RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST QUALITY ACCOUNT 2020/21

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 2020/21.

The Trust also set its own quality priorities for 2020/21, as described in last year's Quality Accounts. Four of these have been fully achieved during the year:

- Reduce Patient Harms in the Trust – Falls.
- Improving Experience for Patients, Carers and Service Users (PCSU)
- Reduce the number of clinical and corporate policies that are beyond their review date at any period in time and have an appropriate audit plan
- Reduce the number of times patients Outpatient clinic appointments are rescheduled.

Progress has been made against the other priority, however as work is still ongoing and therefore has been rolled forwards and added into our 2021/22 quality priorities which are listed below, and described in more detail later in these Accounts:

- Patient wellbeing priority - Ensure that we care for the patients spiritual and pastoral needs whilst at the Royal Orthopaedic Hospital (2020/21 rolled over priority)
- Children's and Young Person priority – supporting the child or young person as patient, visitor or member of local community.

- Volunteer priority – support volunteers and managers to create new volunteer roles.
- Data and Digital inclusion priority – ensuring that our data on ethnicity is collected in a timely fashion and that we do not leave any section of the community behind whilst moving to a more digitally connected patient pathways.
- Surgical Site Infections priority – applying the onetogether UK pathway tool to support reduced risk of surgical site infections for ROH patients.

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. 93.41% of patients stating that they would recommend the hospital as a place to receive treatment, this has fallen from 96% in 2019 and needs to be considered in the context that many more patients were admitted to the hospital outside of an elective pathway than 2019. 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 recorded as 90% in the 2020 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.

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. Progress was impacted during 2020/21 year as the Trust, along with every other healthcare organisation in the country, was affected by the global Coronavirus pandemic and was required to change its model of care to be able to allow system partners the time and space to be able to treat those most affected by the virus. The forthcoming year will also see a focus on partnership working as the restoration and recovery plans are worked through to treat the backlog of patients who have been waiting for treatment. However, as the new Birmingham & Solihull

Integrated Care System matures the focus will again be on standardising pathways and creating excellent service provision across the region, a plan with which the ROH a key provider of care.

This is the second year of my tenure as Chair of the National Orthopaedic Alliance, a role which positions the ROH as lead player in the work to reduce variation in orthopaedic practice and set standards across the specialty.

A particular achievement this year has been the innovation that has been shown as the ROH adapted to the challenges of the pandemic, from the introduction of virtual outpatient clinics to the site adaptations that were implemented to keep our staff and patients safe and protected from the Covid infection. The JointCare 'Coffee Catch Up' sessions were also moved onto a virtual platform and despite the remote nature of these sessions, they continued to be enjoyed by all participating.

We entered 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

24 June 2021

ABOUT THE QUALITY ACCOUNT 2020/21

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 2021/22.
- Our progress against delivery of the Quality Priorities we outlined in 2020/21.
- 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.

Our patients benefit from a team of highly specialist clinicians, many of whom are nationally and internationally recognised for their expertise. Throughout 2020/21, the Trust has worked with partners across the region to respond to the coronavirus pandemic that started in March 2020. We look to continue working with our local partners under the Birmingham and Solihull Integrated Care System to continue improving elective orthopaedic services for patients across Birmingham & Solihull.

We are proud of the research and innovation led by teams at The Royal Orthopaedic Hospital NHS Foundation Trust, including continuing to expand the number of orthopaedic researchers we have across the Trust with continued investment in the research support infrastructure including the funding of research fellowships and trial manager posts. This alongside strengthened academia and commercial partnerships to deliver major grant funded research programmes led by ROH investigators utilising our new Regenerative Medicine research facility.

We are committed to updating our systems and processes so that we are able to offer the most efficient services to patients, and continued to see the expansion of the electronic prescribing and patient record system (PICS) in 2020/21.

In late 2020 we completed the expansion of facilities at the ROH with the Phase 2 implementation of the modular build complex of 4 state of the art theatres and inpatient ward which incorporates the lessons from the pandemic with additional side rooms and the provision of space for donning and doffing personal protective equipment (PPE).

As part of the Trust's ambition to become a centre of excellence. 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'.

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 and live without health inequalities.

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 2020/21.

The Trust's 2019/20 Quality Account set out seven priorities for improvement during 2020/21; these were confirmed following consideration of performance in relation to patient safety, patient experience and effectiveness of care:

- Priority 1: Reduce Patient Harms in the Trust – Falls.
- Priority 2: Improving Experience for Patients, Carers and Service Users (PCSU)
- Priority 3: Reduce the number of clinical and corporate policies that are beyond their review date at any period in time and have an appropriate audit plan
- Priority 4: Reduce the number of times patients Outpatient clinic appointments are rescheduled.
- Priority 5: Ensure that we care for the patients spiritual and pastoral needs whilst a patient at the Royal Orthopaedic Hospital.

The quality improvement priorities have been part of the Clinical Quality Group (CQG) 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 five priorities. This decision was supported by the Trust's Quality and Safety Committee and further accepted by the Audit Committee.

Table 1 over page provides a summary of the Trust's progress in the quality improvement priorities during 2020/21;

TABLE 1: ACHIEVEMENT OF QUALITY PRIORITIES 2020/21.

Priority 1: Reduce Patient Harms in the Trust – Falls.	This priority has been achieved, completed initiatives: • Trust Falls Assessment reviewed and updated. Falls assessment is now on PICS, this generates a falling man alert symbol if the risk of falls becomes apparent. If the patient has a falling man on PICS, nursing staff are now completing a new updated falls prevention care plan either on admission or following a fall. • Patient Information leaflets on falls and the use of bedrails have been reviewed and updated. • Deconditioning and PJ paralysis reviewed**,** training launched around PJ paralysis awareness. We are working with Birmingham City University on a pilot project and academic publication on education impact on the programme. Going forwards, training to be provided 4 x year on HCA induction/update days, training to be monitored. E-learning quiz to be circulated to departments to look at awareness/engagement. • Currently reviewing slips, trips and falls policy. • Thematic review of falls completed • New poster designed for departmental falls and dementia notice boards, aiming to improve consistency of information for staff
Priority 2: Improving Experience for Patients, Carers and Service Users (PCSU)	This priority has been achieved, completed initiatives: • Complaints KPIs are now complainant with NHS Regulatory requirements • Effective Complaints and Comeback Complaints Tracker present and monitored at Executive Level. • Patient Engagement and Experience Group have continued to meet throughout 2020, but the discussion has been limited by the lack of a sitting Patient and Carers Forum. Work is underway to refresh and grow forums (2021/21 priority). • The Patient Experience Strategy remains in place and is being worked through. • Patient Complaints and Concerns are now reported by theme, and feedback is given in weekly meetings with the Divisional Head of Nursing and Operational Managers. • Complaints now have action plans, and they are tracked to completion via Divisional governance (all 2018/19 and 19/20 actions are completed). • The complaints procedure has been reviewed in the last 12 months (last in October 2020). • Reviewing Patient and Carers Forum – we have contacted the current members/potential new members and are scoping the potential to restart via virtual conferencing. • Healthwatch/Heads of Patient Experience Network (HoPE) networking provides greater external collaboration and idea-sharing opportunities

Priority 3: Reduce the number of clinical and corporate policies that are beyond their review date at any period in time and have an appropriate audit plan	Was previously rolled over from 2018/19 with additional actions (noted below). This priority has been achieved, completed initiatives: • Corporate Governance Team utilising Allocate/Health Assure Module after a delay due to policy upload not taking place as contractually requested in November 2020. • All policy authors with policies overdue for review have been contacted and reminded of the need to review, amend if necessary and seek re-ratification of their policies. • A policy report is submitted every month to the Exec team detailing the current policy position and providing each Exec Director with a summary report of the policy compliance position for each of their respective portfolios. • A clinical policy report is also submitted to the Clinical Quality Group every month. • Concentrated work with some key departments to review overdue policies or policies that require audit where guidance is open to regular change.
Priority 4: Reduce the number of times patients Outpatient clinic appointments are rescheduled.	Was previously rolled over from 2018/19 with additional actions (noted below). This priority has been achieved, completed initiatives: • Working Group meeting every week with a project charter and Standard Operating Procedures for staff to follow removing variation in practice. • Partial Booking waiting lists created and partial booking work completed (an outstanding initiative from 2019/20). • Additional human resource in post to support outpatient clinic appointments and partial booking work.
Priority 5: Ensure that we care for the patients spiritual and pastoral needs whilst a patient at the Royal Orthopaedic Hospital.	This priority is recommended to be rolled over to 2021/22 priorities. Initiatives completed or underway: • Trust Chaplain working on a GAP analysis against the NHS Chaplaincy Guidelines. • New Spiritual and Religious Care Guideline for The Care of Patients, Staff and Visitors in progress. • End of Life Care and Care of the Dying Patient Policy has been amended and refreshed but is still awaiting ratification. • Breaking Bad News Training under review by Oncology Nurse Consultant. • Patient and Carers Forum has not sat during the pandemic and is therefore not able to offer regular feedback on items above, but the Patient Engagement Team is working to renew and restore.

2.4 QUALITY PRIORITIES FOR IMPROVEMENT 2021/22.

The quality improvement priorities for 2021/22 were agreed following a review of the quality priorities from 2020/21, 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 2021/22 were agreed at the Trust's Executive Team in April 2021, and the Clinical Quality Group in April 2020. The priorities were shared and agreed with the Trust's governors in June 2021 including their sponsored quality priority. The quality improvement priorities will be cascaded to all staff via team brief in May 2021.

Priority 1: Children's and Young Person.

Rationale: Recognising the importance of the Children and Young People (CYP) and their experience within the ROH.

Initiatives to be implemented in 2021/22

- The evaluation of a youth worker role within the ROH to support our young patients/visitors and support the children's voice.
- Young People Mental Health First Aider, build on the success of the Trusts Mental Health First Aider scheme and roll out the concept to our CYP on site.
- Work to ensure that job opportunities at the ROH are equitably available for all age groups, including 16-25.
- Establish a Learning Disability forum.
- Establish a Youth (10-25 yrs.) forum.

How progress will be monitored, measured and reported.

Monitored and evaluated by the Children's Board; reported to the Clinical Quality Group meetings and Quality and Safety Committee.

Priority 2: Volunteers

Rationale: Increase the number of ROH volunteers. Volunteers make a considerable contribution to the ROH, giving their time, skills and expertise freely each year to support the ROH. They are crucial to the ROH's vision for the future of health and social care, as partners with, not substitutes for, skilled staff.

Open the range of roles available to volunteers at the ROH and provide education opportunities for volunteers to aid them in their role and enrich their skills and subsequent personal opportunities.

Initiatives to be implemented in 2021/22:

- Engagement with Helpforce to open up increased educational opportunities to volunteers.
- Help managers plan, create and develop new roles to support services.
- Seek to widen the diversity of volunteer group, aiming to ensure it represents both the local and patient populations.
- Use volunteering as a recruitment tool giving people new to care a window to new jobs.

