal emergency service. On this basis, the tailored priorities set are:

• Daily ward rounds by a spinal surgeon.

• Availability of diagnostic services for emergency patients on a 24/7 basis - either in house or via a Service Level Agreement (SLA), including radiologist reporting to inform patient management.

• Availability of an emergency theatre 24/7.

• Availability of the wider Multi-Disciplinary Team (MDT) across the 7 day week where this is required.

3.3.2 RESPONSE TO THE GOSPORT INDEPENDENT PANEL REPORT – FREEDOM TO SPEAK UP

The Trust encourages to speak up over matters of patient safety, quality and issues of bullying and harassment.

A freedom to speak up Guardian is in post who is visible and accessible to all members of staff, be they clinical or non-clinical. The remit of the Freedom to Speak Up Guardian (the Guardian) is principally around patient safety concerns. The Guardian routes concerns raised through the Company Secretary who in turn decides which Executive Director should take responsibility for resolving the issue raised. The Guardian keeps those reporting concerns who do not wish to remain anonymous updated with progress with resolving the concerns and a confirmatory response is given to the individual via the Guardian that the matter has been investigated and closed where possible. Staff are able to access an ‘app’ via their personal mobile phones which also allows them to register

concerns if they do not wish to access the Guardian on a face to face basis. The Guardian meets with the Chief Executive on a routine basis and also reports to the Trust Quality and Safety Committee and Trust Board on at least an annual basis. A Non-Executive Director is assigned as the Freedom to Speak Up Board champion, with whom the Guardian meets regularly. The Trust has a corporate Freedom to Speak Up policy in place which signposts staff to the routes by which they can raise their concerns.

Staff wishing to raise an issue of bullying and harassment are encouraged to speak to their line manager in the first instance. If they do not feel this is an appropriate route then they may access the network of contact officers, who offer support to the individuals and suggest impartially a route to resolving the issues. The Human Resources department also supports staff wishing to raise a grievance or feel that they are experiencing bullying and harassment in the work place by guiding them through the appropriate corporate policies that the Trust has in place.

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 financial 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 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20.* 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 2019 to March 2020.
- Papers relating to quality reported to the board over the period April 2019 to March 2020.
- Feedback from governors dated 14th May 2020
- The 2019 national patient survey.
- The 2019 national staff survey.
- CQC inspection report dated November 2019.

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 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.

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

19 June 2020 Chairman

19 June 2020 Chief Executive