NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Quality Account 2023/2024

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Executive Sponsor: Jo Williams, Chief Executive Officer

Foreword from Chief Executive Officer

I am pleased to present the Quality Account for the Royal Orthopaedic Hospital for 2023/2024. This report highlights our ongoing commitment to providing exceptional care and achieving remarkable quality improvements. Quality is the cornerstone of our care and I hope you'll see this reflected throughout the report.

I'm pleased that we are a patient-centred hospital - feedback, engagement and co-production continues to shape the services we offer and the quality which underpins them. Our vision is '***less pain, more independence, life-changing care'*** and this vision relies on delivering the highest standards of quality.

Over the past year we have continued to deliver against a comprehensive quality improvement framework. This has guided our efforts to enhance patient safety, clinical effectiveness, patient experience, and staff well-being. By analysing data, conducting clinical audits, and gathering feedback, we have identified areas for improvement and implemented targeted interventions. Our commitment to patient safety remains a top priority. We have invested in safety protocols, training programmes, and technologies to ensure the highest standards of care. Our commitment and investment are reflected in the quality outcomes we have achieved over the year and I'm grateful to our incredible team who make this possible.

The Care Quality Commission (CQC) did not conduct a full inspection at The Royal Orthopaedic Hospital in the past year, but we continue to build good working relationships with our regulatory body to ensure transparency, constructive dialogue and the highest standards of quality and safety are upheld.

I'd like to thank every member of the Royal Orthopaedic Hospital team. The work of this team is outstanding, and quality is foundational in what they do. Of course, quality is not a destination, it is an ongoing journey for us. We are committed to continually improving what we do to ensure that our patients receive the very best care possible.

With warm regards,

Jo Williams, Chief Executive Officer

Contents

1.0. What is the Quality account?

Patients want to know they are receiving the very best quality of care. Providers of National Health Service (NHS) healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and the Health and Social Care Act 2012 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 require all NHS Foundation Trusts to produce quality account. 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 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 2024/25.
- Our progress against delivery of the Quality Priorities we outlined in 2023/24.
- 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.

1.1. Who has been involved in producing the Quality Account?

The Quality Account has been developed by The Royal Orthopaedic Hospital (ROH) with input and assistance from a range of stakeholders, including:

- ✓ The ROH Council of Governors.
- ✓ The ROH Quality and Safety Committee.
- ✓ The ROH Clinical Quality Group.
- ✓ The ROH Patient Engagement and Experience Group.
- ✓ The ROH Audit Committee

1.2. Our Hospital - Royal Orthopaedic Hospital (ROH)

The ROH is a single speciality Orthopaedic hospital offering elective and specialist services at a local and regional level. Our vision is '***Less pain, more independence, life-changing 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. We work with our local partners in the Birmingham and Solihull (BSOL) Integrated Care System (ICS) to continue improving elective Orthopaedic services for patients across Birmingham and Solihull.

We are proud of the research and innovation led by teams at the ROH, including continuing to expand the number of Orthopaedic researchers we have across the ROH with continued investment in the research. This alongside strengthened academia and commercial partnerships to deliver major grant funded research programmes led by ROH investigators utilising our Regenerative Medicine Research laboratory.

The ROH leads the Birmingham and Solihull ICS Musculoskeletal (MSK) Transformation Programme, which aims to standardise the design and delivery of MSK services for our population. The programme is underpinned by five workstreams focusing on: standardising procedure level pathways and clinical decision making; improving patient information and Advice and Guidance; developing digital solutions for self-management; enhancing public health promotion and prevention; and developing the MSK workforce for the future. This programme reports into the ICS Integrated Care Board and is closely aligned to the national Best MSK Health High Impact Strategy.

1.3. Equality and Diversity

Equality is about creating a fairer society where everyone can fulfil their potential and have equal opportunity to achieve their desired outcomes and live without health inequalities. We recognise the rights of all our patients, visitors, and employees to be treated fairly and value the different perspectives they have to offer irrespective of age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability, and social status.

2.0. Our Quality Priorities for 2023/24

During 2023/24 we continued to focus on quality improvement. We have developed the capability of our staff within the organisation through Quality Service Improvement and Redesign (QSIR) training, supported by the arrival of a Quality Improvement Nurse. The Continuous Improvement team have led initiatives such as Quality Improvement huddles and designed huddle boards as well as engaging with teams to foster a culture of continuous quality improvement.

We have continued to promote links between hospitals within BSOL and built connections with the third sector partners to ensure the quality of care and access to services for our patient's is of the highest quality.

Last year we identified five priority areas for improvement as outlined below in Table 1.

Safe	Continue to embed a Safety Culture through the implementation of the Patient Safety Incident Response Framework (PSIRF) in the Trust. While continuing to embed safety initiative into the Trust.
Caring	Improve the quality of communication to our patients.
Effectiveness	Improve awareness of good 'Antimicrobial Stewardship'.
Responsive	Optimisation of patient's health prior to surgery.
Well-led	Ensuring clinical knowledge gaps are identified and addressed to ensure our workforce are culturally responsive to the needs of the people we serve using a continuous improvement methodology.

Table 1. Quality Priorities 2023/24

The quality priorities formed a key part of the working plan for the Clinical Quality Group (CQG) throughout the year, with a quarterly reporting cycle. The meeting is chaired by the Chief Nurse. The five quality priorities (QP) for 2023/24 were presented in the later part of quarter 4 to the CQG, at which time it was agreed that three priorities, QP 1,3 and 5 had achieved their target and would be managed under business as usual. However, two priorities QP2 & QP4 required further work and scrutiny to ensure that they embedded and achieve the goal, therefore the committee recommended they would continue into 2024/25. This decision was supported by the Trust's Quality and Safety Committee.

2.1. Performance on 2023/24 Quality Priorities

Priority 1: Continue to embed a Safety Culture through the implementation of the Patient Safety Incident Response Framework (PSIRF) in the Trust. While continuing to embed safety initiative into the Trust.

Background:

Patient safety is everyone's business and as the Trust works with system partners to implement the new framework, we will continue to ensure that the foundation work already embedded is built on over the coming year.

Initiatives:

Implementation and embedding of the Royal Orthopaedic Hospital NHS Foundation Trust (ROH) PSIRF Policy and Response Plan into Trust Governance processes.

- Transfer from the Serious Incident Response Framework to PSIRF.
- Engage with 'check and challenge' system meetings as a BSOL partners. Ensuring progress is in line with the Patient Safety Strategy and NHS England PSIRF Implementation Plan and Guidance.
- Continuing to develop a safety culture through engagement and roll out of Human Factors Training.
- Continuing to develop a safety culture through sharing improvement methodology (Quality Service Improvement and Redesign – QSIR) Training.
- Develop continuous quality improvement Huddles to engage all staff in improvement methodologies and activities.
- Introduction of 'Quality and Safety walk arounds' in all clinical areas. With target action plan for improvement to be owned locally.

Successful actions:

- PSIRF policy was approved at Board in August 23. Work continues in FY 24/25, with full implementation.
- Quality & Safety walkabouts have now been embedded into practice, with action plans shared. Improvement project underway to adapt the Quality and Safety Walkabout into a recognised and celebrated Service Accreditation project.
- PSIRF investigation training for staff is being procured to support patient safety incident investigations.

Outcome: Achieved

As this is a cultural change it can be difficult to measure success in the short term, evidence shows that cultural transformation can take 3-5 years to implement and embed. However, the following has been achieved with promising results and we will now progress this work as 'business as usual':

- High quality investigation reports are being produced with areas for improvement focusing on systems and human factors improvements instead of with an individual focus.
- Systems Engineering for Patient Safety (SEIPS) framework has been adopted by the Trust when recognising areas for improvement.
- Learning on one Page (LOOP) documents are being widely used to share findings and learning across the organisation.
- Quality Improvement programmes are being developed for the Trusts Safety Priorities as identified in the ROHNFT PSIRF Plan.
- We benchmarked progress against the NHSE PSIRF preparation phase guidance.
- We collaborated with BSOL providers to ensure consistent approach.
- We took part in the 'Check and Challenge' BSOL meetings.
- We noted an increased number of incidents reported, particularly near miss incidents.
- We have seen a positive increase in the numbers of quality improvement projects throughout the clinical teams.

- We noted a positive response in the staff survey results.
- We noted improvements in recruitment and retention.
- We continued to focus on human factors thinking and system approach to incidents.

Priority 2: Improve the quality of written communication to our patients.

Background:
Medical and healthcare information can be complex, if people don't get clear and understandable information, they may make decisions that aren't right for them or not be able to access services at all. Our Patient Advice & Liaison (PALS) contacts data highlighted that in 2022/23 two of our two themes for patients to contact us was related to 'Appointment' and 'Communication' issues.

Initiatives:

- Review all current patient information against the Good Communication with Patient: Core principle (2021). (Included leaflets, letters, and all communications).
- Review the Trust current interpretation / translation service against accessible information standards.
- Review complaints and cancellation on the day related to communication and translation services, to identify themes and trends that can be improved.

Success actions:

- Working group set up to standardise and improve letters.
- Close link with OPD transformation work-particularly on easy read letters and improved text messaging to avoid duplication of time and effort.
- Continued monitoring of PALS/Complaints and incidents relating to communication for themes/trends.
- Tendering process being undertaken to ensure the Trust is commissioning the best quality service for the best value for money.

Target / Outcome:

- **Decrease in complaints related to patient communication by 10% over the year.**

  Significant progress has been made over the last 12 months. However, there is still more work to do to make improvements and embed fully those improvements already made. Whilst incidents, have reduced particularly with appointments, communication does remain a theme within PALS and Communication (As demonstrated section 4.2.1)

- **Reduction in cancelation on the day related to translation services by 5%**

- In 2022 /2023 only one complaint was raised formally regarding translation services. However, local information highlighted that the policy may not have been fully implemented into practice.

In 2023 / 2024 an increase in reporting was noted. However, this followed an awareness and signposting campaign designed to highlight *'when an interpreter should be used'.* This was viewed as a positive result as it demonstrated an increase in awareness and implementation of the services to meet the needs of our patients. This part of the QP will now move to business as usual for monitoring.

Next steps: The first part of this QP (Improve communication to patients), will continue into 2024 / 2025 as the working group feel additional monitoring and work is required.

Priority 3: Improve awareness of good Antimicrobial Stewardship

Background:

NICE recommendations: Antimicrobial resistance (AMR) in the loss of antimicrobial effectiveness and although it evolves naturally this process is accelerated by the incorrect use of antimicrobials, such as prolonged use. Direct consequences of infection with resistant microorganisms can be severe and affect all areas of health, including increased illness and hospital stays, increased costs, mortality, and reduced protection for patients undergoing operations or procedures.

Initiatives:

- Snapshot audit to be undertaken by junior medical staff using 'Start smart then focus toolkit'. Establishing a baseline.
- The trust will be taking part in the SAPPHIRE which is a research trial designed to explore: *Safe Antimicrobial ProPhylaxis for surgery study.* However, the finding of this may not be available in the year.
- Deliver consultant education at clinical audit by Consultant Microbiologist.
- Develop bite size (for safety huddles) education tools for nursing/ODP's teams.

Successful actions:

- National point prevalence survey has been completed. Data to be analysed by IPC lead, pharmacist, and microbiologist.
- Antimicrobial prescribing guidelines updated as a result of surgical prophylaxis audit findings. Awaiting approval by drugs and therapeutics committee.

- National CQUIN audit on IV to oral switch for 2023/24 completed and shows Trust is compliant to CQUIN.
- Trainee pharmacists delivered quick education sessions to nursing staff on the recent MHRA alert on fluroquinolones to ward teams.
- Surgical prophylaxis report presented at Clinical Audit Day. Antimicrobial guidelines updated.
- CQUIN audit results submitted to UKHSA and presented at Antimicrobial Stewardship Steering Group.

Outcome: Achieved

- We continue to monitor antibiotic usage in the Trust and report a positive reduction and conversion to oral antibiotics.

Sponsored from the Council of Governors

Priority 4: Optimisation of patient's health prior to surgery

Background:
To reduce health inequalities amongst the community we serve. In a post pandemic world, cancellations on the day of surgery linked to potential gaps in pre optimisation of patients preoperatively is on the rise. Patients who are not fully ready for treatment are at a greater risk of significant complications after surgery, which can result in extended hospital admissions, leading to longer term health issues and reduced mortality.

Initiatives:

- Develop a '*waiting well for surgery'* pre-optimisation approach for ROH. With key focus on weight management, stopping smoking, eating well, exercising etc.
- Build on the 72 hours pre-surgery checks, by developing digital solution to identify potential risk to surgery (such as skin tear detection).
- Improved patient outcomes though education (Weight loss, stop smoking etc.).
- Reduction of patient cancellations on the day of surgery.
- Reduction in delayed discharges.

Successful actions:

- A Task and finish group was established and met monthly focusing on this QP (reps from operations and digital lead). Data reviewed for last 12 months of cancellations reviewed.
- The Pre-Operative Assessment Clinic (POAC) led the 'waiting well' work, with a launch in Jan 2023 outside café Royal to inform the staff of what was available. They

developed booklets, business cards, posters, and a web page with information. This was followed with a patient launch in Out-patients Department (OPD) in Feb 2024. This included a patient survey to understand what information patients need and require.

The POAC nursing team have also achieved 90% training compliance with smoking cessation training.