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: Ethnicity Data Completeness and Digital inclusion

Rationale: Supporting the Birmingham and Solihull (BSol) Integrated Care System (ICS) Inequalities Work Programme aim of ensuring datasets are complete and timely. New digital pathways must not increase or reinforce health inequalities

Initiatives to be implemented in 2021/22:

- Continue work across the organisation on the completeness of ethnicity coding.
- Virtual clinics will be reviewed to ensure that the 25% target is achieved with the inclusion of all patient groups.
- Engage with patients and communities to ensure our elective pathway recovery continues to tackle inequalities.

- Provide a call centre for a central contact point for patients to discuss appointment changes around virtual clinics.

How progress will be monitored, measured and reported.

This priority will be monitored via the relevant Divisions Divisional Management Board and in Clinical Quality Group.

Priority 4: Surgical Site Infections (SSI).

Rationale: Further to the SSI work completed or underway to reduce the potential risk of SSI infections within the ROH, utilise the One Together UK pathway tool and review our pre-surgical smoking cessation and nutritional advice.

Initiatives to be implemented in 2020/21

- Utilise the One Together Tool www.onetogether.org.uk to complete a gap analysis against the standards and guidance offered to reduce the risk of surgical site infections.
- Smoking Cessation health promotion pre-surgery to encourage better wound healing.
- Nutrition advice health promotion pre-surgery and ROH inpatient catering nutritional review to support wound healing.

How progress will be monitored, measured and reported.

Progress will be monitored through data and KPIs, monitored via SSI Group/IPCC and upwardly into Clinical Quality Group.

Priority 5: Patient Wellbeing (inc Spiritual Health)

Rationale: : Was previously rolled over from 2019/20 with additional actions (noted below). 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 completed in 2020/21

- Breaking Bad News Training work has been completed and an educational package is available to all ROH staff.
- Working Group created and completed work around a Patient Admission Care Pack, standardising the information for patients and the services available.

Initiatives to be implemented in 2021/22

- Continue review of Chaplaincy Service – to support multifaith chaplaincy provision.
- Report workstream into CQG and Patient & Carers Forum.

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 2020/21, 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 86.34% of the total income generated from the provision of relevant health services by The Royal Orthopaedic Hospital NHS Foundation Trust during the year. The funding allocations for 2020/21 have been primarily block contract arrangements with commissioners with additional funding support for the Trusts response to COVID.

2.5.3 PARTICIPATION IN CLINICAL AUDIT

During 2020/21, 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 2020/21 are as follows:

1. National PROMS Programme – Elective Surgery (PROMS)
2. British Spine Registry (BSR)
3. National Audit of Dementia (NAD) - Royal College of Psychiatrists
4. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
5. National Joint Registry (NJR) – (Healthcare Quality Improvement Partnership)
6. Surgical Site Infection Surveillance Service – (Public Health England)
7. Case Mix Programme - (ICNARC)

Table 2 below gives the national clinical audits that The Royal Orthopaedic Hospital NHS Foundation Trust participated in during 2020/21. The national clinical audits that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2020/21

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	Postponed due to Covid-19.
National Joint Registry (NJR)	Compliance number of hip and knee procedures =1,334. Hips = 96% Knees – 96%
Public Health England Surgical Site Infection Surveillance (Hip and Knee)	**Hip** Quarter 1 – 100% (410) Quarter 2 - 100% (22) Quarter 3 – 100% (323) Quarter 4 – 100% (307) **Knee** Quarter 1 – 100% (400) Quarter 2 - 100% (7) Quarter 3 – 100% (233) Quarter 4 – 100% (259)
Case Mix Programme (ICNARC)	Quarters 1-3 = 100% (24/24) – Quarter 4 results not available until after April 2021.

The reports of seven national clinical audits were reviewed by The Royal Orthopaedic Hospital NHS Foundation Trust in 2020/21 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 Audit Quality Improvement Learning and Analysis Group.
- PROMS data is reviewed at both the Audit Quality Improvement Learning and Analysis Group 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 2020/21 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
ROH Nofs – Evaluation of A New Admission Pathway for Fragility Fractures of The Proximal Femur During the Coronavirus Pandemic	The ROH was nominated to receive trauma patients from other Birmingham hospitals during the coronavirus pandemic. This necessitated a rapid change in working practices to accommodate a new pathway, novel surgical sessions, and new demands on ward care. The largest group of emergency trauma patients are those with fragility fractures of the proximal femur, also called Neck of Femur Fractures (NOFs). There is a need to understand the process map from referral to discharge, and identify areas where efficiencies can be made.	• Continue to provide operative care to emergency patients – no action • In the event of a second wave – consider enhancing shielding of vulnerable patients - Convene taskforce to discuss further measures in the event of a second wave (to be activated if needed)
Orthopaedic Oncology Telemedicine Clinic in Response To COVID-19	The Royal Orthopaedic Hospital (ROH) is a specialist centre for the management of orthopaedic malignancy. The world-wide coronavirus pandemic has prompted new ways of working in order to limit viral transmission. One such way is the avoidance of face-to-face consultations where possible. Our centre has started to use telemedicine clinics to review patients remotely. There is a need to determine whether these clinics are acceptable to our patients and staff. If	1. Continue with pandemic telemedicine clinics - none 2. Consider offering telemedicine clinics to those patients who prefer it - Intradepartmental discussion

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	the patients and staff are largely satisfied with telemedicine clinics, they may continue. If they are not satisfied, it may become necessary to further change working practices; this may involve video consultations, or face-to-face consultations with personal protective equipment in certain cases.	
Medtronic Implants – Function and Outcome	This service evaluation is using the stored Trust's outcome data in an aggregated anonymised format to register and improve the implants used during spinal surgery	No Recommendations
Evaluation of Respect Form Completion for Trauma Inpatients at The ROH During The COVID-19 Pandemic.	Due to Covid-19 pandemic, trauma service was started at the ROH towards the end of March 2020. It was recommended that as part of the admission process, ReSPECT Form (Recommended Summary Plan for Emergency Care and Treatment) was to be completed. Hence, this form has been in use since then. ReSPECT form guides clinicians to make decisions regarding the level of care and also about cardio pulmonary resuscitation on admission.	1. Completion of all aspects of ReSPECT form - Dissemination of the Trust guidance and audit recommendations 2. Mandatory 2nd Clinician signature - Junior colleagues on the Ward to prompt the Consultants on the Ward round. Check completion of ReSPECT form as part of "time out" in operating
• Pes Anserine Exostosis- Is It Normal?	• Pes anserine exostosis are rare. We intend to an audit of these lesions and ascertain if they are a normal variant	• Share data with radiologists

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
• Are We Good at Diagnosing Dupuytren Contractures and Similar Lesion of Palm	• Palm masses are not very common, looking at features on imaging and correlating with histology	• Share data with radiologists
• Re-Audit to Assess Adequate Contrast Enhancement of CT Pulmonary Angiograms.	• Suboptimal enhancement of CTPA's leads to non-diagnostic studies and therefore unnecessary exposure to contrast and radiation.	• 1. Discussion with Radiographers regarding standards of contrast opacification and challenges in achieving this - Discussion in Radiology Team meeting • 2. Re-audit in a year to ensure continued good practice - Re-audit in 12 months
• Assessing Foraminal Stenosis on CT of Lumbar Spine	• CT of lumbar spine is done in certain circumstances for back and leg pain for e.g.: in patients with pacemaker.	• Share results with radiologists and spinal surgeons
• Annual Audit Sonographer and Consultant Radiologist Shoulder Ultrasound Rotator Cuff Tear Positive Results Compared with Arthroscopy Results	• Peer review is limited in Ultrasound, with one sonographer on the team - audit by another sonographer is not possible. Ultrasound still images are limited and open to interpretation. This audit would allow assessment of the accuracy of Sonographer Shoulder Scans where the result was Positive for a Rotator Cuff Tear. It is suggested that the scan result - scanned and reported by the	• Continue to support Clinical Fellow with shoulder scanning

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	Sonographer or Radiologist would be checked against Arthroscopy notes. It is somewhat limited by factors which cannot be controlled e.g.: false negative result (no way of assessing this), not all patients with a positive result will choose to have surgery.	
• Evaluation of Respect Form Completion for Trauma Inpatients at The ROH During The COVID-19 Pandemic. (Re-Audit)	• An initial audit was undertaken in May 2020. Due to Covid-19 pandemic, trauma service was started at the ROH towards the end of March 2020. It was recommended that as part of the admission process, ReSPECT Form (Recommended Summary Plan for Emergency Care and Treatment) was to be completed. The findings from this audit showed that although, majority of the forms have been completed, some of the sections were not complete. Findings and recommendations were emailed.	• If there is a further continuation of use of ReSPECT form, these can be re-audited against the current audit findings
• To Evaluate the Use of The FACTIP Classification in The Management of Central Cartilage	• To see if the implementation of the Birmingham Fibula Atypical Cartilage Tumour	• All cartilage tumours around the shoulder and knee referred to the department will have the tumours graded by the

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
Tumours Around the Proximal Fibula. A Service Evaluation.	Imaging Protocol (FACTIP) resulted in a delay in diagnosis of an enchondroma converting to a chondrosarcoma.	FACTIP classification and be followed up using this grading system. - An outline of the classification should be put in all reporting areas to act as an aide memoir.
• Evaluate the Outcomes of Radiofrequency and Pulsed Radiofrequency Ablation Over A One Year Period at Royal Orthopaedic Hospital.	Radiofrequency denervation has evolved as a treatment for spinal pain over the last 40 years and is a minimally invasive and percutaneous procedure performed under local anaesthesia or light intravenous sedation. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves under imaging guidance. This focussed electrical energy heats and denatures the nerve. This process may allow axons to regenerate with time requiring the repetition of the radiofrequency procedure. The NICE guidelines published in November 2016 for 'low back pain and sciatica in over 16s: assessment and management' recommends to consider referral for assessment for radiofrequency denervation for people with chronic low back pain when: Non-surgical treatment has not worked for them and The main source of pain is thought to come from	• 1. Follow up review should be done at 4 months and 12 months – a. Make staff aware of importance of following up at a set standard time in order to accurately evaluate the outcomes achieved. Pain nurses to make every effort to ensure follow up review is done at these times. b. Make patients aware of follow up review at discharge. If patients hard of hearing or unable to answer over the telephone to provide them with a paper form which could be posted back at 4 months and 12 months • 2. Educate staff by presenting findings at the trust clinical governance meeting. - To present findings at the next clinical governance meeting.