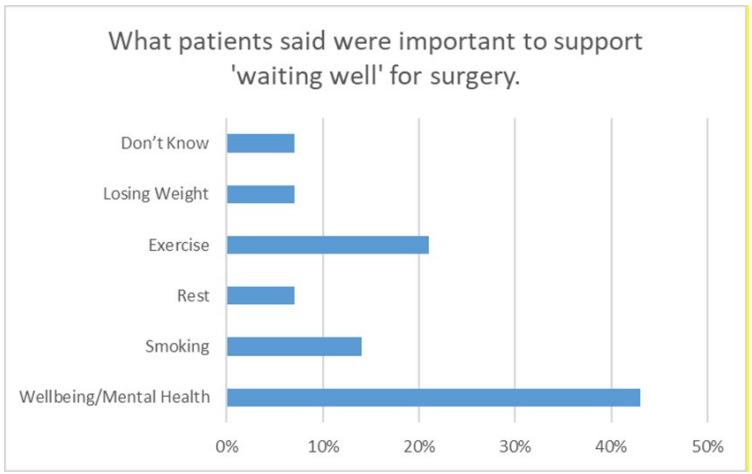
In addition, the Task & Finish group focused on a digital approach to support the 72-hour pre-operative checks, specifically skin (damage that might prevent surgery). The first approach was unsuccessful due to digital challenges; however, the team have continued to explore, and the work will continue. (ACCRUX are due to present to the team on a free and widely digital approach that is used by NHS GP's already).

Outcome:

- Reduction in Cancellations on the day (To be monitored in 2024/25)
- We received initial positive patient feedback about the campaign. We will continue to monitor effectiveness and understand digital challenges in 2024/25.
- Measure health promotion data shared with patients and survey to see if data provided was effective/useful.

Picture 1 & 2. Launch of 'waiting well for surgery in OPD and outside Café Royal

Campaign poster is displayed around the Trust in varies areas such as: OPD and POAC.



Aim: During the launch of 'Waiting Well for surgery' a survey was undertaken by the POAC team. The aim was to gain an insight into what was important to patients.

Outcome: Patient told use well-being and mental health was the key area of importance to them.

Next steps: This QP will continue into 2024/25 as the working group feel additional monitoring and work is required to ensure this work is fully embedded.

Priority 5: Ensuring clinical knowledge gaps are identified and addressed to ensure our workforce are culturally responsive to the needs of the people we serve using a continuous improvement methodology.

Background:

To reduce health inequalities amongst the community we serve. To ensure safety of all patients we serve, whilst recognising differing needs due to ethnicity. We must have the ability to recognise risk factors amongst specific groups and be able to take actions to improve their healthcare outcomes.

Initiatives:

- Using Quality Improvement (QI) methodology identity gaps in knowledge among the clinical staff and develop 'fast tutorials' that can be used to educate staff when at risk patients are admitted.
- Recruit and embed a Quality Improvement Nurse within the nursing structure.

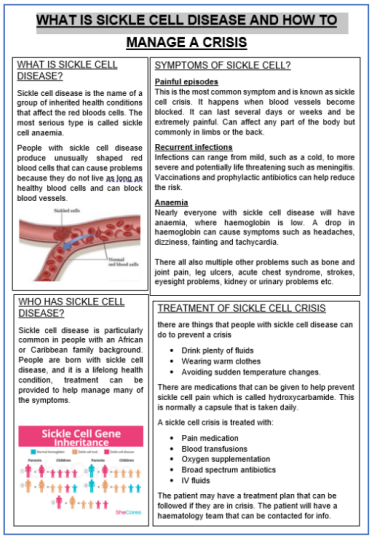
- Introduce 'shared governance' empowering the teams to identify and continue improving initiatives and identify gaps in knowledge.

Successful actions:

- Appoint a Quality Improvement nurse to support the delivery of the Trust Strategy and introduce shared governance.
- Identify gaps in learning for clinical staff (protected characteristics) and develop short teaching tutorials for staff to raise awareness.

Outcome: Achieved

- Quality Improvement nurse commenced in post, focusing on encouraging the wider clinical team to take part in QI and introduced huddle boards (Shared Governance methodology).
- Draft Health Inequalities Plan developed with year on- a-page presented to Trust Board.
- First Orthopaedic Nursing & AHP Conference in April 24 focused on Quality Improvement and Innovation. Successful day, with over 75 guests from across England.
- Short teaching tutorials were developed in year: Sickle cell and Transgender awareness training.



WHAT IS SICKLE CELL DISEASE AND HOW TO MANAGE A CRISIS

WHAT IS SICKLE CELL DISEASE?

Sickle cell disease is the name of a group of inherited health conditions that affect the red bloods cells. The most serious type is called sickle cell anaemia.

People with sickle cell disease produce unusually shaped red blood cells that can cause problems because they do not live as long as healthy blood cells and can block blood vessels.

SYMPTOMS OF SICKLE CELL?

Painful episodes
This is the most common symptom and is known as sickle cell crisis. It happens when blood vessels become blocked. It can last several days or weeks and be extremely painful. Can affect any part of the body but commonly in limbs or the back.

Recurrent infections
Infections can range from mild, such as a cold, to more severe and potentially life threatening such as meningitis. Vaccinations and prophylactic antibiotics can help reduce the risk.

Anaemia
Nearly everyone with sickle cell disease will have anaemia, where haemoglobin is low. A drop in haemoglobin can cause symptoms such as headaches, dizziness, fainting and tachycardia.

There all also multiple other problems such as bone and joint pain, leg ulcers, acute chest syndrome, strokes, eyesight problems, kidney or urinary problems etc.

WHO HAS SICKLE CELL DISEASE?

Sickle cell disease is particularly common in people with an African or Caribbean family background. People are born with sickle cell disease, and it is a lifelong health condition, treatment can be provided to help manage many of the symptoms.

Sickle Cell Gene Inheritance

TREATMENT OF SICKLE CELL CRISIS

there are things that people with sickle cell disease can do to prevent a crisis

- Drink plenty of fluids
- Wearing warm clothes
- Avoiding sudden temperature changes.

There are medications that can be given to help prevent sickle cell pain which is called hydroxycarbamide. This is normally a capsule that is taken daily.

A sickle cell crisis is treated with:

- Pain medication
- Blood transfusions
- Oxygen supplementation
- Broad spectrum antibiotics
- IV fluids

The patient may have a treatment plan that can be followed if they are in crisis. The patient will have a haematology team that can be contacted for info.

Box 1. Sickle cell tutorial

The ward manager carried out a short survey prior to rolling out training. The survey was designed to gain an insight into staff understanding of sickle cell pre-training and then post training. The tutorials are designed so they can be used anytime a patient is admitted with sickle cell as a reminder.

Health Inequalities Plan on Page

HEALTH INEQUALITIES PLAN 2023 - 2028

NHS
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2024-25 ACTION PLAN

DATA AND INSIGHT

Introduce a clear framework for collecting health inequalities data and create a dashboard to support insight and improvement.

GOVERNANCE AND MONITORING

Ensure that our governance supports consistent monitoring of health inequalities data to enable improvement.

SYSTEM ALIGNMENT

Ensure that the data we collect and actions we take, aligns with the strategic approach of BSol ICS in tackling health inequality.

CAPACITY AND SUPPORT

Build adequate leaderhsip, capacity, support and resources to deliver our health inequalities agenda.

IMPROVEMENT INTERVENTIONS

Create a high impact action plan that prioritises measureable improvement interventions that reduce health inequality.

3.0 Our Quality Priorities for 2024/25

The Trust values the views of our key stakeholders and as in previous years has sought their involvement and feedback to ensure our plans accurately reflect the needs of our patients and the communities we serve. We have done this by consulting with staff, key stakeholders, patients, and members of the pubic using various methods including complaints, PALS, NHS CQC In-patient feedback and reviewing our KPMG report specifically related to Health Inequalities. The consultation process took place during April and May 2024. Five specific areas to focus our attention in 2024/25 were identified.

The quality priorities were presented to the Council of Governors in May 2024, where they agreed to sponsor quality priority 4 for the coming year. This is a continuation of support from 2023/24.

	Quality Priority	Operational Lead	Executive lead
Safe	Reduction in Surgical Site Infections.	Tracey Littlehales Theatre Matron, Victoria Clewer IPC lead & Mr Andrew Thomas Consultant Surgeon	Nikki Brockie Chief Nurse & Matt Revell Medical Director
Caring	Improve the quality of communication to our patients.	Karen Hughes, Head of Nursing Division 1, Nasir Uddin, Associate Director of Operations Division 1	Nikki Brockie Chief Nurse & Marie Peplow Chief Operating Officer
Effectiveness	Development and Implementation of the Health Inequalities Plan.	Nikki Brockie Chief Nurse & Rebecca Lloyd Deputy Director of Strategy	Jo Williams CEO
Responsive	Optimisation of patient's health prior to surgery.	Jennifer Pearson, Head of Nursing Division 2 & Ben Smith Associate Medical Director	Nikki Brockie Chief Nurse & Matt Revell Medical Director
Well-led	Introduction of Service accreditation.	Emma Steele Deputy Chief Nurse & Nikki Brockie Chief Nurse	Jo Williams CEO

Table 2: Quality Priorities for 2024/25

How will progress be monitored:

Performance will be monitored and tracked quarterly at the Clinical Quality Group and Quality & Safety Executive Meetings (specifically for Health Inequalities plan), to allow early escalation of complications or failure to deliver against action plan.

Quarterly reports will then be presented to Quality & Safety Committee for oversight and assurance via the Chief Nurse report. The quarterly report will be presented to Trust Board for assurance and scrutiny. Twice yearly updates will be provided to the Council of Governors for assurance against their sponsored priority.

The Trust quality improvement methodology *Quality Service Improvement & Redesign* (QSIR) will be applied to each quality priority and supported by the Quality Improvement Lead Nurse.

Quality Priority 1:

Safe	Reduction in Surgical Site Infections.
Background	Surgical site infection (SSI) is an infection that occurs at the site of a surgical incision. It is a serious complication that can prolong the hospital stay, increase the risk of death, and lead to additional surgeries. The ROH has noted an increase in SSI over the last year. Therefore, the multidisciplinary team will focus on implementing a reduction plan utilising a 'care bundle' approach (based on NICE NG125) over the coming year.
Initiatives	• Continuous monitoring and deep dive into quarterly SSI data as submitted to UKHSA. • Establishment of the Surgical Site Infection Prevention Group and merging of workstreams. • Benchmarking data with Robert Jones & Agnes Hunt NHS Trust and The Royal National Orthopaedic Hospital to understand shared themes and improvement approaches. • Six work streams identified (based on NICE NG125 guidance) and working groups established.
Success Evaluation	• An overall reduction in surgical site infection across the three SSI surveillance categories. • Improved compliance with NICE guidance NG125.

	• Improved benchmarking reporting and shared approach to improvement.

Quality Priority 2.

Caring	Improve the quality of written communication to our patients and develop easy-read materials that improve patient experience and accessibility to services.
Background	This quality priority was partially achieved in 2023/24; however, it was felt that additional focus was required on reducing occurrences of communication issues and further development of easy-read letters and materials is required. Therefore, the working group will focus on these areas in 2024/25.
Initiatives	• Easy-read working group to be established, with clear focus for the coming year e.g. patient information leaflets, letters etc. • Monitor impact of work carried out in 2023/24 to understand effectiveness and identify further areas of improvement.
Success evaluation	• Decrease in complaints/PALS/Incidents related to communication by 10% over the year to be tracked quarterly. • Approved, standardised (where possible) easy-read letters in place for all specialities by end of Quarter 2. • Easy read materials to be available more broadly by end of Quarter 3 and an evaluation of impact undertaken in quarter 4.

Quality Priority 3.

Effectiveness	Develop and implement a Health Inequalities Plan with clear targets and objectives to improve patient access / experience and to meet the needs of our local population.
Why we chose this Quality Priority	Health Inequalities are ultimately about differences in the status of people's health. But the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status (Kings fund 2022). Over the next year our ambition is to develop a plan that will meaningfully improve the MSK and orthopaedic care of our local population.
Initiatives	• Delivery objective outlined on the plan-on-page as presented in 2023/24 • Deep dive into the data and agree clear monitoring criteria. • Agree governance 'Ward to Board' pathway. • Review initiatives underway and capture within plan.

	• Align with the LD & Autism strategy.
Success evaluation	• Approved 3-year plan. • Improved data and understanding of our patient demographic affecting access and choice. • Improved governance and reporting routes. • Improved access for our local communities.

Quality Priority 4.

Sponsorship from the Council of Governors

Responsive	Continue to strengthen the pre-optimisation of patient's health prior to surgery focusing on health promotion and early pre-operative screening.
Background	'*Waiting well for surgery*' was introduced in February 2024 at the ROH as a key Quality Priority of 2023/24. The focus is the optimisation of patient's health prior to surgery, however, as this QP has only been in place for a short time the working group felt it would benefit from continued monitoring and improvement in 2024/25. With a focus on ensuring patients who are listed for surgery are optimised at the earliest possible point in their pathway through effective early screening processes. The working group are also keen to implement a digital solution that allows patients to share concerns about skin integrity prior to surgery, thereby reducing cancelations on the day.
Initiatives	• The working group with aim to develop a pre-screening pathway working with divisional colleagues. • Working with IT department to explore and evaluate the introduction of digital and remote pre-operative skin inspection tools. Implementation as able following a thorough evaluation and risk assessment. Ensure patient who are digitally excluded are considered and supported. • Evaluate 'wating well for surgery' in quarter 2 and continue to improve provision over the year.
Success evaluation	• Patient review of 'waiting well for surgery' by the POAC department with an action plan to continue to build on the foundations and make improvements. • Monitor feedback from 'coffee catch-up' and feed information into QI processes. • Introduction of a digital solution to checking skin integrity prior to surgery with a 25% reduction in cancelations on the day of surgery.