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	structures supplied by the medial branch nerve and They have moderate or severe levels of localised back pain at the time of referral Radiofrequency denervation is only performed in people with chronic low back pain after a positive response to a diagnostic medical branch block. Genicular nerve radiofrequency ablation (GNRFA), including conventional, cooled, and pulsed techniques, has been used in the treatment of symptomatic knee osteoarthritis (OA). This management option has the capacity to decrease pain and improve function and quality of life in certain patients. GNRFA is reserved for patients with symptomatic knee OA who have had failure of conservative treatment and surgery or are poor candidates for surgery. GNRFA has been shown to consistently provide short-term (3 to 6-month), and sometimes longer, pain relief in patients. GNRFA has been demonstrated to be safe to administer repeatedly in patients who respond well to this minimally invasive procedure. A study looking at the short and long term effects of ganglion impar radiofrequency treatment in	

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	chronic coccydynia showed that radiofrequency treatment of the ganglion impar in patients with chronic coccydynia resulted in effective outcomes, and patients who responded to it had significantly lower pain scores. At present, at the Royal Orthopaedic Hospital we offer radiofrequency ablation for lumbar medical branch, genicular nerve, ganglion impar, cervical medial branch, sacroiliac lateral branch nerve and pulsed radiofrequency for suprascapular nerve and to trapezius/ cervical paraspinal. In this service evaluation project, we looked at the effects of radiofrequency ablation on lumbar medial branch, genicular nerve, ganglion impar and pulsed radiofrequency on suprascaupar nerve which are the more commonly done procedures in our trust.	
• To Determine the Value of Chest and Skeletal Staging in Patients with Parosteal Osteosarcoma (POS), And the Incidence of Late Local and Chest Recurrence.	• Parosteoal osteosarcomas are rare tumours. The staging of these tumours has involved CT chest and bone scan.	• Share the findings with radiologists and oncology surgeons – no actions
• Retrospective Analysis of Oncology Inpatient	Incubation period is thought to be 14 days. Symptoms are known to include high temperature and cough.	All symptomatic patients, particularly with confirmed SARS-CoV-2 should not undergo surgery; appropriately screened

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
Admissions During Covid Crisis	How many patients developed symptoms a) during admission and b) within 14 days of discharge? What proportion (if any) had PCR confirmed Covid 19 a) during or b) 14 days post-admission?	asymptomatic patients can continue to have urgent oncology surgery at ROH. – no actions.
• Are We Good at Diagnosing Heel Pad Lesions?	• We see several heel pad lesions in our routine practice.	• Share results with orthopaedic oncology surgeons and radiologists – no actions
• End of Life Care Audit	• To ensure end of life patient care meets the national standards	• 1. The End of Life Care Guidelines be reviewed and updated to include the new end of life care documentation 'Optimising Care at the End of Life'. - Guideline review • 2. Staff training in End of life care be available on e-learning via ESR - Liaise with Learning and Development and ESR teams
• ADCU Discharge Letter PICS Audit	Electronic discharge summaries (EDS) for patients following elective surgical procedures are essential to ensure effective communication between primary and secondary care. They enable greater continuity of care from the hospital to general practice lending to better patient safety and patient experience of care. EDS are necessary to clearly list the expectations for post-operative treatment, while also providing patients with key information about possible complications to be	• 1. A review required to assess who is best placed to create the patient discharges to avoid mistakes and harm to the patient - Discuss at CSL meeting opinion and need for Doctors to complete PICS Discharges • 2. Fewer data entry points for simple day-case discharges

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	aware of and signpost them to where they can access help. As such, doctors involved in the care of these patients are best placed to complete EDS to facilitate clear and accurate communication of post-operative plans to GPs as well as provide patient specific information. •	
• Loop Completion of Audit on Compliance of Bare Below Elbow in Out Patient Clinics	• Health care professionals who are in direct contact with the patient care must take necessary precautions to avoid the risk cross infection by using optimum hand hygiene, using personal protective equipment. Bare below elbows is a standard practice that need to be followed as per NICE guidelines.	• Need clinicians to achieve 100% bare below compliance in the outpatients - Posters advising to practice bare below elbow in every clinic
• Annual Review of Readmissions Within 30 Days Post Discharge at The Royal Orthopaedic Hospital. Dec 2019 Till Nov 2020	Emergency readmissions – where patients are readmitted to hospital in an emergency within 30 days of discharge – are frequently used as a measure of the quality of care provided by a health care system. They are also used as an indicator for when poor patient outcomes could potentially have been avoided. ROH currently has 6-9 patients readmitted within 30-days of discharge every month (all specialities). We	• 1. Involve ROCS team - Meeting with ROCS team • 2. Updating Patients discharge template - To be done after the ROCS team and finalising action points • 3. Re-audit - After implementing the above changes

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	would like to review all such cases and record their reasons for readmissions. We hope to establish a pattern among these reasons and identify potential simple measures or system changes to reduce our overall readmission rate. Inter hospital coordination and direct access to discharge coordinator from the patient could be a good initiative to prevent unnecessary admission. Since we area tertiary unit our cohort of patients are far different to others they usually had multiple failed surgeries and complex clinical need who need far greater community and medical support these scenarios are usually unpredictable and cannot be averted	
• Restoration of Elective Surgery Following The SARS-Cov-2 Pandemic in A Tertiary Specialist Centre	• Discussing the categorisation of patients and risk factors associated with considerations for choosing patients for surgery and the impact of these factors on COVID related mortality.	No recommendations were made from this audit and the trusts careful consideration for risk stratification of patients showed that no patients had a worst outcome during this initial phase. Should a re-audit be done, a longer duration could be reviewed. A further project looking specifically at BAME patients, with Actual vs perceived risk of perioperative mortality and respiratory complications during the

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
		next wave of the pandemic could be looked at. As well as a 14th and 30th day follow up of patients post discharge, to determine if any of these patients became covid positive in this time. No date has been agreed to do such projects, as yet.
• A Re-Audit to Investigate the Complication Rate and Re-Operation Rate of Static Spacers.	Endoprosthetic replacement in oncology patients are known to have higher rates of complications. Two staged revision for complications such as infection are preferred. The overall success of eradicating infection is 91% at one year and 74% at five years. During the primary audit of these patients, we identified high mechanical failure rates (57%), leading to re-operation in patients undergoing a staged procedure with static spacers. The majority of these failures were due to mechanical failure leading to dislocation or sublation. High rates of fracture and perforation also noted. Worryingly 72% of the complications occurred within two weeks of implantation. We noticed that spacers were prone to failure if they did not span the defect	Within the next calendar year, we expect to analyse new data and will define the final parameters for fixation. Once this is achieved we will perform another audit that will assess compliance with the current recommendations. It will also help to validate the geometrical parameters that we recommend.

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	adequately. The total length of the spacer should be double that of the defect. Also, when a terminal, either proximal or distal, had less than 10% of the spacer inserted, the fracture rate was 91% (10 of 11 patients). The recommendation made were: Appropriate size and positioning of the spacer can decrease chances of mechanical complications Re-x-ray at 2 weeks following implantation and mobilisation Consider intra-operative radiographs to minimise the complications Alternative method of Proximal and Total femoral EPR spacer reconstruction necessary Flint MN, et al. Two-Stage Revision of Infected Uncemented Lower Extremity Tumour Endoprostheses. J Arthroplasty 2007;22(6):859-865. Jeys LM, et al. Endoprosthetic Reconstruction for the Treatment of Musculoskeletal Tumours of the Appendicular Skeleton and Pelvis. J Bone Joint Surg Am 2008;90:1265-71. Grimer R, et al. Two-Stage Revision for Infected Endoprostheses Used in	

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
	Tumour Surgery. CORR 2002;395:193-203.	
• Outstanding Care Every Time	This report has been completed in retrospect following implementation of the project. Our nursing Strategy from 2017-2020 outlines that we will deliver the fundamentals of nursing care well. This is developed from the Nursing strategy for England 'Leading Change, Adding Value: A framework for nursing, midwifery and care staff. The Royal Orthopaedic NHS Foundation Trust strategy states, 'we will focus on delivering safe, high quality care to our patients at all times. We will reduce harm and ensure that we focus on the things that make a difference to our patients'. In order to achieve this objective, the fundamentals of nursing working group was developed to identify the areas of basic nursing which we deliver well as a trust and what areas of nursing required improvement, in order to make changes to current practice to enhance patient experience and care delivery at the ROH.	• 1. Deliver the Outstanding care Every Time training programme to all clinical ward staff including Registered nurses and Health Care assistants. • 2. Deliver Pain Pathway training to all registered nurses in ward areas • 3. Implement revised fluid balance chart documentation and posters • 4.Implement revised repositioning and skin assessment documentation • 5.Implement revised catheter care plans and launch discharge catheter packs • 6.Implement revised Anti-embolism stockings assessment documentation • 7.All wards/ clinical areas to have standardised and suitable commodes • 8.Signs to be added to computer monitors and posters to be put in clinical areas to ensure staff are maintaining information governance. • 9.Standardised cleaning rota to be implemented across all ward areas

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
		• 10.Mobile phones and iPads to be made available in clinical areas for patient use • 11.Care packs available for ward areas for patient use when needed • 12.The role of the Meal time co-ordinator is to be implemented in all ward areas • 13.Passport to home revised document to be launched in clinical areas • 14.Enhanced Observation dementia and delirium boxes to be completed and launched to all stated clinical areas. • 15.New handover process to be implemented and used in all ward areas. • 16.Recommendations implemented to be evaluated and reviewed following implementation in practice.
• Re-Audit on Compliance of NICE Guidelines for The Indication of Caudal Epidural Injections. (Ref 19-028)	• We intend to look at the compliance with this guideline among the patients selected for the caudal epidural in out trust following the initial audit which demonstrated 86% compliance with the guidelines.	• Nil recommendations - Can be re-audited in the future
• Exclusion of The Lens of The Eye in	The exclusion of the lens from the standard brain CT examination will:	• 1.Develop a protocol for brain CT in which the base

NAME OF LOCAL AUDIT	BACKGROUND	RECOMMENDATIONS - ACTIONS
Routine Head CT Examinations	Reduce the radiation dose to the eye Reduce the likelihood of lens damage and cataract formation	line is set so as to exclude the eye lens • 2. Identify exclusions to this protocol (e.g. examination) • 3. Emphasise to radiographers the importance of excluding the eye. - To put up a poster in the radiographer's room about importance of excluding lens in CT Head scans by 01/03/21 • 4. Persuade supervising radiologists to avoid making exclusions to the protocol
• Arthroscopic Meniscectomy and Meniscal Repair at ROH – Does it conform to BASK Meniscal Surgery Guidelines?	This is a re-audit of a previous audit performed in 2019 by Jenner, Rajgor & Hussain (Audit number 19-031) 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.	1.Patients should only undergo arthroscopic meniscal surgery according to the BASK guidelines - Presentation of & dissemination of BASK guidelines to surgeons performing arthroscopy 2.Patients should have a trial of conservative treatment, and this has already happened then it should be documented - As above Re-emphasise importance of documentation in particular 3. If deviating from BASK guidelines, reasons why need to be clearly documented - As above

2.5.4 PARTICIPATION IN CLINICAL RESEARCH

The Royal Orthopaedic Hospital NHS Foundation Trust has a large portfolio of clinical trials, observational studies and translational medicine research programmes which underpin our delivery of evidence-based care and the development of new therapies and orthopaedic innovations. This portfolio includes the development of better approaches to post-surgical physiotherapy rehabilitation, advanced cellular therapies to regenerate diseased bone tissue or pharmaceutical treatments which aim to reduce the need for invasive surgery and speed up recovery.