Quality Priority 5.

Well-led	Introduction of Service Accreditation across all clinical areas.
Background	The service accreditation system is a quality assurance programme that follows a structured approach using a uniformed set of standards to measure the quality of care delivered across clinical service units or areas. It is a key driver to improving patient care and celebrating good practice. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, unit, or team level (NHS England, 2019) Currently The ROH does not have a formal service accreditation system for nursing and allied health services which drives continuous improvement across the Trust. The design and implementation of a Service Accreditation program aiming for Outstanding Care Every Time will enable the Trust to deliver outstanding, safe, and quality care to our patients and our communities. This aligns with the Trust's strategic ambitions and provides a local assurance system for the Trust.
Initiatives	• Establish a Service Accreditation working group using QSIR methodology approach to the project. • Engage with all wards and departments to ensure the accreditation programme can be implemented into all clinical areas. • Developing a set of standards against which to measure quality of care that demonstrates improvement. • Create a platform for shared learning so that wards and units can learn from each other and disseminate excellent practice. • Implement a pilot inspection in early quarter 3, with full roll-out by the end of quarter 3.
Success evaluation	• Increases staff engagement, encourages team working and improve staff morale, leading to reduced turnover, sickness, and reliance on temporary staff. • Monitor and track staff experience using Pulse survey (quarterly) and staff survey data specifically in relation to '*we feel empowered to make improvements"*.

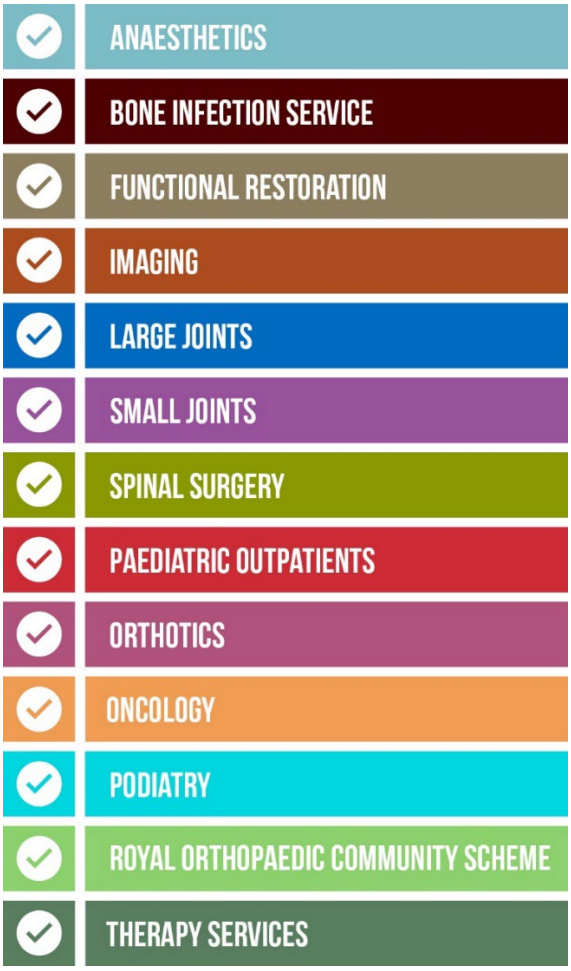
	• Improved ward-to-board assurance on the quality of care and compliance with fundamental standards which enables preparedness for external inspections. • Reduces unwarranted variation by providing an evidence-based, standardised approach to supporting the delivery of care and improving quality. Standardises practice in key processes: for example, patient discharge, patient observations, staffing, risk assessments for patients and audits.

4.0 Statements of Assurance

4.1 Priorities for improvement and statements of assurance

During 2023/2024 The ROH have 14 relevant health services. The ROH has reviewed provided all the data available to them on the quality of care in these health services.

The 14 services provided by the Trust are:



4.2 Percentage of Income Generated by ROH Services

During 2023/24 The ROH provided and or subcontracted £129,533,728 of relevant health services.

The income generated by these health services reviewed in 2023/24 represents 95.51% of the total income generated from the provision of health services by The ROH during the year. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. Aligned payment and incentive contracts form the main payment mechanism under the NHSPS.

In 2023/24 API contracts contain both a fixed and variable element. In 2023/24 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments were accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at tariff price.

4.3 Participation in national clinical and local clinical audits.

During 2023/23, the Royal Orthopaedic Hospital participated in 7 national clinical audits that covered health services that the Trust provides. This was 100 percent of the national audits the trust was eligible to participate in.

The national clinical audits that data collection was completed for during 2023-24 are listed below.

4.3.1 National Audits

Project Number/ Governing Body	**Project Title**	**Team**	**Lead**	**Progress**
NHS DIGITAL	Elective Surgery: National PROM'S Programme	Arthroplasty	Mr K. Moholkar / Lijun Wen	Hip Q1 compliance 100% Knee Q1 Compliance 100% Hip Q2 Compliance 98% Knee Q2 Compliance 99%

HQIP/QA	National Joint Registry (NRJ)	Arthroplasty	Mr D. Dunlop / Deb Wright	99% latest audit compliance 95% Consent rate
20-085	BOOM - British Orthopaedic Oncology Management Audit	Oncology	Mr J. Stevenson	Confirmation of data submission from 1st April - 30th June 2021. Report not yet released. Last report 2015.
UK FATE	Venous thromboembolism in Foot and Ankle surgery.	Foot & Ankle	Mr H. Rajgot / Mr B. Budiar	Data collection completed February 2023. Report not yet published.
21-028	The PFF Study: A National retrospective review of femoral periprosthetic fracture management. Is there variation in practice?	Arthroplasty	Mr D. Dunlop / Mr M. Khalefa	Report not yet published. Confirmation of data submission on Redcap.
22-044	RADICAL: Robotic Assisted Data Evaluation Collaborative on Alignment	Arthroplasty	Prof E. Davis / Mr S. Bleibleh	NO ACTIONS YET
NAP 7	NAP 7 - Perioperative Cardiac Arrest	Anaesthetist	Dr Siddaiah	Report sent to Dr B Smith for review 20/11/2023

4.3.2 National Audits Cont.…

Speciality	Brief description of audit/Improvements
Arthroplasty PROMS	Latest report published 12 August 2021, there is a hold due to the changes with NHS digital we therefore keep a monthly rolling ROH in house figure of the compliance on data collections however the results below are from the 2021 report. • 97.3% of hip replacements reported improvements, from Oxford Hip score. • 94.5% knee replacements reported improvements in health from Oxford Hip score. • 65.1% of Hip participation rate Post Operative questionnaire • 65.4% of Knee participation rate Post operative questionnaire Following on from the publication it was identified that more engagement with patients was required to improve the participation rate following Hip and knee procedures. Telephonists now collect data by contacting the patient and completing the questionnaire with them. This has proved to be successful, and we now have an average of 98.9%. **Current participation rate at ROH.** • 89% participation rate - 1309 Primary Hip procedures and 89 revisions have been completed 23-24 • 87% participation rate – 1239 knee procedures and 92 revisions have been completed 23-24 • PROMS data us reviewed at both AQULA and Quality and Safety Committee.
National Joint Registry (NJR)	All primary and revised arthroplasty is registered on the NJR system. In 2020-21 the audit compliance was 96% and 2022-23 97%. The national compliance target was 95%. Therefore, we exceeded the national target in both preceding years. The trust is currently looking at the revisions and identifying areas for improvement.
BOOM - British Orthopaedic Oncology Management Audit	The Birmingham Orthopaedic and the British oncology society have developed a national audit to assess the management of patients with metastatic bone disease against the

	BOOS guidelines. We have not yet received the report following data submission. This is due April 2023.
Venous thromboembolism in Foot and Ankle surgery	The audit aimed to capture thromboembolism data on foot and ankle patients. We were unable to measure all areas of the audit because we are an elective trust. The data showed that the areas that we were able to complete we were 97% compliant, and no further actions were required.
The PFF Study: A National retrospective review of femoral periprosthetic fracture management. Is there variation in practice?	The audit is to look at standardisation of management of periprosthetic fractures across the region. To report the mode of fixation for each fracture subtype. We have submitted data to Redcap and await the final report.
NAP 7 Perioperative cardiac arrest	The Royal College of Anaesthetics will examine perioperative cardiac. We cannot look at recommendations for NAP 6 because this was Perioperative anaphylaxis. Report for NAP7 to be published April 2023

Table 4: National Audits

4.4 Local Audits

Speciality	Title	Summary/Actions
Large Joints	An Evaluation of Factors Influencing the Adoption and Usage of Robotic Surgery in Lower Limb Arthroplasty Among Orthopaedic Trainees: A Clinical Survey	The study contributes to the understanding of factors influencing trainees' interest in robotic surgery and emphasises the importance of creating a supportive environment for its adoption. Recommendations include establishing dedicated robotic training programs, providing collaborative efforts between Orthopaedic consultants and trainees, and providing ample resources for hands-on experience. By equipping trainees with the necessary skills, orthopaedic training can effectively embrace the potential of robotics and deliver high-quality care to future patients.
Pharmacy	Antibiotic Audit focusing on the appropriateness of Meropenem prescribing at The Royal Orthopaedic Hospital	Overall, the audit found that there is a good understanding of antibiotic treatment following surgeries where infection is suspected. However, there is room for improvement in terms of ensuring that patients receive the correct course of antibiotics for the shortest possible duration. This will help to reduce the risk of antibiotic resistance and improve patient outcomes.
Large Joints	Assessing the PCL function on our CR and PS TKR on MRI imaging- Is the PCL DE functioned relative to our implant size	In conclusion, this study revealed that the PCL is often completely detached during total knee arthroplasty (TKA), especially with larger tibial cuts. Preserving the PCL becomes challenging as the tibial cut size increases. Gender and knee laterality did not significantly affect PCL measurements, but discrepancies were observed when comparing measurements at different cut lengths to the PCL footprint. Techniques to protect the PCL during TKA should be employed when there are concerns of PCL detachment. Overall, the study provides valuable insights into the implications of PCL measurements during TKA procedures and calls for further research to enhance surgical techniques and understand the PCL's impact on outcomes. Further investigations are warranted to explore the clinical implications of these findings and guide surgical decision-making effectively.

Small joints	Assessment of therapeutic injections in operating theatres for foot and ankle patients	Currently injections are taking on average 24 minutes per injection with an estimated cost of £193.11 per injection. Patients' average length of stay for these procedures is 5 hours and 40 minutes. This represents a longer stay than for patients under the ultrasound pathway, but it does provide relatively good cost-effective treatment. We will aim to try and ensure injections are performed early on theatre lists to allow them to be discharged home more expediently. Consultants/theatre managers informed to put injections first where possible.
Large Joints	Radiation Exposure in Robot-Assisted Total Knee Arthroplasty – A Comparative Study	Our study has provided important information regarding the benchmark dose of radiation exposure associated with the use of the CT in RATKA in reference to the other RATKA imaging modalities for preoperative planning. Our findings indicate that there was a significant difference in radiation exposure between long leg alignment films and CT, which may potentially expose patients to higher levels of radiation. Nonetheless, the radiation dose is still within acceptable limits and a relatively low dose compared to imaging of the chest or abdomen. Our study provides valuable guidance for clinical decision-making in selecting appropriate preoperative imaging modalities for patients undergoing RATKA and important factors to include during the consenting process.
Pharmacy	Safe and Secure handling of medication on Division 1 Re-audit	Results demonstrated that there was an improvement from cycle one. Ward 2 was 100% compliant and all previous actions had been acted upon and compliance improved in other areas. New actions which included fridge PAT testing. Has been completed. Areas still to be improved and actions ongoing for the treatment door being propped open on ward 4 and 11, this is failing to meet standard 9. Further actions are being re-embedded prior to re-audit.
Spines	Post operative follow up appointments in spinal surgery	Timely follow up of post-operative surgical patients is important both for continuity of care but also for efficiency of patient flow to facilitate early discharge following successful completion of treatment. This audit highlighted that only 16% of patients in the audited group had their follow up review within 7 days of the standard time frame. Actions have been implemented to ensure post-operative patients have their outpatient appointment arranged at point of discharge and be prioritized for follow up both to ensure good continuity of care, but also to facilitate patient throughput and free up clinic capacity for new patients by

		promoting early discharge following successful treatment. Re-audit to be completed in 2 months.
Xray	Correlation between Lumbar offset Distance (LOD) and Lumbar lordosis angle (LLA) measurements on Sagittal MRI to assess Lumbar spinal alignment.	Linear measurements show good diagnostic accuracy of LOD in evaluating lumbar spinal alignment, including normal alignment, hypo lordosis has been relayed to colleagues as an alternative measurement to measure Lumber Lordosis.