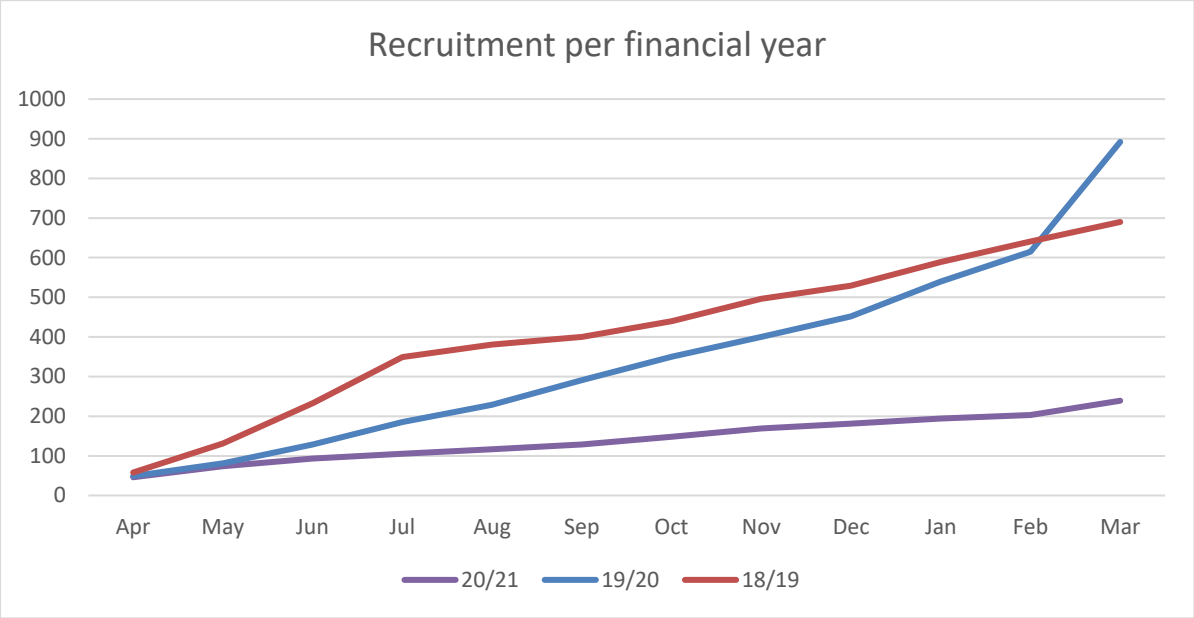
Performance report 2020/21

The Trusts research recruitment has reduced in parallel to the reduction in elective clinical activity levels throughout 20/21 due to Covid-19. Forty-four percent of the active studies were temporarily closed to new recruits by the research sponsor during the first national lockdown. While 36% of studies which were open before the pandemic remained open, recruitment of new patients during this period was impacted due to a temporary suspension of elective care. The research team continued to support existing participants on these studies via remote and in-person follow-up visits, ensuring continuity of patient safety and study delivery.

The R&D Management Team worked closely with the regional and national research networks to respond to urgent public health research priorities posed by Covid-19. This included the rapid adoption and delivery of eight new Covid-19 Urgent Public Health Studies, ensuring that all eligible staff and patients within the Trust were able to participate in these Covid-19 research programmes.

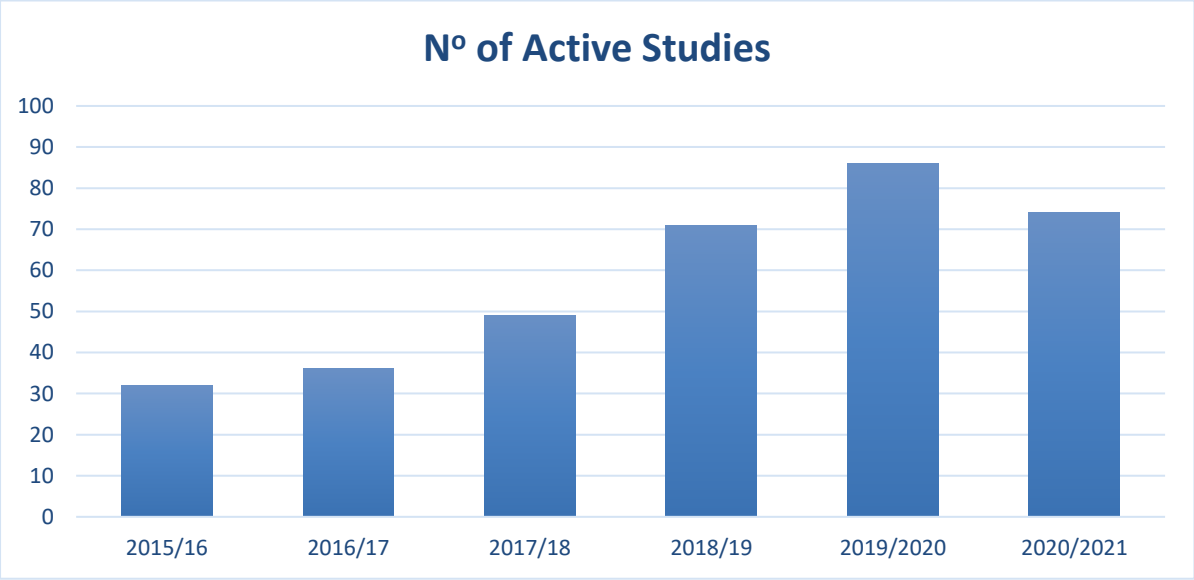
The impact of the pandemic on patient recruitment compared with previous years is shown in the graph below (Graph 1).

GRAPH 1: RECRUITMENT PER FINANCIAL YEAR



The opening of other types of study to patient recruitment was also delayed due to the pandemic, resulting in a slightly lower number of active studies compared with previous years. This represented the first reduction in our portfolio in a number of successive years. The portfolio reduced from 86 active studies during the 2019/20 calendar year to 74 across 2020/21, but remained higher than other previous years.

GRAPH 2: NUMBER OF ACTIVE STUDIES



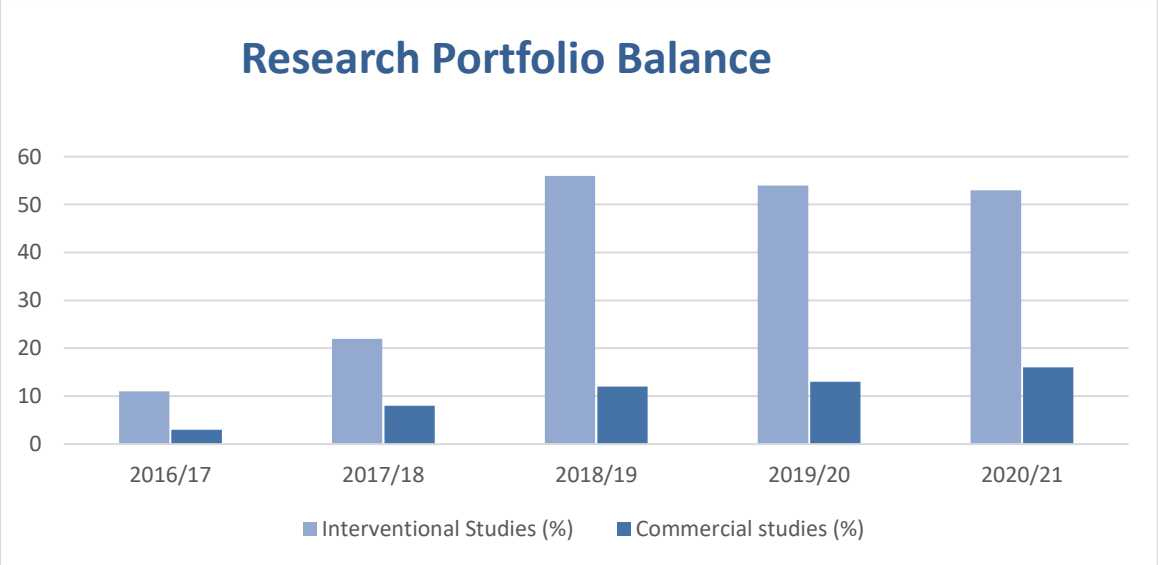
This reduction was due to the impact of the pandemic on opening new studies. This impact included a) a lack of eligible patients due to the suspension of elective procedures within the Trust, b) the need

to prioritise the delivery of national Urgent Public Health Studies in allocation of, as directed by the National Institute for Health Research and the UK Government and c) the need to redeploy research staff to support critical functions across the Trust.

Following the first lockdown, the R&D team worked hard to reopen every suspended study and restart recruitment into those recruiting patients attending for elective care procedures. This placed unique demands on the service due to the synchronized timing of this surge in activity. In anticipation of this, a recruitment process was undertaken to increase staffing numbers by refilling vacancies within the team to meet this increase in activity as studies restarted. At the end of 2020/21, 33 of the 73 active studies were open and recruiting, 18 were in follow-up, 20 are in set-up. Only 1 study in set-up remained suspended due to the need to identify an alternative funding source, and another study in set-up was withdrawn due to research pathways not being compatible with current ROH clinical pathways.

Throughout the year we have continued to deliver a balanced project portfolio and sustained the progress made against this strategic intention over the preceding few years with more than half of all of our studies (52%) involving new treatments and interventions for our patients.

GRAPH 3: RESEARCH PORTFOLIO BALANCE



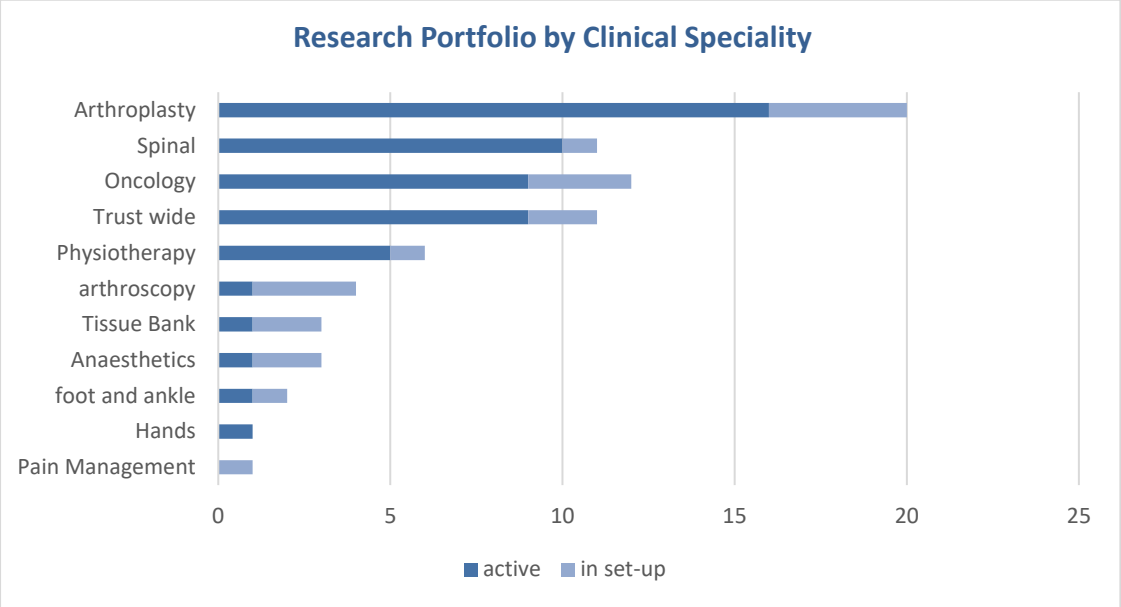
In parallel with this, we have also increased the proportion of commercially sponsored studies at 16% of our study portfolio (compared with 13% in 2019/20). This has allowed us to continue to deliver our strategic intention to provide patients with access to the latest pharmaceutical and technological innovations developed within the commercial and academic sectors.

Other 2020/21 achievements against our strategic goals include:-

- **Developing the next generation of orthopaedic researchers**

Throughout the pandemic there has been a marked increase in clinician engagement in research across the Trust. This has been demonstrated through the development of an unprecedented number of new ROH-led research proposals across all core clinical specialities.

GRAPH 4: RESEARCH PORTFOLIO BY CLINICAL SPECIALITY



The research support infrastructure put in place in the previous two years, including the creation of Research Fellowships and Trial Manager post's together with the Trusts NIHR Clinical Trials Scholarship award, have been critical to meeting this increased demand and provide ROH investigators with the dedicated support, guidance and research expertise.

- **Strengthening the Trusts research sponsorship capabilities**

A new internal peer review processes has been implemented in the past year which ensures that research projects receive critical evaluation and refinement from a multidisciplinary panel of clinical and scientific experts. This ensures that the projects submitted for grant funding calls are more likely to be awarded. We have also worked closely with the ROH Charity to ensure a unified research funding strategy for locally developed research proposals.

- **Increasing partnership working with industry and academia**

Commercial and academic partnerships which were in development before the pandemic have continued to be strengthened. This was included working in collaboration with University Trials Units in several major institutions to deliver major grant funded research programmes led by ROH investigators and to develop translational medicine programmes which will take place within our new Regenerative Medicine research Facility. We have also supported both small and large biotechnology companies to develop orthopaedic device proposals into clinical trials which again are led by ROH investigators. This has played a major part in our planning to ensure sustainability and continued growth of our research activities and culture and ensuring we have a robust pipeline of new collaborative research programmes ready to commence in 2021/22.

- **Developing our Research Facilities**

Significant progress has been made in 2020/21 in ensuring that the Trust has the optimum facilities and resources for future translational medicine research programmes. This included:

- Rehousing of the Trusts Research Tissue Bank to a new licenced premises in order to safeguard this unique resource for the future and ensure is maintained to the highest quality standards.
- Commissioning of the newly constructed Regenerative Medicine Research Facility and the implementation of the first research programmes to use this facility in collaboration with Aston University.

- Supporting the Orthopaedic Oncology service to put in place new clinical pathways to integrate whole genome sequencing for oncology patients 2021/22. This will allow the routine use of new genomic technology to rapidly increase opportunities for genomic research into sarcoma diagnosis and care.

In summary

Despite the setbacks in research delivery due to the pandemic, other 2020/21 achievements demonstrate a major step-change towards our fulfilment of our strategic goals and ensures the Trust retains its position as a knowledge leader in orthopaedic care.

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.

Due to Covid the NHS introduced block payments for all Trusts to provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract. This minimised the burden of formal contract documentation and contract management processes, so that staff could focus fully on the COVID-19 response.

These block payments included CQUIN. The operation of CQUIN (both CCG and specialised) for Trusts has been suspended for the period from April 2020 to March 2021; providers therefore did not take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data.

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 2020/21.

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.

The Trust has not received a formal CQC assessment against the CQC assessment framework since October/November 2019. The Trust's report from this visit was published in December 2019 and saw the Trust retain an overall rating for the Trust of 'good'.

The CQC reported noted the following improvements that should be considered:-

- 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.

The Trust is monitoring the responses to these recommendations via a CQC Action Plan through the Trust's quality governance framework.

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:*

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

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

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

*Figures cover the latest available period: April 2020 – February 2021.

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 111 mandatory requirements prescribed by the National Data Guardian. As at the baseline assessment in February 2021, the Trust could evidence 87 requirements and is working towards full compliance by June 2021. Covid has hindered progress this year with IT staff in particular being diverted to support new systems and infrastructure. The Trust has a robust action plan in place and is doing everything reasonable to address the gaps which gives it the status of 'Standards not fully met (plan agreed)' status for 2020/21. This does 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 2020/21 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 on our Trust Website. As well as the Trust learning from deaths dashboard.
There was a rise in mortality within the Trust in 2020/21 as a result of emergency pathways being in place under coronavirus pandemic conditions which had significantly higher morbidity due patient group and emergency admission in comparison to the Trust's normal elective case mix.

During 2020/21 the following number of deaths which occurred and were captured on the Learning from deaths process;

- 24 Deaths were reported as in-hospital deaths at the ROH
- 22 deaths within 30 days of being discharged from the ROH
- All deaths were reviewed as part of the LFD process - All of these deaths were deemed unavoidable (score 6 on the RCP guidelines)
- All cases were initially screened by the named consultant or the Associate medical director from the 46 deaths
    - 17 cases were referred to the coroner and were concluded
        - All of these deaths were deemed unavoidable (score 6 on the RCP guidelines)
- There were no deaths associated to Mental Health or Learning Disabilities Patients

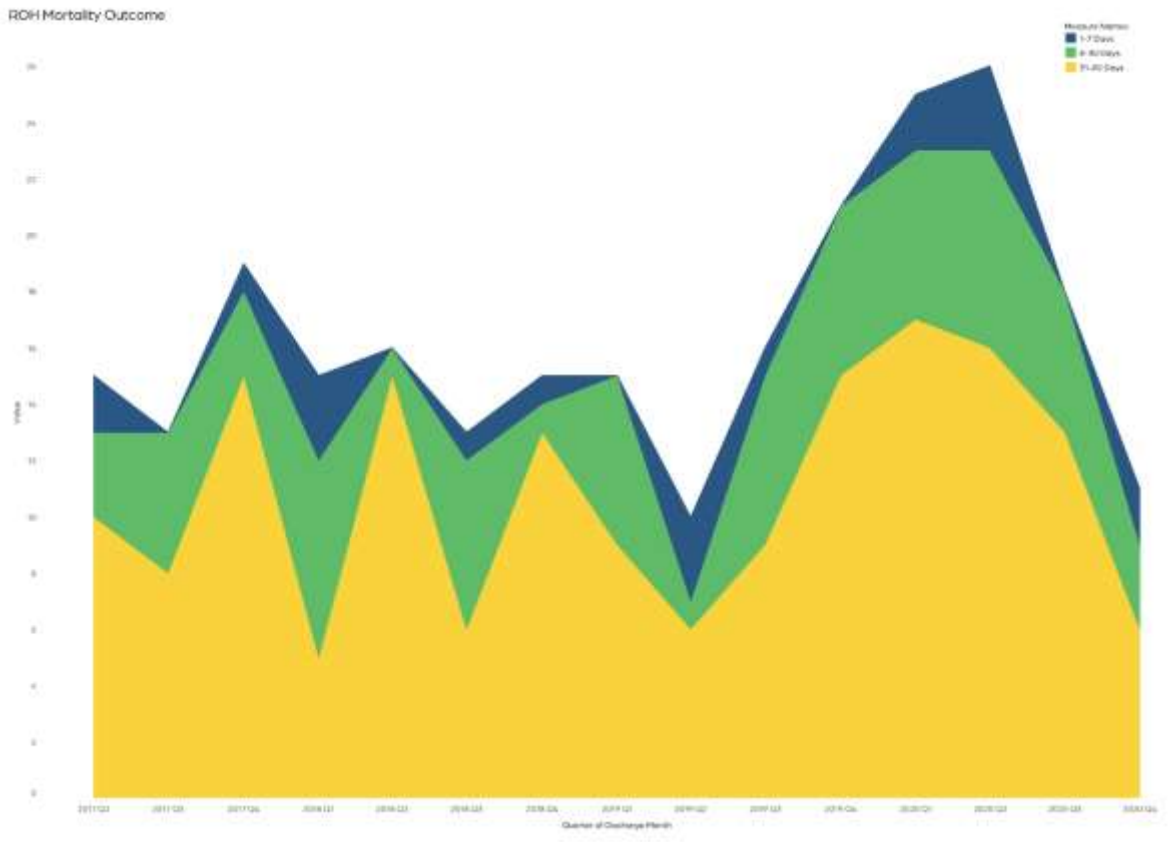
2.6 REPORTING AGAINST CORE INDICATORS.

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.

GRAPH: ROH Mortality Outcome 2017 Q2 to 2020 Q4.



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.

Whilst a number of factors can influence the impact of joint replacement on our patients quality of life, the national joint registry provides information about how well placed and how long lived our implants are by looking at the number of them that have been revised. We pride ourselves that we are confident with revision surgery and will tend to intervene sooner rather than later if returning to a joint replacement has a realistic chance to help – for example near the end of a joint replacement's life if it wears or loosens.

As with PROMs the number of operations we do is very large and in the same way as PROMS this means that we to some extent define the national average. Nevertheless, we are pleased to see that with this solid measure of quality we find ourselves consistently (at 5 years and 10 years from surgery, for hip and for knee replacement) below or well below the national average revision rate. Again, our arthroplasty unit surgeons review all cases that need revising together on a weekly basis. Like the PROMs information, the unit review their individual performance data together annually with the clinical service lead. Individual performance in any area that requires it can therefore be recognised and supported. Within the team we have examples of surgeons at various levels of experience coming forward and receiving support in a particular area of their practice, based on the feedback information that the NJR data provides and the supportive environment that the multi-disciplinary team continues to develop.

TABLE 5: PROMS FINAL DATA APRIL 2019 – MARCH 2020 (PUBLISHED FEBRUARY 2021)

Procedure Type	Measure	England Average	England Highest	England Lowest	ROH	Position
Hip Replacement Primary	EQ-5D Index	0.459	0.539	0.352	0.455	Below National Average
Hip Replacement Primary	Oxford Hip Score	22.69	25.55	17.06	22.74	Above National Average
Hip Replacement Revision	EQ-5D Index	0.307	0.380	0.238	0.269	Below National Average
Hip Replacement Revision	Oxford Hip Score	14.07	16.13	10.65	12.24	Below National Average
Knee Replacement Primary	EQ-5D Index	0.335	0.419	0.215	0.318	Below National Average
Knee Replacement Primary	Oxford Knee Score	17.49	20.69	12.62	17.48	Below National Average
Knee Replacement Revision	EQ-5D Index	There are too few revision knee replacements with completed data in 2019/20 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 Audit-Quality Improvement-Learning-Analysis (AQUILA) Committee and Quality and Safety Committee.