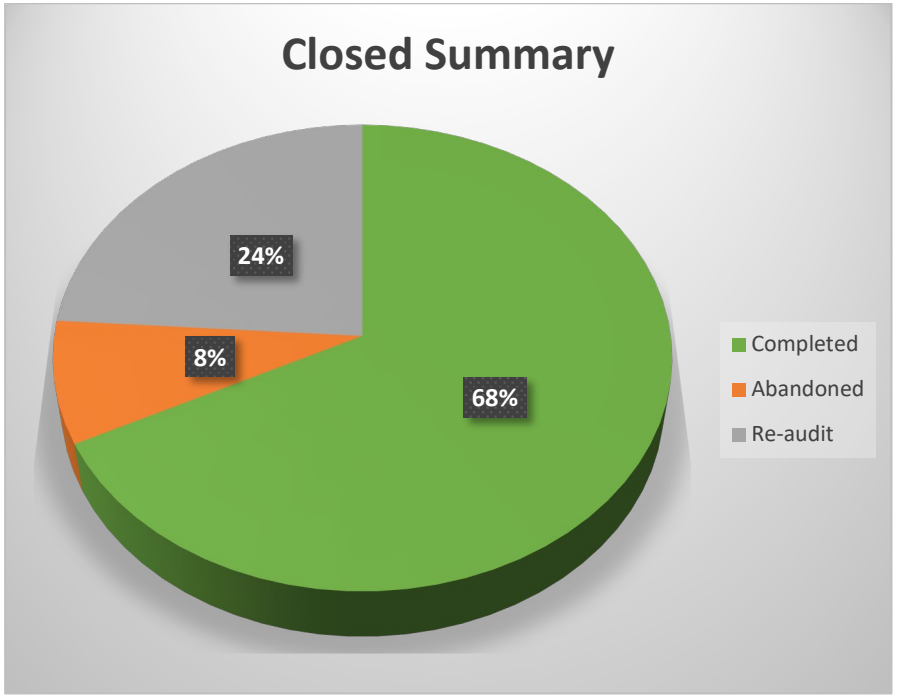
4.5. Audit Overview

Above is the annual breakdown of the Clinical audits registered for 2023-24 and the audits that are outstanding or require re-auditing. The Trust currently participates in seven National Audits, these audits are compulsory audits that are published each year as part of the quality accounts.

The Local audits are registered within the Trust by clinicians to improve patient care and outcomes through systematic review of care against explicit criteria.

Any audits that do not meet the essential criteria initially set out at registration would require a re-audit following embedding of actions to check if the service has improved.

Division	Registered 2023-2024
1	49
2	38
Trust Wide	10
TOTAL	97



Summary	
Completed	48
Abandoned	6
Re-audit	17
Completed Within Time Frame	Extended
76%	24%

Figure 6: Closed summary of Closed Audits 2023/2024

4.6 Priorities for the Audits in 2024-25

The Audit team are embedding the new Audit platform AMaT. All audits including Clinical and Ward audits are now live on the system and training has been given to all areas. A monthly report is distributed for Clinical Audit at governance meetings and AQILA and a Ward audit report sent to head of nursing for both divisions. This enables departments to share best practice, to measure and monitor improvements between departments to improve the overall care at the ROH.

The NICE guidance module has now been successfully rolled out on AMaT and all guidance back to 2021 has been disseminated to clinicians. We are working together with our colleagues to complete Baseline assessments, actions and audits on these guidelines when required.

Given the restricted time limitations some clinicians have the audit team now offer pro-former building, analysis and support with action planning we hope that this will encourage the completion of audits and positive outcomes moving forward.

4.7 National Confidential Enquiries

The Trust did not take part in any National Confidential Enquiries during 2023/24 as they did not cover the services that ROH provide.

4.8 Clinical Research

4.8.1 Information on Participation in Clinical Research

The ROH continues to actively participate in all forms of Musculoskeletal (MSK) research, from basic science to clinical studies, demonstrating fully our “bench to bedside” philosophy.

The ROH continues to prioritise the opening of and recruitment to new studies, as outlined in the West Midlands Clinical Research Network Progression Plan. The successful implementation of this programme is seen by the year-on-year increases in recruitment of participants to research studies at ROH.

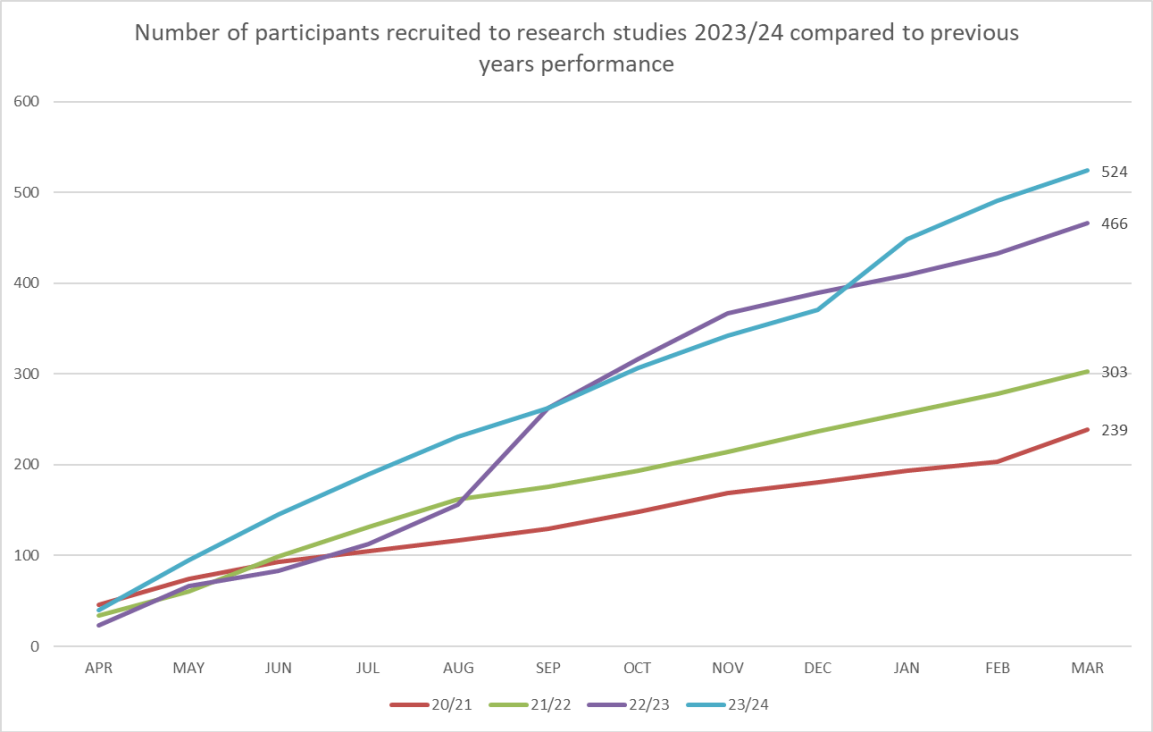


Figure 7: Total recruitment- All ROH research studies 2023/24, compared to previous years.

During financial year 2023/24, 524 participants were recruited to research studies, a 12.4% increase on the 2022/23. Of these, 376 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 148 were recruited into non-NIHR portfolio studies. The increase in recruitment to non-NIHR portfolio studies is driven by a significant increase in research through our Research Tissue Bank (RTB). Studies approved via the RTB are not currently eligible for NIHR portfolio adoption, but account for 146 of the 148 non-portfolio recruits. This represents a 41.7% increase in the number of tissue samples provided for research compared to our performance in 2022/23. The number of participants recruited into commercially sponsored studies has decreased from 19 in 2022/23 (the highest it had been for 5-years) to 6, in 2023/24. The participants were all recruited to the same research trial. Improving our commercial performance will be a key focus for the next few years, as outlined in the Research and Development Strategy, reported in 2022.

As outlined in the West Midlands CRN Progression Plan, the Research & Development department has worked hard to create more capacity for research by closing studies in a responsible manner that are either finished, or not recruiting well. This has enabled the Trust to deliver a diverse portfolio of research. Over 2023/24, the 524 participants were recruited over 36 studies, across 8 clinical areas.

During this period 11 new studies were opened, and 14 studies were closed to recruitment. At the end of 2023/24, the department is delivering 36 open research studies: 10 interventional studies and 26 observational. Eighteen of these studies are NIHR portfolio adopted studies, and 16, are non-portfolio adopted.

4.9 Information on the use of The Commissioning for Quality and Innovation (CQUIN)

In 2023 / 2024 four CQUIN were agreed with the Integrated Care System (ICS) as outlined in table 6. There was no financial value assigned to the CQUIN this year.

CQUIN	Target	Outcome	
CQUIN01: Staff flu vaccinations	75-80%	59.23%	Not Achieved
CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria.	<less than 40%	3.05%	Achieved
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	To achieved 0.5 – 1.5%	0.77%	Achieved
CQUIN12: Assessment and documentation of pressure ulcer risk	70 – 80%	33%	Not achieved

Table 6: CQUIN for the ROH

4.10 Information Relating to Registration with The Care Quality Commission (CQC) and Special Reviews/Investigations

- The ROH 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 ROH during 2022/23.
- The ROH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.
- The ROH has not received a formal CQC assessment against the CQC assessment framework since October / November 2019. The report from this visit was published in December 2019 and saw the ROH retain an overall rating of 'Good'.

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.

Figure 8: November 2019

4.11 Information on the Quality of Data

The ROH submitted records during 2023/24 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:

- 99.9% 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:

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

4.12. Information 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 information (e.g. patient records) and corporate information (e.g. staff personal records, financial records)
The organisation is assessed using the Data Security and Protection (DSP) toolkit which has 10 data security standards with 108 mandatory requirements prescribed by the National Data Guardian. As at the baseline assessment in February 2024 the ROH could evidence 104 requirements. We have less assurance around disaster recovery and business continuity planning, and for supplier contract management, but the Trust is working towards full compliance by the June 2024 submission date. This does not impact on the ROH ability to

protect, use and share information safely and there are dedicated IT security resources and software in place to monitor and manage potential cyber-attacks.

4.13 Payment by Results Clinical Coding Audit

The ROH was not subject to the payment by results clinical coding audit during 23/24.

4.14. Improvements in Data Quality

The ROH has several operational and clinical systems that collect and store data about patients. This data is critical to the running of the ROH to ensure effective and timely care to patients and enables the ROH to plan and make future business decisions. High quality data is essential to aid business intelligence reporting and ensure operational efficiency. The ROH has the following actions in place to ensure good data quality:

- There is a Data Quality Group chaired by the Executive Chief Operating Officer and includes key stakeholder members from the business intelligence, operations, education, and training teams. This group monitors data quality KPIs, audits and addresses any risks and issues as they arise.
- The Business Intelligence team carries out over 75 automated data quality checks on the ROH data, creating reports which highlight data quality issues. These are shared on the Health Informatics dashboard accessible by operational staff to action and resolve.
- The ROH has a Data Validation team focusing on waiting list management which identifies and resolves errors caused by data quality.
- The ROH has a Systems Training Advisor whose role is to support staff carrying out system training on key patient systems with an emphasis on accurate and timely record keeping.
- Clinical coders regularly advise consultants to ensure accuracy and depth of coding.
- The Integrated Performance Dashboard has improved the accessibility and depth of reporting available to relevant parties, this allows data to be viewed in a timely manner.

4.15. Medical Rota Gaps

Our postgraduate workforce continues to be resilient. There is an ongoing threat of further industrial action. The ROH management have continued to support the doctors and the ROH is still considered one of the most supportive employers in the region.

There is Guardian of Safe Working (GSW) in post, to ensure that our doctors have the support they require to raise issues relating to safe working. This is supported electronically by our Exception Reporting Process; Allocate. Exception Reporting is managed by our Guardian and supported by the Medical Workforce Department.

The Guardian also completes a quarterly Guardian of Safe Working Report, including data of our Exception Reports and Mitigating Actions. A final extended Annual Report is presented at the end of each academic year to the ROH Board of Directors.

The post graduate tutor and 'mid-level care provider clinical lead' support and oversee the postgraduate doctors' training and administrative needs.

Information is provided to postgraduate doctors on induction and guidance is available to all staff via the hospital internet pages. A comprehensive post graduate doctor's handbook is provided and regularly updated.

There are monthly Postgraduate Doctor's Forum meetings to listen to and improve our doctor's experience of working at the ROH. Senior management support ensures minimal rota gaps and regular review of processes to maintain safe working practices. There are fewer GP trainees in the region and in the hospital with gaps being filled by a combination of mid-level doctors and locums when necessary.

Doctors have access to a mess area/business lounge and steps have been taken to appoint a postgraduate doctors wellbeing champion. The minutes of the postgraduate doctors' forum evidence the cycle of requests and improvements that are being made throughout the year in response to feedback from the doctors.

4.16. 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.