The AQILA group received a detailed report from the clinical service leads for arthroplasty and corporate clinical lead for outcomes. There is renewed energy to incorporate a refresh of our Joint care pathway (including a refresh of pain control and mobilisation), planned GIRFT and regional pathway work. The group also heard that, as a result of benchmarking, there is a consensus that much more can be done about engaging and interesting patients in out outcomes work. Our ultimate goal is that patients have the first access to their own recovery data through apps or our planned patient portal"

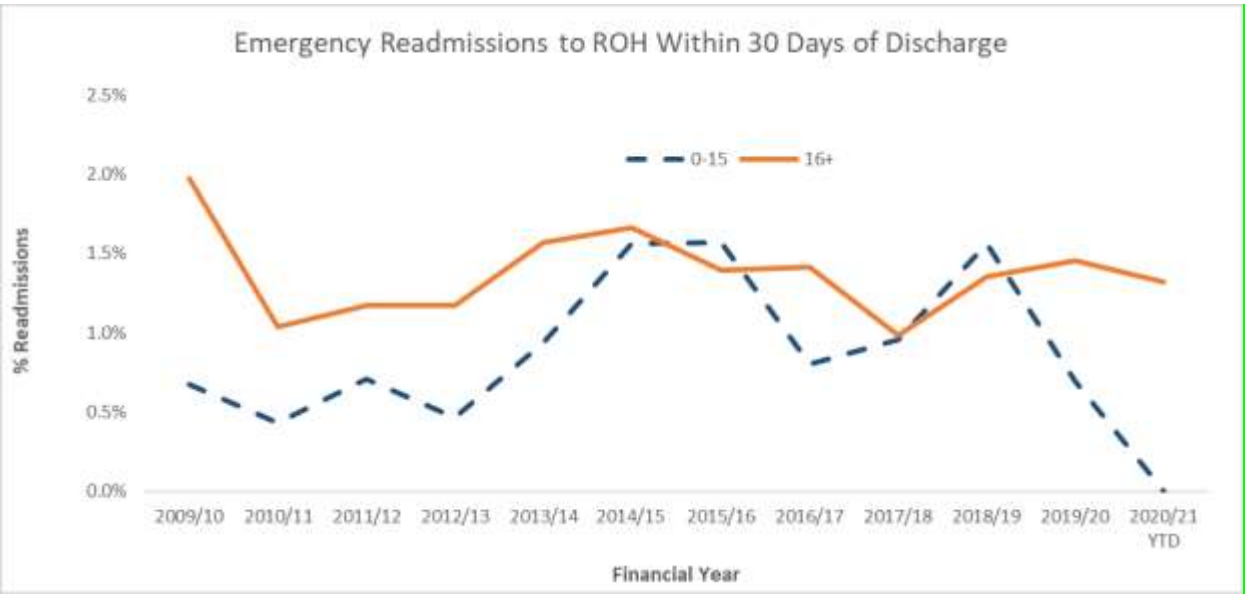
2.6.3 READMISSIONS WITHIN 28 DAYS OF DISCHARGE

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 5 below.

TABLE 6: READMISSION RATES WITHIN 28 DAYS

Readmission Rate	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 YTD
0-15	0.7%	0.5%	0.9%	1.6%	1.6%	0.8%	1.0%	1.6%	0.7%	0.0%
16+	1.2%	1.2%	1.6%	1.7%	1.4%	1.4%	1.0%	1.4%	1.5%	1.3%
All	**1.1%**	**1.1%**	**1.5%**	**1.7%**	**1.4%**	**1.3%**	**1.0%**	**1.4%**	**1.4%**	**1.3%**

GRAPH 5: 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.

The AQILA group has run two cycles of a more strategic audit looking at readmissions within 90 days to any hospital. The basis of this is that these readmissions are of huge relevance to the patients and the teams who care for them. Each Clinical Service Lead received clinician level and patient level information to disseminate and discuss with the team in October 2020 and April 2021. The intention is to continue this bi-annual cycle as part of a wider Patient Progress Dashboard development project. During the first report cycle leads received spark line trend indicators for each clinician in their service. We also used highlight tables to look for patterns visually, plotting reason for readmission by unit an clinician. The work identified a "hot spot" around osteotomy surgery. This area is one where there has been difficulty reaching a national consensus hitherto. The lead surgeon

and the team took away the question and discussed with the VTE committee and have not only adjusted practice internally but taken this as a platform for and audit and recommendations taken back to inform the national consensus. On another level, better feedback about readmissions refocused minds on the patient impact and on a wider post operative period than statutory payment by results review data would normally do, limiting its focus to about a month. We cite this as an example of innovation in presenting data, an opportunity taken to turn challenge into national leadership and a small improvement in patient safety that would have been difficult to achieve otherwise.

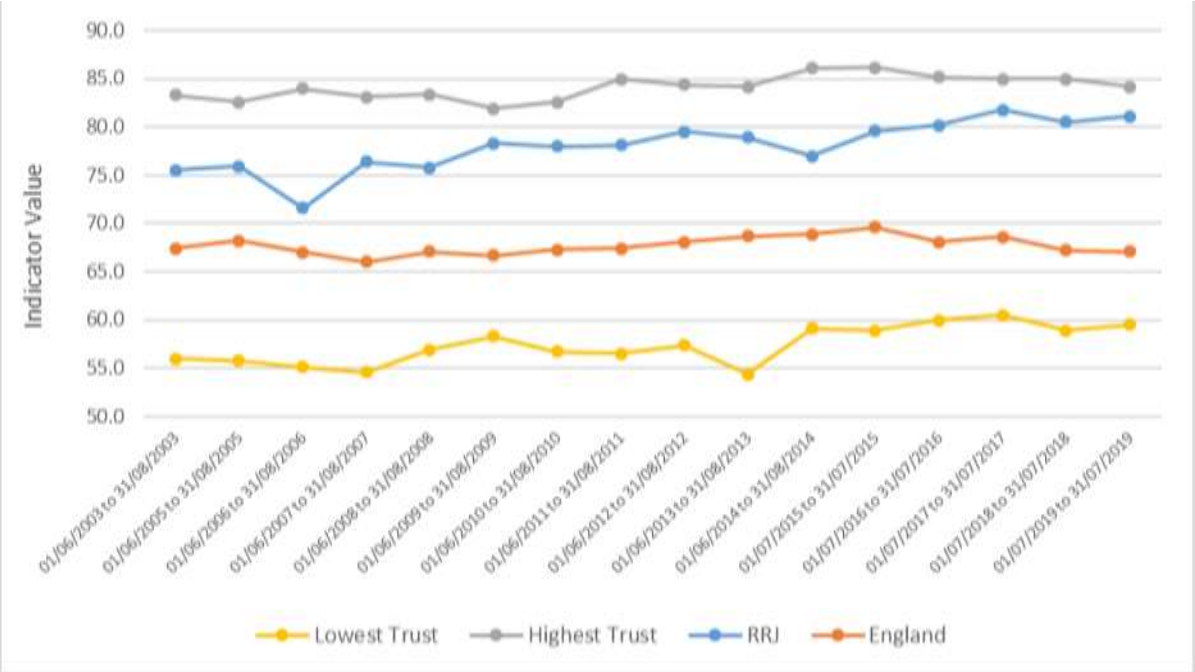
2.6.4 RESPONSIVENESS TO PERSONAL NEEDS

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 6: 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	RRJ	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
01/07/2019 to 31/07/2019	81.1	67.1	84.2	59.5

Data source: Informatics

2.6.5 FINDINGS FROM THE STAFF SURVEY/STAFF FRIENDS AND FAMILY TEST 2020/21

This section presents the findings from the 2020 annual NHS Staff Survey. Trusts were asked to temporarily suspend the Staff Family and Friends Test in 2020/21 until further notice due to the coronavirus pandemic. It is expected we will restart in 2021/22.

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, at directorate level, focus groups, 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), Team development and to support the Business Planning process.

In 2020, 1044 staff were asked to take part in the National Staff Survey with 54% (n=631) of staff responded using a mix mode of online and paper copy completions. This was a 3% increase from the previous year. The Trust is in the benchmarking group with 14 other Specialist Acute Trusts

The overall staff engagement score in the NHS Staff Survey saw a slight decline to 7.3 from 7.5 in 2019 and 7.4 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' declined to 90.1% from 92.4% in 2019.

Question 21c 'I would recommend my organisation as a place to work' saw a decline to 73.9% from 77.2% in 2019.

ACCOMPLISHMENT

Considering the challenges of the pandemic over the last 12 months, the Trust is encouraged by the scores and the fact that percentage of staff members completing the staff survey has increased by 3%. Overall the results show good progress:

- The Trust has increased its focus on supporting diverse staff groups across the Trust through support sessions and access to resources
- The Trust has seen the introduction of three new staff network groups - Multi Minority Ethnic Group (MMEG), LGBTQ+ BeMyself and Menopause awareness
- The Trust has increased the number of categories and nominations for the Staff Awards ceremony in recognition of staff commitment and excellence
- The Trust has been ranked at 34 in the Top 50 listing from Inclusive Companies for 20/21
- The Health and Wellbeing approach continues to be well embedded in the Trust and responded well during the pandemic with additional dedicated resource since November 2020.
- The Trust has further developed a network for Mental Health First Aiders to support both patients and staff members

- The Trust runs regular Inclusion and Wellbeing events to support staff members, patients and visitors. These include Virtual Wellbeing week, listening sessions, Manager Wellbeing briefings and Schwartz Rounds
- The Trust has continued to run Staff Walkabout to allow Non-Executive Directors to meet teams across the Trust
- The Trust has been awarded the Thrive at Work accreditation at Foundation Level by West Midlands Combined Authority (WMCA).

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 so the quality of its services, by;

- Work closely with managerial and union representatives to ensure support is in place for staff to give feedback on the staff survey results.
- 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 an inclusive culture
- Continue to embed a coaching style of leadership and management supported by 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 all areas of business planning, team building and communication
- Continue to implement the staff wellbeing approach with key actions to support staff and patients post Covid-19
- Achieve the **Thrive at Work** Bronze level through accreditation 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:

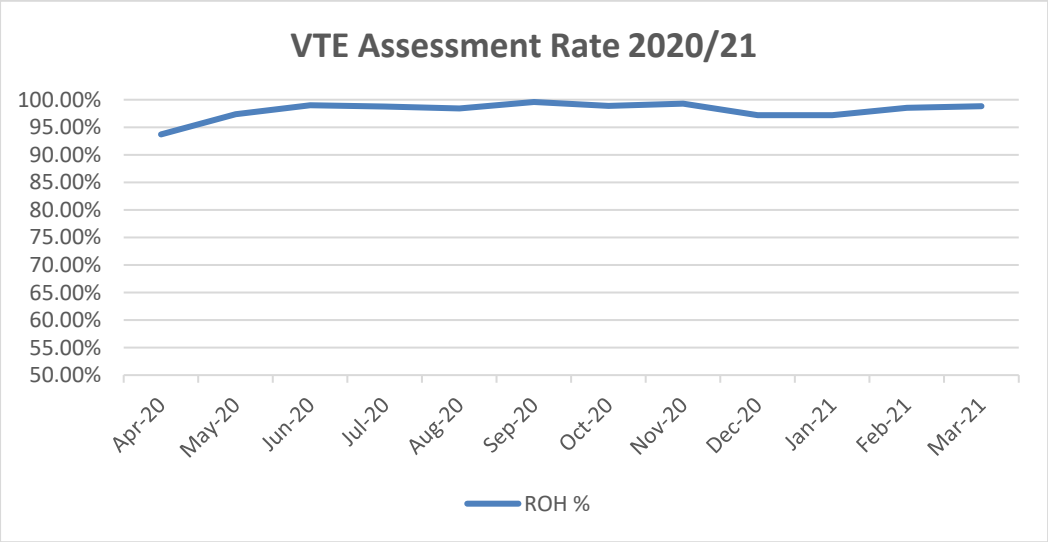
- Monitoring and compliance against the national standard was suspended within the NHS during the pandemic for the year 2020/21. However, Table 4 and Graph 7 below shows Trust compliance with VTE assessments over the past 12 months.