Year	Number of Patient safety incidents reported	Number of patient Safety Incidents with Severe harm	% of patient safety incidences that resulted in severe harm	The rate of patient safety Incident per 1000 bed days	National Rate (Best)	National Rate (Worse)
2023/24	4006	3	0.07%	Data not available	Data not available	Data not available
2022/2023	3780	1	0.02%	Data not available	Data not available	Data not available
2021/2022	2857	1	0.04%	Data not available	Data not available	Data not available
2020/2021	2874	0	0%	61	31	118
2019/20	2953	4	0.14%	49.24	18.7	107
2018/19	2202	1	0.20%	75.9	26.3	184
2017/18	1530	7	0.50%	45.38	19.1	142

Table 8: Patient Safety Incidents 2017/2018 to 2023/2024

The ROH considers that this data is as described for the following reasons:

- The ROH submits patient safety incidents to the NRLS (and as of April 2024 via the Learning from Patient Safety Events (LFPSE) process) which enables benchmarking against other similar organisation in respect of numbers and types of patient safety incidents.
- The ROH grades incidents 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 ROH who will seek clarity on the level of harm at the bi-weekly Divisional Governance meetings from clinical staff where necessary and amend the initial categorisation if required.
- The ROH actively promotes a culture of incident reporting so that issues can be identified, actions initiated, and lessons learned.
- The ROH wide information relating to patient safety and patient experience activity is contained within the ROH Quality Report that is presented monthly at the Clinical Quality Group and Quality and Safety Committee and Trust Board. Monthly reports are also shared with BSOL ICB via contracting meetings.
- The ROH bi-weekly Divisional Governance meetings include review of any incidents that are graded by the reporter as moderate harm or above, any complaints and local and divisional risks.
- A review of the way actions from incidents are tracked and shared across the ROH, 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 versions of patient safety investigation reports are anonymised and sent to all clinicians, these are discussed at local level and at Trust wide forums.
- Continue to deliver incident investigation training to members of staff who undertake investigations.
- On-going implementation of the Patient Safety Incident Response Framework (PSIRF) is underway within the Trust.

4.17. Learning from Deaths

At ROH, all deaths within 30 days of surgery are included in the Learning from Deaths process, regardless of whether the death is in hospital or outside the hospital. This is due to low number of inpatient deaths and therefore the additional cases add value.
Following the completion of an initial screening tool the Associate Medical Director examines the written record breaking an analysis down by phases of care, taking into account the External Medical Reviewer assessment. In this Structured Judgement Review, each phase of care is examined, and judgement statements generated about any notable features of care, both good and bad. The assessor reaches a verdict about the quality of care for each phase and the care overall. They identify whether there was any aspect of avoidability in the death. If there is an aspect of avoidability in the death due to lapses in care at ROH, then a Patient Safety Incident Investigation (PSII) is commenced to identify the relevant learning, in accordance with the Patient Safety Incident Response Framework (PSIRF).

During 2023/24 there were:

- 3 x inpatient deaths
- 18 x deaths within 30 days post discharge

The Learning from Death process has raised no concerns regarding ROH care that caused or contributed to the cause of death in any of the above cases.

4.18 Readmission

Readmissions to hospital usually represent a significant complication of treatment or the concern of a significant problem after treatment such that a patient is brought back into hospital for investigation or treatment.

Years	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Readmission Rate	1.0%	1.4%	1.4%	1.3%	0.8%	1.0%	0.9%

Figure 10: Readmission from 2017/18 to 2022/2023

Readmission rates for ROH have remained constant in the last few years with an average rate of 1.3%. The exception to this was during the first COVID peak in 2020 as can be seen in the SPC chart below.

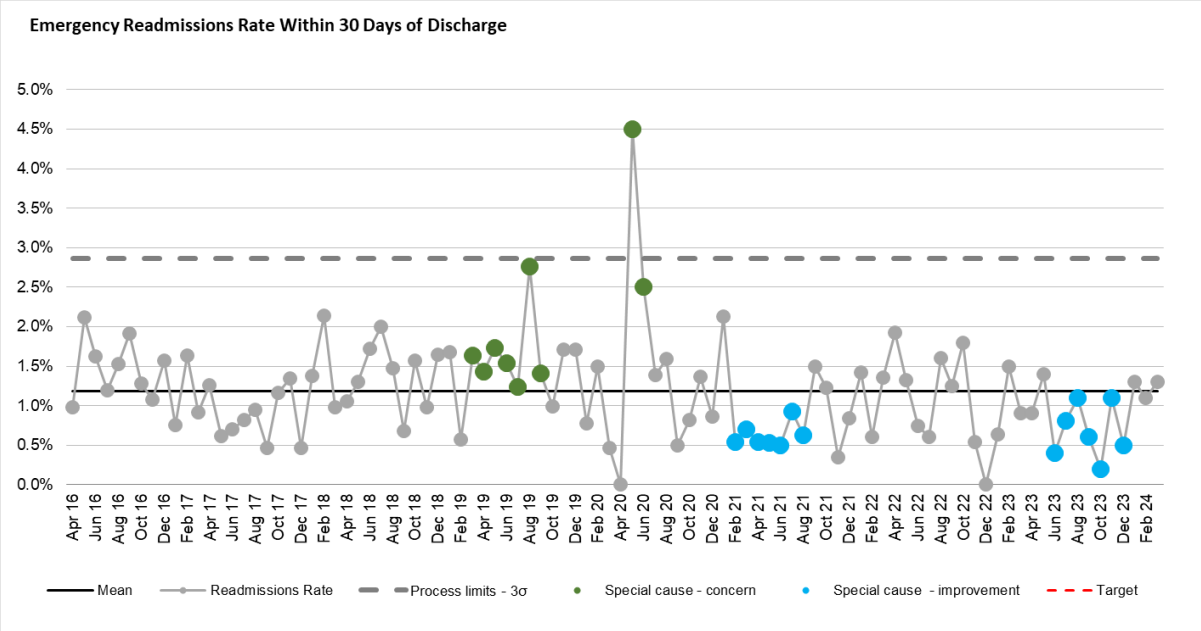


Figure 11: SPC Chart- Emergency admission rate within 30 days April 2016 to February 2024

4.19 Response to personal needs

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

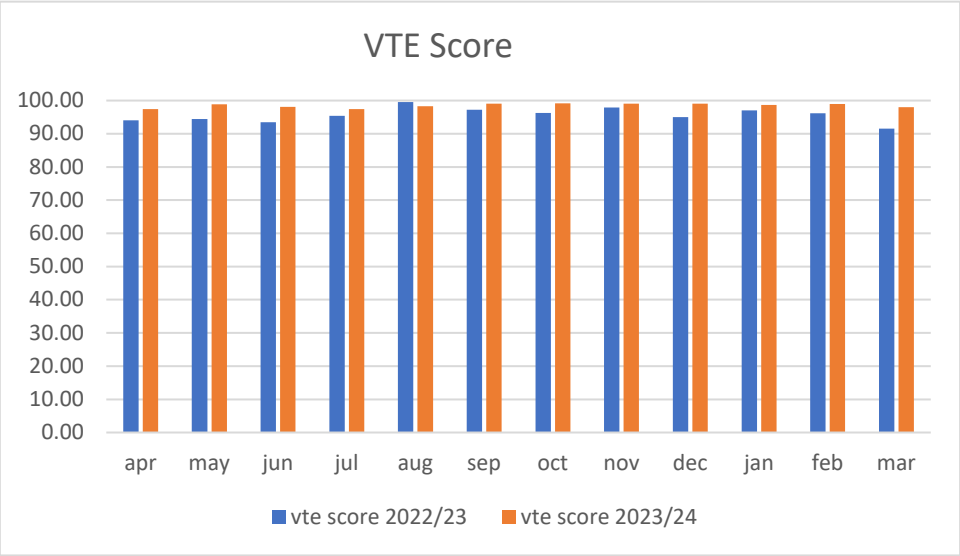
- Were you as involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about the medication 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 last in-patient survey was completed in 2023 by patients receiving care in 2022. The results have been reviewed and an action plan developed.

Following the merger of NHS Digital and NHS England on 1st February 2023 the proposals from the review of the NHS Outcomes Framework (NOF) announced in March 2023 are now being presented as part of a wider consultation on statistical outputs which was released on 12th December 2023. As part of the consultation, it is proposed that only a limited number of NOF indicators will still be published by NHS England on an annual basis. Further announcements about this dataset will be made on the NHS Outcomes Framework publication page in due course.

4.20 Venous Thromboembolism (VTE)

The Trust continues to closely monitor VTE risk assessment completion. National standard requirement is a minimum 95% VTE risk assessment of all inpatients on admission.



Month	VTE score 2022/23	VTE score 2023/24
April	94.02	97.40
May	94.45	98.86
June	93.46	98.07
July	95.44	97.39
August	99.56	98.34
Sept	97.23	99.06
Oct	96.26	99.20
Nov	97.94	99.04
Dec	95.06	99.11
Jan	97.02	98.72
Feb	96.20	98.97
March	91.51	98.05

Figure 11. VTE on admission risk assessment completion; 2022/2023 VS 2023/2024

- All patients 16 years + who are coded as in-patients have a mandated VTE risk assessments on admission. No prescribing can occur until the initial risk assessment is complete.
- Validation process in place for any identified as missed from data.
- 95% risk assessment requirement exceeded without exception 01/04/2023-31/03/2024.
- All reported suspected or proven Hospital Acquired VTE's are reviewed in accordance with Governance process. These are in process of being aligned to PSIRF methodology.

- No potentially avoidable VTE's identified in year.

4.21. Clostridioides difficile Infection (CDI)

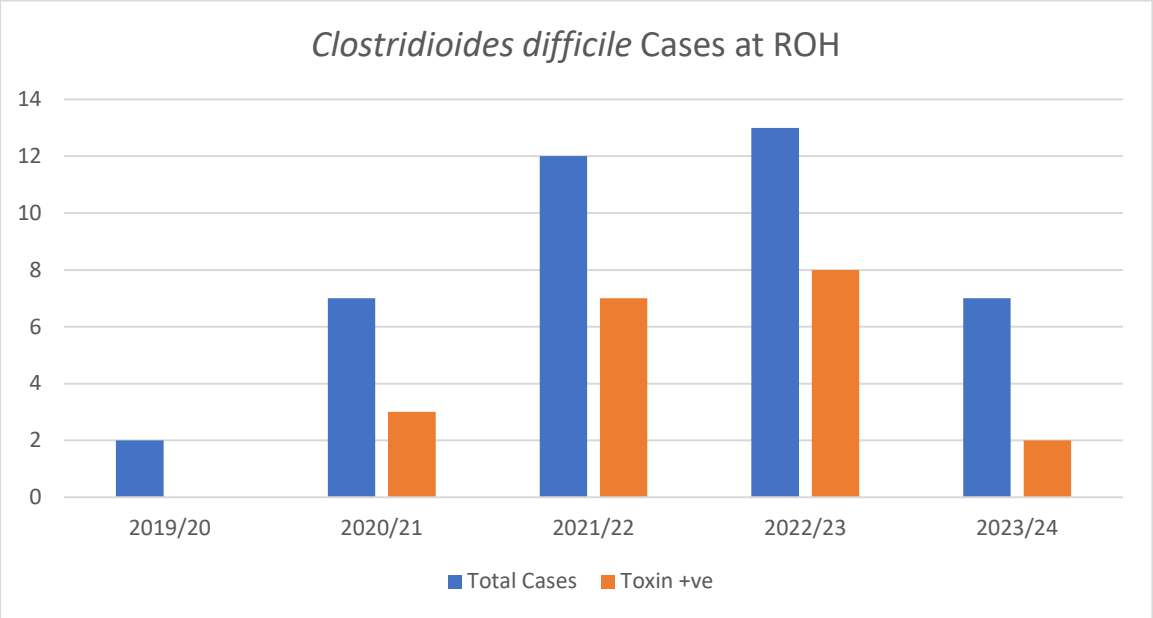


Figure 13: *Clostridioides difficile* cases reported by ROH between 2019/20 to 2023/24

The ROH considers that this data is as described for the following reasons:

- ✓ *Clostridioides difficile* infections are monitored and reported monthly, with a post infection review conducted on every toxin-positive Community-onset, healthcare associated (COHA) or Hospital-onset, healthcare associated (HOHA) case.
- ✓ The control of infection is of paramount importance for our patients; during 2023/24, there have been two cases of reportable CDI. Which is six cases less than was reported during the previous year.

The ROH is taking 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 for hand hygiene principles will continue, and we will ensure application of the principles of bare below the elbow.
- ✓ We will continue to maximise the effectiveness of ward rounds and ensure that best practice is upheld in respect of the antimicrobial stewardship.
- ✓ Support environmental cleaning processes to minimise the risk of potential cross contamination.

4.22. Compliance with National Targets and Regulatory Requirements

4.22.1 Referral To Treatment (RTT)

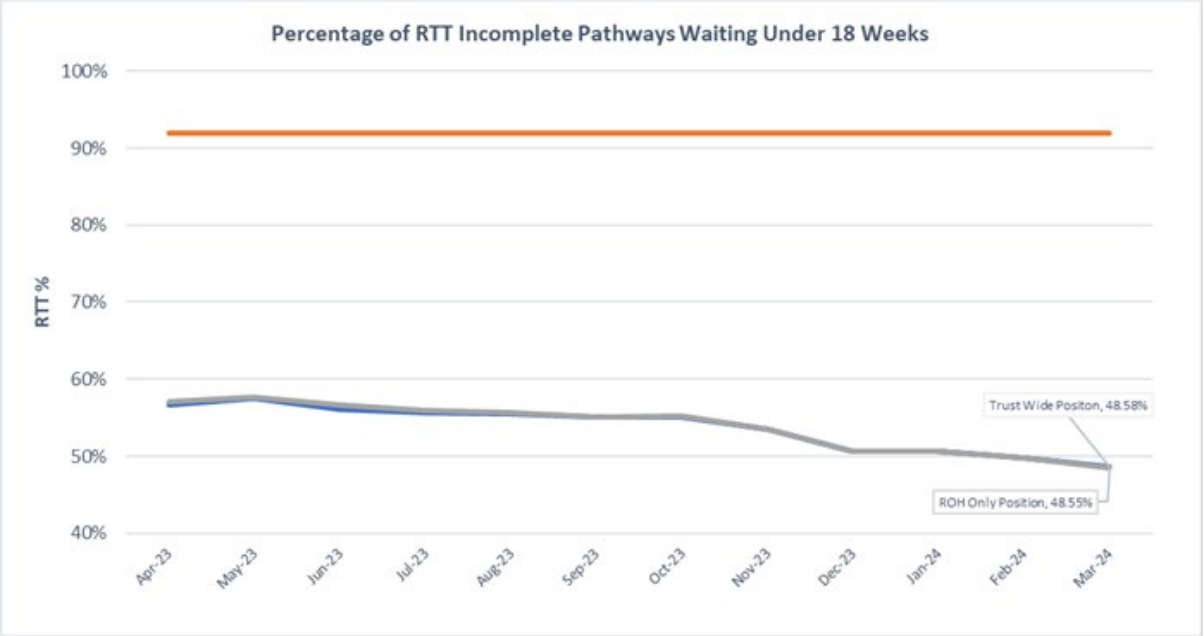
The ROH like many other NHS providers have seen constitutional targets such as RTT profoundly affected due to the national backlog of patients waiting for treatment. All Constitutional targets continue to be presented and discussed at the monthly Trusts Finance and Performance Committee Meeting, Trust Quality and Safety Committee and within the Divisional structures. Further discussions are held weekly at the System Oversight Group aligned to the national elective recovery operational performance standards, including activity delivered against plan, trajectories for improvement and cancer performance.

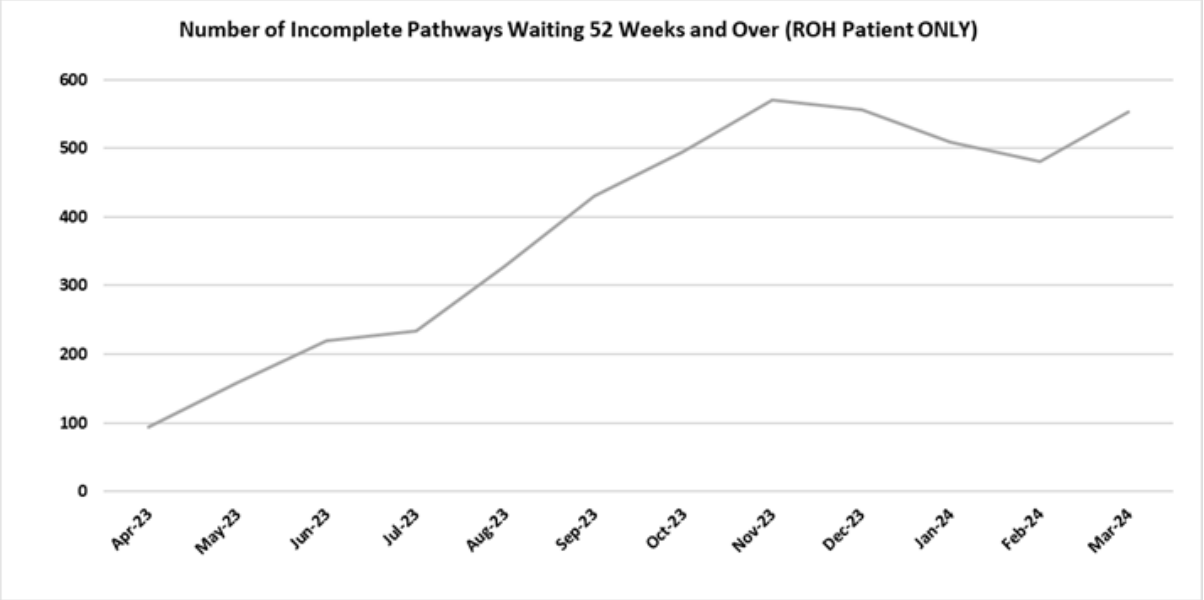
Operational performance metrics are monitored internally at weekly patient tracking list (PTL) Meetings, Theatre Planning, Theatre Lookback Meetings and Divisional Management Board in order to provide full assurance that all admitted and non-admitted waiting lists are being actively managed. These oversight meetings aim to reduce the number of patients waiting over 18 and 52 weeks. Additional PTL meetings are scheduled at the discretion of the Deputy Chief Operating Officer should the number of long waiters increase.

During 2023/24, the ROH has seen an increase in long waiting patients following the impact of supporting other trusts with long waiters by providing mutual aid across the NHS. The ROH has provided mutual aid to circa 3,000 patients.

The Referral to Treatment (RTT) position for March 2024 ended at 48.58% against the national compliance target of treating 92% of patients within 18 weeks of referral. This is reflective of the cumulative impact of growing waiting time pressures within Spinal at a Regional and National level.

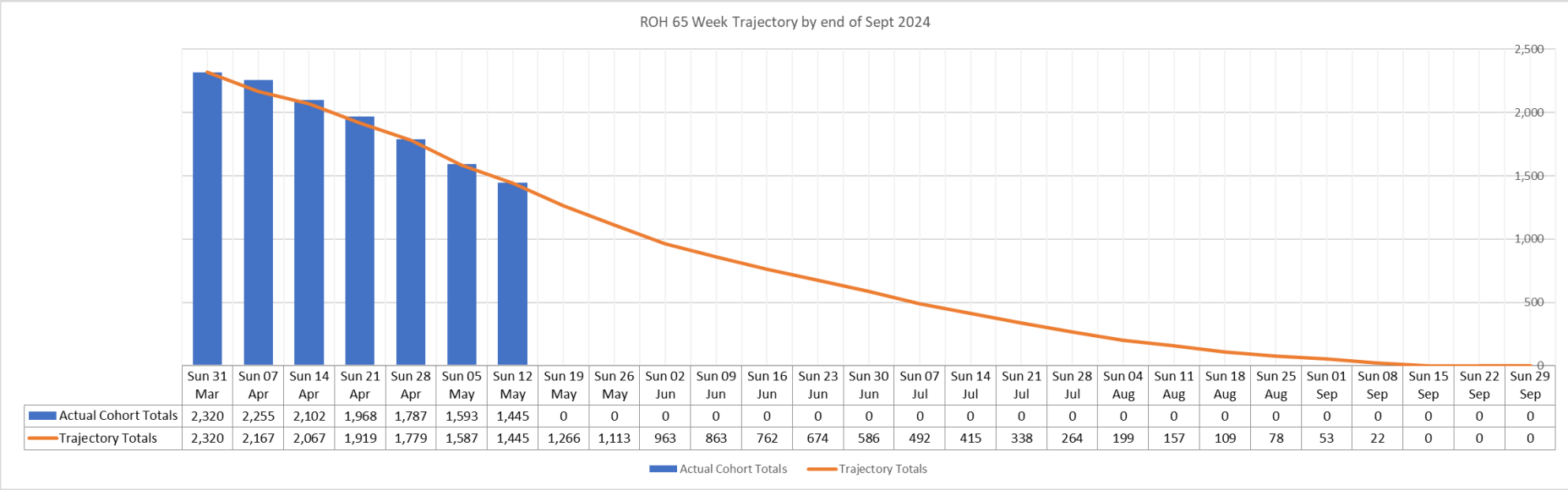
The graphs below represent the changes in incomplete pathways during 2023/24:





The majority of waits over 52 weeks sit within the Spinal services and the teams are working hard to reduce the waiting times. All other services are working towards the delivery of 0 waits over 52 weeks and this will be achieved ahead of the national requirement that is currently set to be achieved by 3rd March 2025.

Below is the Trust's trajectory to eradicate patients waiting over 65 weeks by 30th September 2024:



	Sun 31 Mar	Sun 07 Apr	Sun 14 Apr	Sun 21 Apr	Sun 28 Apr	Sun 05 May	Sun 12 May	Sun 19 May	Sun 26 May	Sun 02 Jun	Sun 09 Jun	Sun 16 Jun	Sun 23 Jun	Sun 30 Jun	Sun 07 Jul	Sun 14 Jul	Sun 21 Jul	Sun 28 Jul	Sun 04 Aug	Sun 11 Aug	Sun 18 Aug	Sun 25 Aug	Sun 01 Sep	Sun 08 Sep	Sun 15 Sep	Sun 22 Sep	Sun 29 Sep
Actual Cohort Totals	2,320	2,255	2,102	1,968	1,787	1,593	1,445	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory Totals	2,320	2,167	2,067	1,919	1,779	1,587	1,445	1,266	1,113	963	863	762	674	586	492	415	338	264	199	157	109	78	53	22	0	0	0

The trajectory total is comprised of any patient that could breach 65 weeks between now and 30th September 2024. The Trust intends to have 0 patients waiting over 65 weeks by the end of June 2024.

4.23. Cancer Treatment Targets

Cancer Standards

The table below represents the performance against cancer targets prior to the change to reporting metrics in October 2024:

Performance Indicators: Cancer Services 2023/24	Target	Q1	Q2	Q3	Q4
% urgent cancer referrals seen within 2 weeks wait	93%	98.6%	96.4%	96.3%	97.5%
% patients treated within 31 days of decision to treat	96%	90.0%	94.3%	100.0%	100%
% patients receiving subsequent treatment within 31 days (surgery)	94%	96.0%	100.0%	100.0%	94.7%
% cancer patients treated within 62 days of urgent GP referral	85%	48.0%	60.9%	68.7%	47.8%
Faster Diagnostic standard (FDS)	75%	79.3%	78.4%	78.3%	85.1%

The table below represents the performance against cancer targets after the change to reporting metrics in October 2024:

Key Performance Indicators: Cancer Services 2023/24	Target	Q1	Q2	Q3	Q4
28 Day Faster Diagnostic Standard	75%	79.3%	78.4%	78.3%	85.1%
31 day standard (combined)	96%	92.3%	96.4%	100%	97.96%
62 day standard (combined)	85%	72.5%	77.2%	84.6%	71.19%

A significant amount of work has taken place following changes to the cancer standards in October 2023. There has been a change of emphasis from the 2 week wait standard to the 28 Day Faster Diagnostic Standard (FDS), whereby patients should receive a definitive diagnosis within 28 days of referral from primary care. This has allowed improvements to be made in respect to the patient pathway, which is reflected in the Quarter 4 performance, which improved patient experience even with a continued effort being made to achieve the former 2 week wait target as a quality indicator.

Achievement of the combined 31 day and 62-day standards have improved as metrics are combined, allowing for better tracking against the standards and equitability to patients on

cancer pathways. Quarter 4 experienced some challenges arising from industrial action leading to late tertiary referrals being sent to the Trust for treatment.

The ROH has continued to lead on an international level for Sarcoma treatment and research, hosting the national BOOM (Birmingham Orthopaedic Oncology Meeting) which was attended by representatives from around the globe.

The ROH is one of only five specialist metastatic bone and sarcoma centres in the United Kingdom and receives referrals from a wide geographical spread. Some of the patients have been referred to the Trust after a prolonged pathway and are of high complexity which makes treatment within 62-days challenging to achieve.

Individual root cause analysis with detailed timelines is completed for all patients who breach the 62-day standard. These patients are discussed and monitored at the Cancer Board and as part of the trust harm review process. Any lessons learnt are captured and changes in process adopted. Improvements are continually being made to optimise these patient pathways to ensure the highest quality of care is delivered.

The graphs below show the 62-day standard performance for the Trust. The standard changed in October 2023 to a combined target.

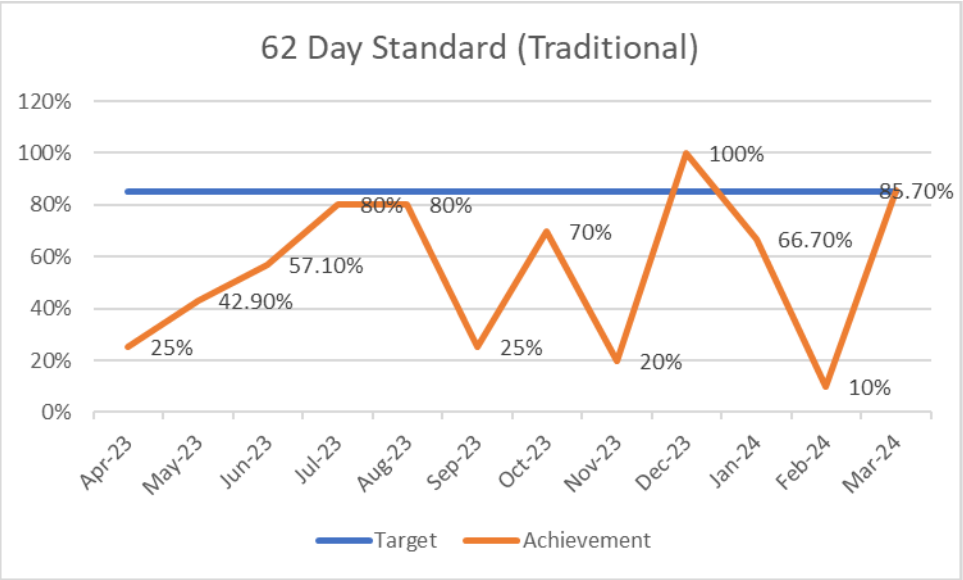


Figure 18: 62 Day Standard Performance 2023/24

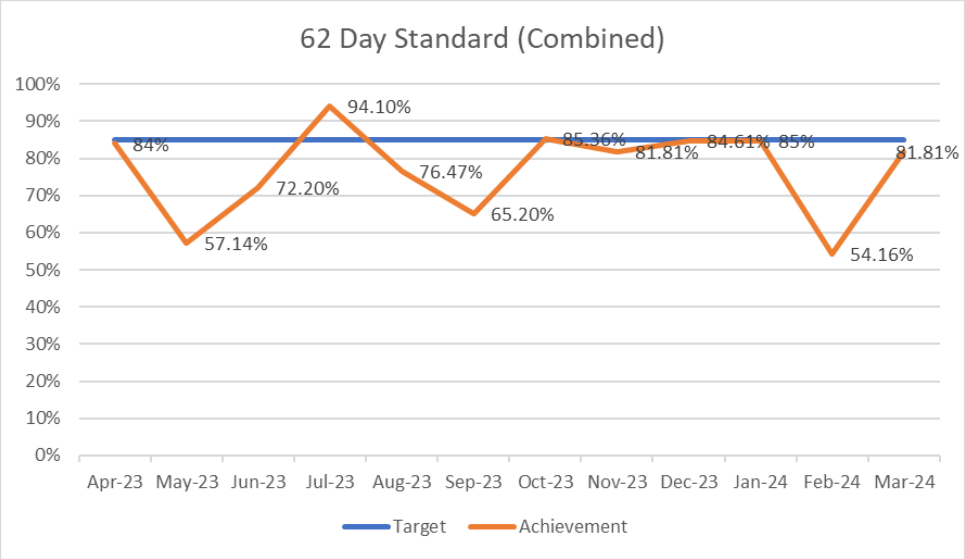


Figure 19: New 62 Day Standard (Combined) Performance 2023/24

The below graph shows the 28 Day Faster Diagnosis Standard performance against the national standard. As a specialised tertiary provider, the ROH received referrals from other oncology providers after 28 days have passed due to the rarity of the disease.