TABLE 8: VTE RISK ASSESSMENTS BY MONTH 2020/21

Month	No. Assessed	No. Admitted	ROH %	National Achieved %
Apr-20	833	889	93.70%	Reporting suspended
May-20	370	380	97.37%	Reporting suspended
Jun-20	288	291	98.97%	Reporting suspended
Jul-20	567	574	98.78%	Reporting suspended
Aug-20	567	576	98.44%	Reporting suspended
Sep-20	723	726	99.59%	Reporting suspended
Oct-20	715	723	98.89%	Reporting suspended
Nov-20	570	574	99.30%	Reporting suspended
Dec-20	551	567	97.18%	Reporting suspended
Jan-21	449	462	97.19%	Reporting suspended
Feb-21	397	403	98.51%	Reporting suspended
Mar-21	586	593	98.82%	Reporting suspended

*Data source: Informatics

GRAPH 7: VTE RISK ASSESSMENT VS NATIONAL AVERAGE



The Royal Orthopaedic Hospital NHS Foundation Trust has continued to risk assess for venous thromboembolism (VTE) on admission using the PICS electronic system. Thereby improve the quality of the services to the patient.

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 toxin-positive case.

The control of infection is of paramount importance for our patients; during 2020/21, there have been three cases of reportable 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 Chlorine solution 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)
2020/2021	2874	0	0%	Data no longer available for the NRLS	Data no longer available for the NRLS	Data no longer available for the NRLS
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 Trust had saw an increase in death related incident. This was due to the Covid 19 pandemic and the change in cohort of patients typically seen at the ROH. This is not included in this data as all deaths were deemed as unavoidable and expected.

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 structure has allowed improved reporting at a speciality level
- The Trust bi 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.
- Introduction of an executive level Governance meeting to discuss emerging risks and incidents.
- 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.

PART 3

3.0 REVIEW OF QUALITY PERFORMANCE 2020/21

3.1 REVIEW OF QUALITY PRIORITIES 2020/21

The Trust's 2019/20 Quality Account set out five priorities for improvement during 2020/21; these were confirmed following consideration of performance in relation to patient safety, patient experience and effectiveness of care:

- Priority 1: Reduce Patient Harms in the Trust – Falls.
- Priority 2: Improving Experience for Patients, Carers and Service Users (PCSU)
- Priority 3: Reduce the number of clinical and corporate policies that are beyond their review date at any period in time and have an appropriate audit plan
- Priority 4: Reduce the number of times patients Outpatient clinic appointments are rescheduled
- Priority 5: Patient Wellbeing (inc. Spiritual Health)

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 five 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 2020/21;

TABLE 10: ACHIEVEMENT OF QUALITY PRIORITIES 2019/20.

Priority 1: Reduce Patient Harms in the Trust – Falls.	This priority has been achieved, completed initiatives: • Trust Falls Assessment reviewed and updated. Falls assessment now on PICS, this generates a falling man alert symbol if the risk of falls becomes apparent. If the patient has a falling man on PICS, nursing staff now completing a new updated falls prevention care plan either on admission or following a fall. • Patient Information leaflets on falls and the use of bedrails reviewed and updated. • Deconditioning and PJ paralysis reviewed**,** training launched around PJ paralysis awareness. We are working with Birmingham City University on a pilot project and academic publication on education impact on the programme. Going forwards, training to be provided 4 x year on HCA induction/update days, training to be monitored. E-learning quiz to be circulated to departments to look at awareness/engagement. • Currently reviewing slips, trips and falls policy. • Thematic review of falls for completed • New poster designed for departmental falls and dementia notice boards, aiming to improve consistency of information for staff
Priority 2: Improving Experience for Patients, Carers and Service Users (PCSU)	This priority has been achieved, completed initiatives: • Complaints KPIs are now complainant with NHS Regulatory requirements • Effective Complaints and Comeback Complaints Tracker present and monitored at Executive Level. • Patient Engagement and Experience Group have continued to meet throughout 2020, but the discussion has been limited by the lack of a sitting Patient and Carers Forum. Work underway to refresh and grow forums (2021/21 priority). • The Patient Experience Strategy remains in place and is being worked through. • Patient Complaints and Concerns are now reported by theme, and feedback is given in weekly meetings with the Divisional Head of Nursing and Operational Managers. • Complaints now have action plans, and they are tracked to completion via Divisional governance (all 2018/19 and 19/20 actions are completed). • The complaints procedure has been reviewed in the last 12 months (last in October 2020). • Reviewing Patient and Carers Forum – we have contacted membership and potential new membership to restart via virtual conferencing. • Healthwatch/Heads of Patient Experience Network (HoPE) networking provides greater external collaboration and idea-sharing opportunities

Priority 3: Reduce the number of clinical and corporate policies that are beyond their review date at any period in time and have an appropriate audit plan	Was previously rolled over from 2018/19 with additional actions (noted below). This priority has been achieved, completed initiatives: • Corporate Governance Team utilising Allocate/Health Assure Module after a delay due to policy upload not taking place as contractually requested in November 2020. • All policy authors with policies overdue for review have been contacted and reminded of the need to review, amend if necessary and seek re-ratification of their policies. • A policy report is submitted every month to the Exec team detailing the current policy position and providing each Exec Director with a summary report of the policy compliance position for each of their respective portfolios. • A clinical policy report is also submitted to the Clinical Quality Group every month. • Concentrated work with some key departments to review overdue policies or policies that require audit where guidance is open to regular change.
Priority 4: Reduce the number of times patients Outpatient clinic appointments are rescheduled.	Was previously rolled over from 2018/19 with additional actions (noted below). This priority has been achieved, completed initiatives: • Working Group meeting every week with a project charter and Standard Operating Procedures for staff to follow removing variation in practice. • Partial Booking waiting lists created and partial booking work completed (an outstanding initiative from 2019/20). • Additional human resource in post to support outpatient clinic appointments and partial booking work.
Priority 5: Ensure that we care for the patients spiritual and pastoral needs whilst a patient at the Royal Orthopaedic Hospital.	This priority is recommended to be rolled over to 2021/22 priorities. Initiatives completed or underway: • Trust Chaplain working on a GAP analysis against the NHS Chaplaincy Guidelines. • New Spiritual and Religious Care Guideline for The Care of Patients, Staff and Visitors in progress. • End of Life Care and Care of the Dying Patient Policy has been amended and refreshed but is still awaiting ratification. • Breaking Bad News Training under review by Oncology Nurse Consultant. • Patient and Carers Forum has not sat during the pandemic and is therefore not able to offer regular feedback on items above, but the Patient Engagement Team is working to renew and restore.

3.1.1 PATIENT EXPERIENCE – COMPLAINTS AND PALS

During 2020/2021 the Trust has received 57 formal complaints. This is a 40.1% decrease compared with 2019/2020. 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
2016/2017	**4136**	**170**
2017/2018	**5094**	**148**
2018/2019	**1531**	**137**
2019/2020	**770**	**142**
2020/2021	**678**	**57**

*Data source: Complaints department/ Ulysses system

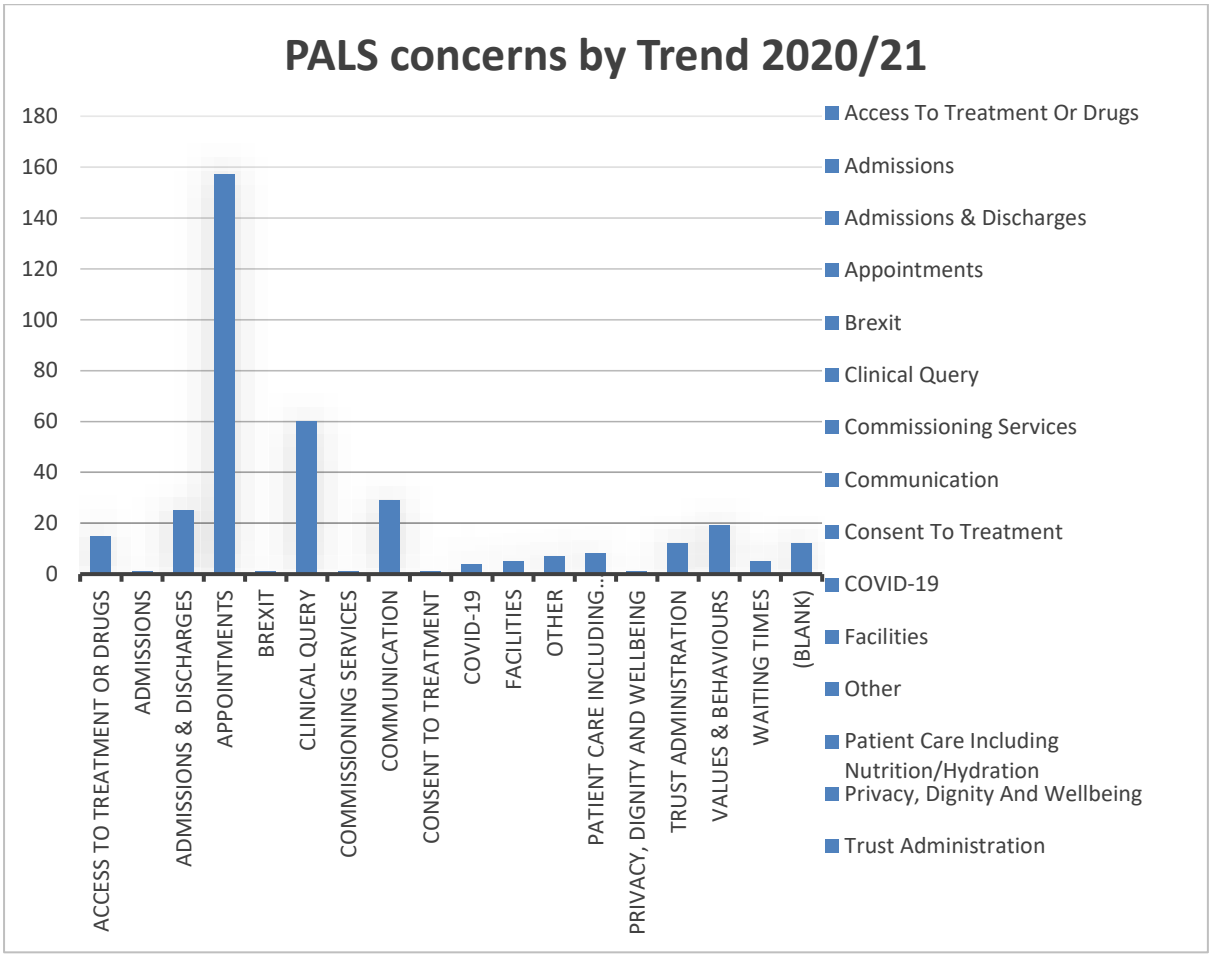
Top three categories for Complaints through 2020/2021 were:

- Clinical Query; including clinical treatment and complication following surgery
- Appointments, including delay failure to provide, referral not authorized and cancellation.
- Access to treatment including COVID-19, access to services and operation cancellation

65 actions have been identified as specific to a complaint, an individual action plan is created, which is monitored though the Divisional Governance structure. 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 2020/2021, 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. Any trends identified are also compared to other sources of patient data and discussed at Divisional Governance meetings, Divisional Management board for each division and wider forums where appropriate.
The PALS department has handled 678 individual contacts in the last twelve months, which has reduced (due to a COVID-19 pandemic), 84% of PALS calls this year were concerns that required more assistance, compared with 67% the previous year.