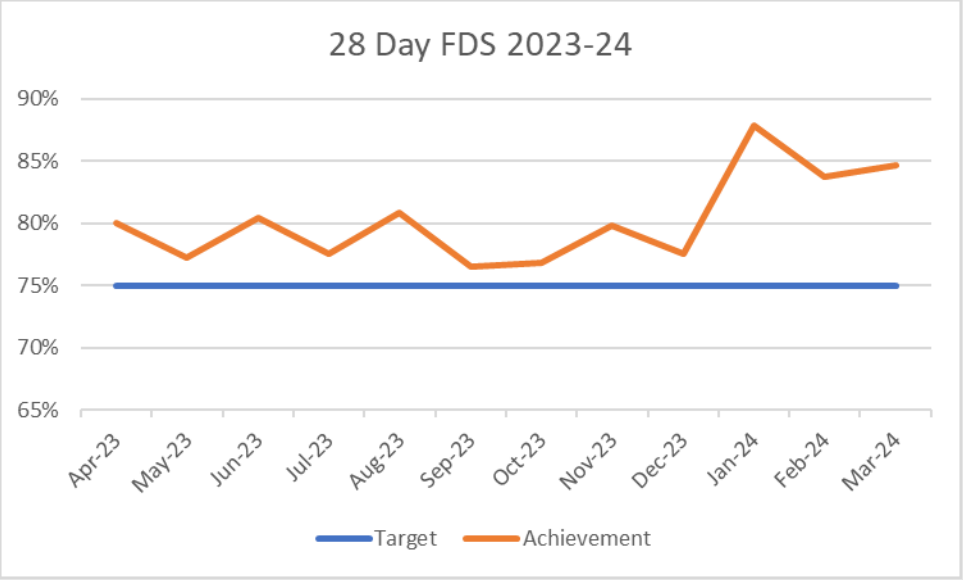


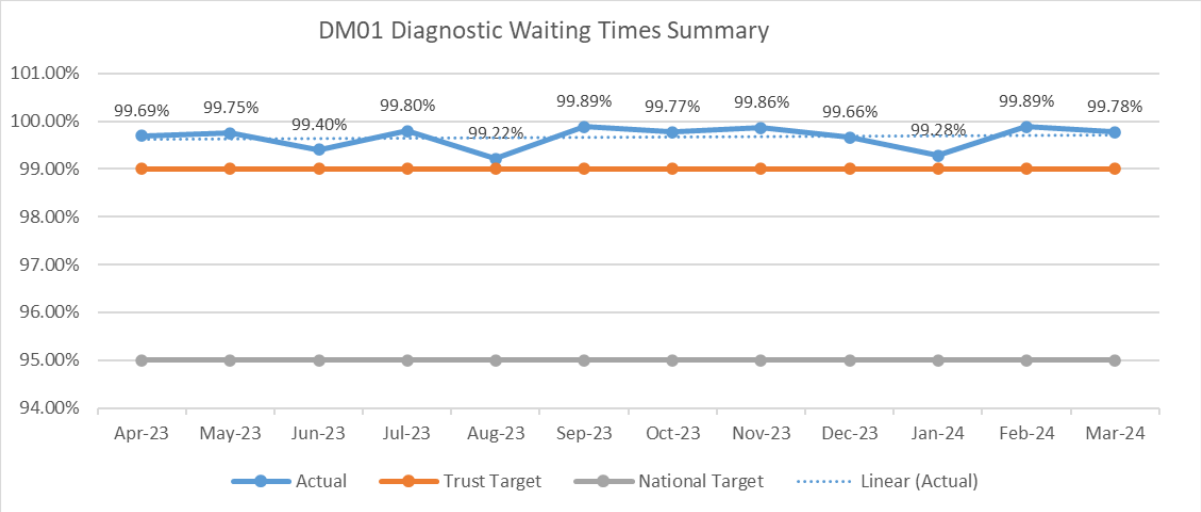
Figure 20: 28 day Faster Diagnosis Performance 2023/24

4.24 Diagnostics within 6 weeks

Diagnostic Performance

2023/24 the Imaging team consistently achieved the diagnostic standards target with the service performing over 99% throughout the year.

This 2023/24 diagnostic performance is demonstrated in the graph below:



The installation of accelerator software to one of the MRI machines has also contributed to improvements in productivity, reducing the time patients are waiting for an MRI scan to 4 weeks.

5.0 The ROH Internal Quality Measures

The ROH monitors a variety of information and feedback to assess the service it provides for: patient safety, clinical effectiveness, and patient experience.

The ROH has 4 main meetings that oversee quality:

- **Quality & Safety Committee**

Chaired by the Non-Executive Director for Quality and Safety.

- **Quality & Safety Executive**

Chaired by the Chief Executive Officer.

- **The Clinical Quality Group**

Chaired by the Chief Nurse. This committee is responsible for safety and risk.

- **AQILA**

Chaired by the Medical Director. This committee is responsible for overseeing clinical effectiveness.

5.1 Are we keeping our patients safe and protecting them from avoidable harm?

The NHS monitors the number of incidents and the harm those incidents caused. We can then focus in on areas of concern and ensure we learn from them.

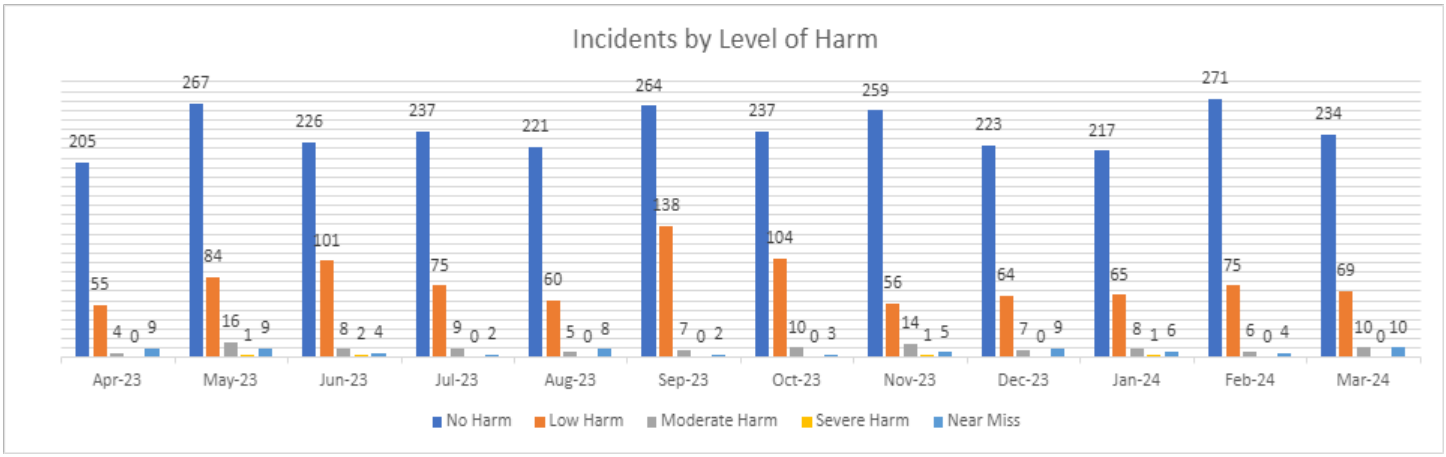


Figure 21: Incidents by Harm 2023/24

5.1.1 Serious Incidents

The occurrence of a serious incident or a patient safety incident that meets the criteria for a PSII (Patient Safety Incident Investigation) in accordance with PSIRF (Patient Safety Incident Response Framework) and the Trust's own PSIRF Response Plan demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.

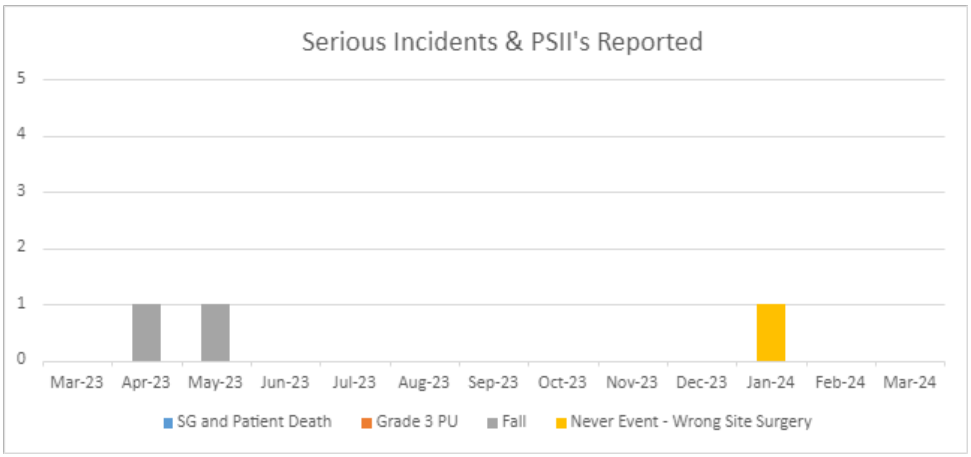


Figure 22: Serious incidents reported 2023/24

5.2 Our Patient Experience

We aspire to be an outstanding Trust where we create the conditions for patients, families and carers to have positive experiences of the care they receive with us. We strive to identify need and work towards continuous improvements, involving patients, families, and our community. We recognise there is no better or more important way of improving our services than by listening to what our patients think, feel and experience throughout their care journey and beyond. We aim to involve patients, carers, and the public in how we improve our services for the future.

Members of Healthwatch Birmingham are invited to sit on our Patient Engagement & Experience Group and report on the community's feedback about our services. We meet and liaise with Healthwatch to gain and understand the feedback received and respond to all comments and reviews left on the Healthwatch Birmingham website about our Trust, recognising the importance of independence this provides to our patients, carers and their families.

The PALS and Complaints Policy has been updated in line with the PHSO Guidance in 2024 and aims to make the resolution of PALS Concerns and Formal Complaints a more transparent process for Patients and Staff.

5.2.1 Complaints

From April 2023 to March 2024, the Trust received 45 Formal Complaints. Of these 3 were withdrawn, 1 was resolved without needing to proceed through Formal management and 1 was a joint concern managed by the ICB. Therefore 40 Complaints went through the formal process, this is a 6.25% decrease from the previous year.

It should be noted that complaints received in 2022/2023 were not recorded within the report if they had not proceeded through formal management. The revised number of complaints received would be 48 formal complaints received in 2022/2023.

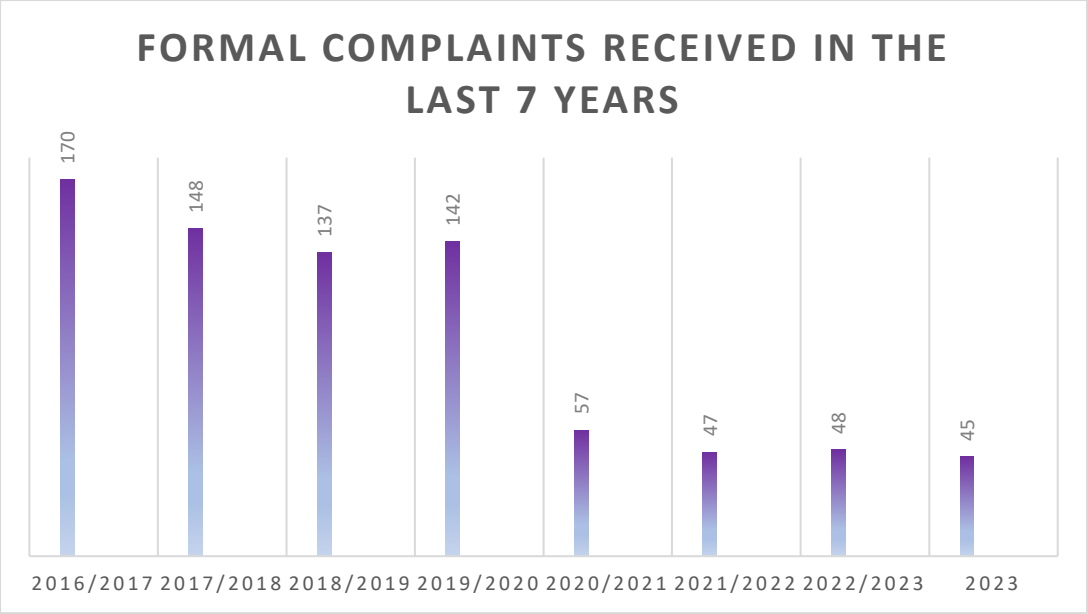
A key measure of quality concerning how we manage our complaints is the number that are requested to be reopened by the complainant as they are unsatisfied with the response once the complaint has concluded.