GRAPH 8: PALS CONCERNS BY TREND 2020/2021



*Data source: Complaints department/Ulysses

The top 3 categories for PALS contacts continue to be Appointment Queries, Clinical Queries and communication respectively with a detailed breakdown of activity shown in graph 8 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 have had very good or good experience within service that they have used are considered to have provided positive feedback. Similarly, patients who indicate that they

have had very bad or bad experience within service that they have used 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 2020/2021, 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 just over 6,000 individual pieces of feedback from the Friends and Family Test in 2020/2021, across all areas and departments. All data is was collected via the 'iwantgreatcare' system until February 2021, February and March data was collected internally; all feedback is read on receipt by the Patient Experience Team and action is taken immediately where necessary. Compliments, concerns and feedback from these are now recorded and shared with individuals and teams on weekly basis. In September 2020 the focus of the FFT questions changed to the focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. The Trust has maintained a 96.5% positive score for recommendation from June to August 2020 meaning that over 5500 patients have indicated that they are happy with and would recommend the care that they have received here in the last twelve months. The Trust started with measuring patient experience from September 2020 and average positive score for inpatient area was 93.41% patients have indicated that they are happy with and would recommend the care that they have received here in the last twelve months.

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 12 below outlines the key quality metrics; a sustained or significant improvement has been demonstrated across 7 of 9 quality metrics in 2020/21

TABLE 12: TRUST QUALITY METRICS 19/20 AND 20/21

QUALITY METRIC	NUMBER OF 19/20	NUMBER OF 20/21
Pressure Ulcers – Category 3 Avoidable	1	0
Pressure Ulcers – Category 2 Avoidable	7	10
Patient Falls All harms	93	76
VTE Avoidable	3	1
VTE Serious Incidents	3 (Avoidable)	1(Avoidable)
Never Events	3	0
Serious Incidents Non VTE Related	7	11
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.
- 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 – awaiting to develop in line with UHB's which are under review and a review of wound dressings was took place
- 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 to support wound healing and management.
- 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

- Guideline developed to manage patients with skin tears developed (Many patients admitted from UHB during lockdown with mild – severe skin tears)

Developments in the prevention and management of falls:

- 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.
- New updated nursing paperwork for 'falls risk assessment care plan', to be used for those patients identified at risk of falling
- Patient Falls leaflet and Bedrails leaflet both reviewed and updated
- Three new hoverjack hoists purchased for staff training and use with patients that have fallen, previously only 1 in Trust
- Replacement of all hoists across the Trust, many of previous ones were obsolete or broken
- PJ paralysis relaunched, including info given to patients at pre-op appointment, PJ paralysis training now on clinical update day
- New falls/dementia information board designed & being printed for clinical areas
- Ongoing thematic reviews of falls to ensure that we identify any key areas or practices that impact on our patients.

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 2020/21 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 an NHS organisation we must consider and fulfil.
- The views and ideas from volunteers, patients and the public, seeking to understand 'what matters to them'.
- Our Patient and Carer Forum.
- Gaining the views from and involving our staff with consultation.
- 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.
- Virtual 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(s) 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 2020/21, the following improvements and actions have been implemented:

- Mental Health First Aid trainers have completed accredited Mental Health First Aid instructors training by Mental Health First Aid England.
- The Trust now has 149 staff members who have received Mental Health First Aid training, with further training sessions planned.
- Tier 1 Mental Health awareness training for all staff as part of the Trust's induction commenced 2020, following delivery to current staff. All staff expected to MH awareness course.
- 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, including clinical supervision for the incoming Mental Health Lead.
- A mental health intranet page and resource folders, 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, suspended during pandemic but maintained small meeting of key representatives to maintain agenda.
- 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.
- Mental Health provision on site for under 18-year olds, currently two members of staff within CYP OPD department. Progressing towards completing Instructor Training to allow others to be trained in First Aider Role.
- Posters for Children and Young Person's mental health displayed in all wards and departments offering information for both staff and patients.
- Funding agreed for a mental health post to support mental health programmes in Trust.

Objectives for 2021/2022:

- Appoint Mental Health (MH) Lead Nurse/AHP.
- Introduce clinical supervision for Mental Health First Aiders via MH lead
- Train further 3 Adult and 2 Youth MHFA instructors
- Deliver MHFA adult and youth training quarterly
- Further develop triage system via notification process already in place to ensure patients are screened and support put in place prior to admission as appropriate
- Develop training plan for 3yr MHFA refresher course as those trained to date will start requiring this from October 2021
- Maintain compliance with MH awareness training for all new starters
- Re launch working group in July 2021 once restrictions lifted
- Review ROH Mental Health Act policy and carry out gap analysis with proposed changes (white paper closes for consultation 21.4.21)

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 2020/21 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

3.2.1 REFERRAL TO TREATMENT (RTT)

The Trust like many other NHS providers have been seen key metric such as RTT profoundly effected due to the covid pandemic of 2020/21, the Trust's 18 week referral to treatment (RTT) position as of March 2021 stands at 58.27%. We work currently towards restoration and recovery along with other local ICS partner organisations. Key performance indicators 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 waiting over 18 and 52 weeks.

Table 13 below illustrates how the Trust has performed in 2020/21 against the national target of 92%.

TABLE 13: 18 WEEK REFFERAL TO TREATMENT 2019/20

18-Week Incomplete	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Waiting Under 18 Weeks	4943	4124	3456	3301	3984	4936	5570	5970	6116	5756	5347	5434
Waiting Over 18 Weeks	2306	3046	3674	3868	3228	2365	1910	1869	2152	2746	3606	3892
Total	7249	7170	7130	7169	7212	7301	7480	7839	8268	8502	8953	9326
% Waiting Under 18 Weeks	68.19%	57.52%	48.47%	46.05%	55.24%	67.61%	74.47%	76.16%	73.97%	67.70%	59.72%	58.27%
Longest Wait in Days	357	388	405	437	468	466	473	382	412	443	471	502
Longest Wait in Weeks	50	55	57	62	66	66	67	54	58	63	67	71
Average Days Wait	104.27	121.68	128.09	126.74	123.40	105.80	94.58	92.73	97.88	108.18	119.1	117.0
Average Weeks Wait	14.38	16.80	17.64	17.63	16.92	14.54	13.07	12.54	13.44	14.87	16.4	16.1

*Data source: Informatics

TABLE 14: 18 WEEK REFERRAL TO TREATMENT 2019/20 (COMPARISON)

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 15: 52 WEEK WAITS 2020/21

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
52 Week Waiters	0	4	16	24	33	36	22	5	13	42	142	142

*Data source: Informatics

TABLE 16: 52 WEEK WAITS 2019/20 (COMPARISON)

	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

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. Oncology patients are now following a more stringent tracking process, to ensure the patients are progressed through their pathway effectively. Individual timelines for any cancer breaches 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 now 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.

The service has continued to work through the pandemic to ensure patients are being provide the best available care for them, during their treatment pathway.

TABLE 17: 62 DAY CANCER TREATMENT TARGETS 2020/21

Target Name	National Standard	*Mar-21*	*Feb-21*	*Jan-21*	*Dec-20*	Nov-20	Oct-20	Sep-20	Aug-20	Jul-20	Jun-20	May-20	Apr-20
62 day (traditional)	85%	**56%**	**66.7%**	**76.5%**	**73.3%**	**57.7%**	**77.8%**	**66.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Treated in target		2.5	4	6.5	5.5	2	3.5	2	5	1	1	6.5	9
Treated outside target		20	2	2	2	1.5	1	1	0	0	0	0	0

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

TABLE 18: 62 DAY CANCER TREATMENT TARGETS 2021/22 (Quarterly Figures)

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%	99.1%	1	107	99.4%	1	157	99.5%	1	187	100%	0	127
31 day first treatment	96%	97.7%	1	44	100.0%	0	25	100%	0	36	100%	0	47
31 day subsequent (surgery)	94%	100.0%	0	40	100.0%	0	41	100%	0	23	96%	1	25
62 day (traditional)	85%	100.0%	0	16	89.5%	1	9.5	71.4%	4.5	15.5	58%	6	19
62 day (Cons Upgrade)	n/a	95.0%	1	20	97.1%	0.5	17	96.6%	0.5	14.5	91%	2	22
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
28 day FDS REPORTED	75%	79%	26	121	85.8%	23	162	78.6%	58	213	72.6%	45	164

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

3.2.3 6 WEEK WAIT – DIAGNOSTICS

Table 19 below illustrates how the Trust has performed in 2020/21 in relation to the diagnostic 6 week wait, against the national standard of 99%.

TABLE 19: DIAGNOISTIC 6 WEEK WAITS 2020/21

	ROH				National Position
Month	Over 6 Weeks	Under Six Weeks	Total	% Under Six Weeks	% Under Six Weeks
Apr-20	1,303	87	1390	6.26%	44.26%
May-20	1186	67	1253	5.35%	41.50%
Jun-20	283	255	538	47.40%	52.20%
Jul-20	2	361	363	99.45%	60.40%
Aug-20	5	573	578	99.13%	62.00%
Sep-20	6	854	860	99.30%	67.00%
Oct-20	10	1152	1162	99.14%	70.80%
Nov-20	7	1073	1080	99.35%	72.50%
Dec-20	24	1240	1264	98.10%	70.80%
Jan-21	231	870	1101	79.02%	66.70%
Feb-21	154	528	682	77.42%	71.50%
Mar-21	6	864	870	99.31%	Not published

*Data source: Informatics

TABLE 20: DIAGNOISTIC 6 WEEK WAITS 2019/20 (COMPARISON)

	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%	89.81%

*Data source: Informatics

3.3 ADDITIONAL 2020/21 CONSIDERATIONS

3.3.1 CORONAVIRUS PANDEMIC

March 2020 saw the start of the national NHS response to the Coronavirus Pandemic, the ROH was not able to continue with its normal elective case mix due to the additional risk of surgery alongside widespread community infection. Emergency Spinal and Oncology work was secured within Ward 3. A level 4 emergency was declared on March 3rd 2020, with decisions then co-ordinated at a national level.

The Trust then proceeded to remodel its services to support University Hospitals Birmingham (UHB), providing trauma services to patients who would otherwise need an inpatient stay or daycase procedure at UHB either through caring for the patient within the ROH inpatient or day case facilities.

An Incident Management System was in place to continually ensure that Executive oversight was provided to the delivery of services on a daily basis. Key issues were:-

- Following nationally issued guidance
- Provision and monitoring of PPE
- Monitoring Staffing throughout the Trust
- Supporting system agreed pathways to support the Birmingham and Solihull System.

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 *Quality accounts requirements 2020/21* and supporting guidance *NHS foundation trust annual reporting manual 2020/21.* 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 2020 to March 2021.
- Papers relating to quality reported to the board over the period April 2020 to March 2021.
- Feedback from governors dated June 2021
- The 2020 national patient survey.
- The 2020 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

24 June 2021 Tim Pile Chairman

24 June 2021 Jo Williams Chief Executive