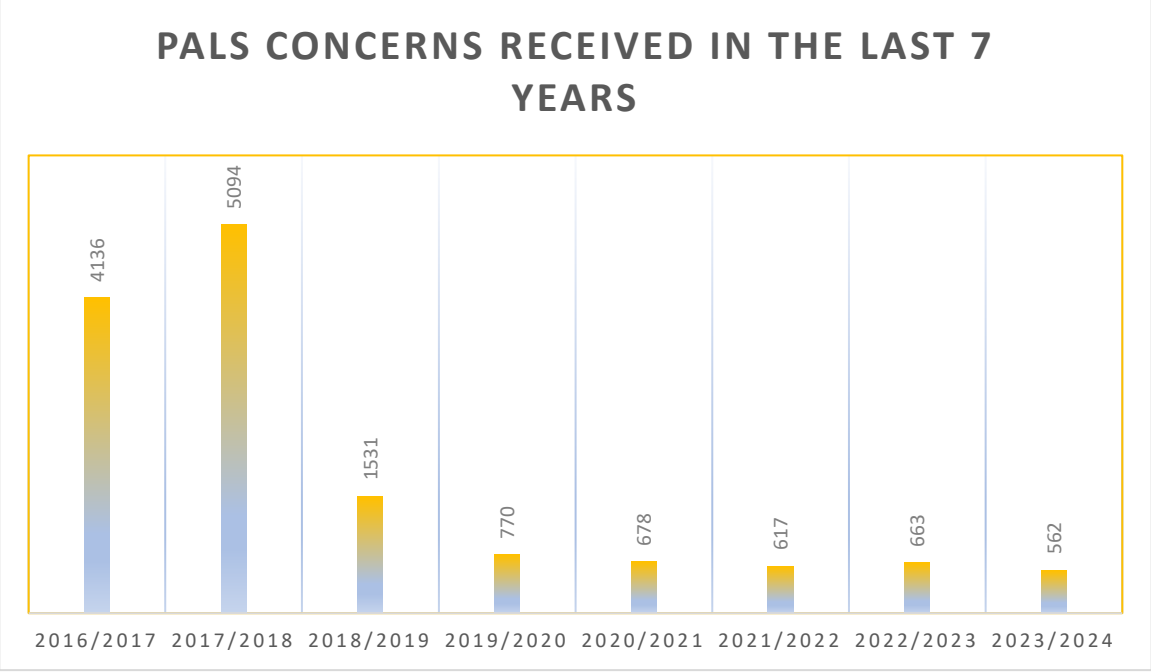
Between April 2023 and March 2024, the Trust received requests from patients and their families' requests to reopen 2 complaints. This represents 7% of the total closed complaints during that same period.

The Complaints Department continues to try to manage all complaints in a proactive manner. We continue to aim for resolution in 25 working days and local resolution meetings are always offered to facilitate improved communication and successful resolution for complainants. Time scales for investigations vary depending on the complexity of the

complaint and if the criteria is met for a complex complaint, then we aim to resolve this within 60 days. The complainant is involved and updated regularly with any extension of timescales.

Annual Complaints and Patient Experience 2023/2024 Report will outline PALS, Complaints and Patient Experience in more depth. The report will be published on www.roh.nhs.uk/pals





Number of Complaints and PALS Contacts from 2016/2017 to 2023/2024

*Data source: Patient Experience Department/ Ulysses system

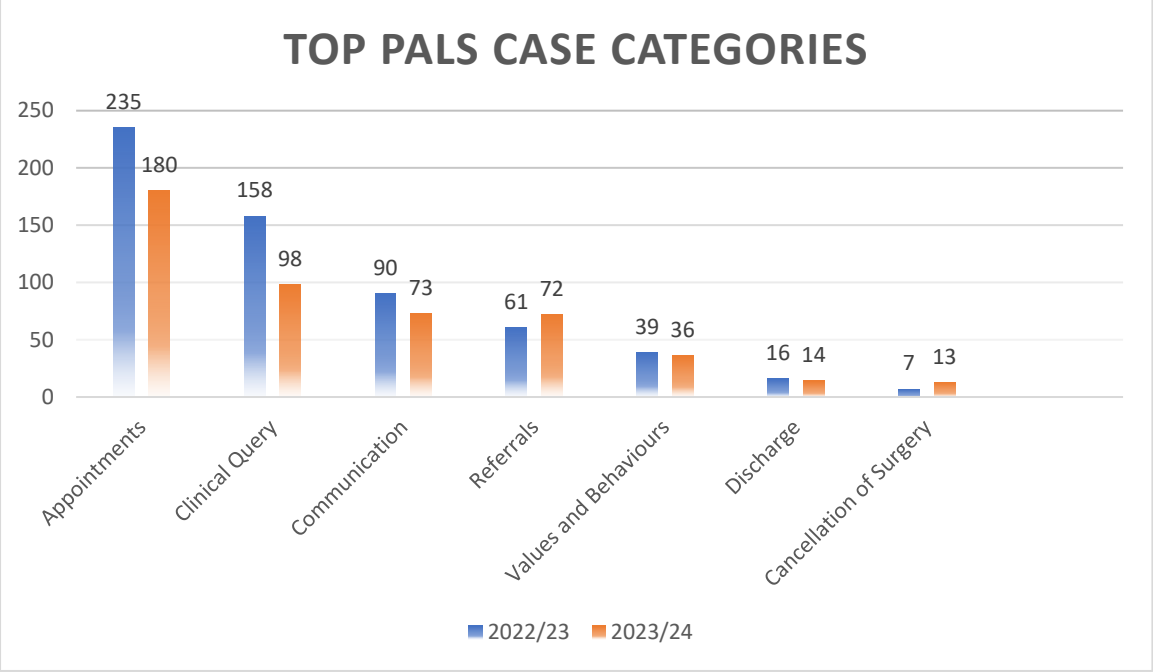
The top three themes identified from the complaints in 2023/2024 that required improvements:

- Appointments, including cancellations, failure to receive follow up appointments, multiple rescheduled appointments.
- Communication; including incorrect or lack of information given, attitude of nursing, medical and admin staff.
- Clinical Query; including clinical treatment and diagnosis and lack of onward referral.

All complainants are offered the opportunity to provide feedback on the outcome of the process both at the time of resolution and via FFT feedback following the conclusion of the complaint or PALS concern.

5.2.2 Patient Advice and Liaison Services

During 2023/2024 the Trust has received 562 PALS contacts from patients and relatives. This is a 15% decrease in the PALS contacts compared with 2022/2023. The Trust continues to strive to improve the service offered to patients to resolve their concerns at the most appropriate level and to ensure that the complainant has all of the information required to make an informed decision. The Patient Engagement team continue to work proactively and provide support to both our patients and carers who raise concerns and to the staff identified to resolve those concerns.



The PALS team have continued to deliver a responsive service throughout 2023/24 with a focus on providing support where concerns are identified. Contacts are made through a range of sources including face to face, telephone, online and email. Contacts through PALS encompass a variety of issues including problems, concerns or enquiries, 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 top 3 categories for PALS contacts are:

- Appointment Concerns
- Clinical Queries
- Communication Issues

5.2.3 Patient Experience survey

At the Royal Orthopaedic Hospital, we are dedicated to providing excellent patient experience, and one of the ways we aim to achieve this is by undertaking various surveys throughout the year. The purpose of these surveys is to help improve patient experience and demonstrate to our patients and visitors that we listen to their comments and feedback and use it to improve our services and future care, which is essential to our Trusts continual improvement programme.

We are proud to announce that we have many different surveys that are live throughout the year which include:

- Friends and Family Test
- CQC National In-patient surveys
- Engagement events,
- Coffee catch-up
- Theatres survey
- National Cancer Inpatient Survey
- Inpatient and Outpatient In-depth surveys
- Compliments and concerns given to our Patient Advice and Liaison Service (PALS)
- Social media and online feedback

5.2.4 Friends and Family Test (FFT)

We recognise there is no better or more important way of improving our services than by listening to what individuals think, feel and experience throughout their journey. We value all feedback from patients and their families and are committed to identifying where patients provide us with examples of where staff went the extra mile, staff have told us how they feel appreciated when this is shared.

Any feedback identifying areas of good practice or highlighting concerns informs the Trust in learning what has gone well and Celebrating Excellence which helps us in developing quality improvement programmes and actions to address the trends and themes of concerns identified.

During the last twelve-month period, we have received more than 6000 responses from patients and carers via our Friends and Family Test on their care and experience and moving forward we have expanded the departments that utilise the FFT feedback to enable a more seamless and cohesive feedback to be collected across the Trust. We can collect this data via paper-based forms, online and through a QR code to enable equitable access to all.

5.2.5 CQC Adult Inpatient Survey

In February 2023 the annual CQC Inpatient Survey questionnaire was sent out to patients who were identified as having been inpatient on 30th November 2022. A total of 1250 patients were invited to participate, and 706 responses were received which gives us a 57% response rate against the 40% national average.

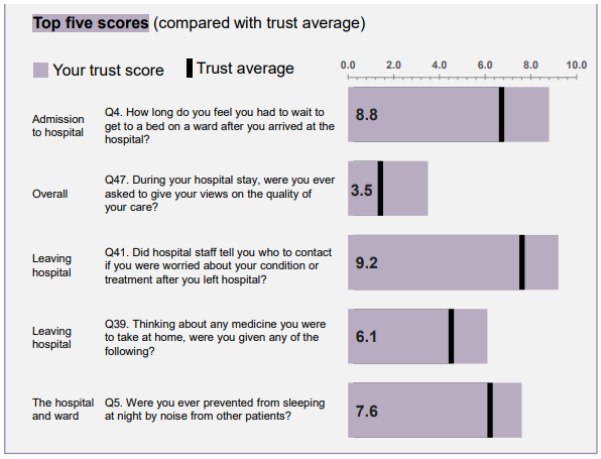
The survey identified:

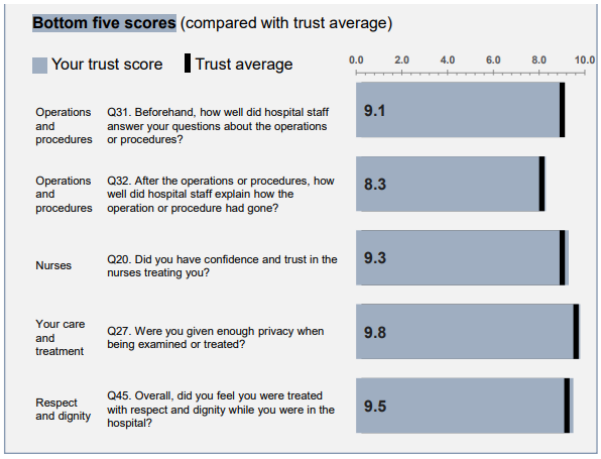
Where patient experience is best against the national average:

- Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital.
- Feedback on care: patients being asked to give their views on the quality of their care.
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital.
- Noise from other patients: patients not being bothered by noise at night from other patients.
- Information about medicines to take at home: patients being given information about medicines they were to take at home.

Where patient experience could improve against the national average:

- Answers to Questions: hospital staff answering patients' questions before the operation or procedure.
- Confidence and trust: patients having confidence and trust in the nurses treating them.
- After the operation or procedure: patients being given an explanation from staff as to how their operation or procedure went.
- Privacy for examinations: patients being given enough privacy when being examined or treated.
- Respect and dignity: patients being treated with respect and dignity while they were in hospital.





Actions taken include:

- Quality and safety walkabouts take place utilising the Multidisciplinary Team and targeting different areas within the patient journey, focusing on patient experience, patient safety and quality care.
- Safety Huddles have been implemented to improve communication and consistency for patients.
- Human Factors training has been rolled out to staff in line with the Patient Safety Strategy.
- Continuous Improvement Huddles are being implemented throughout the Trust.

6.0 Leadership Management and Governance of the organisation

The Governance structure and processes have long been strongly embedded within the ROH around patient safety incidents and complaints, with evidence of learning from incidents within the investigation reports.

During 2023/24 the ROH implemented the new Patient Safety Incident Response Framework (PSIRF), as required by NHS England. The ROH went 'live' with PSIRF, along with all other Trusts within BSOL ICB system, on the 6 November 2023. The ROH PSIRF Policy and PSIRF Response Plan, as approved by Trust Board and BSOL ICB, have been embedded into the ROH governance structure and processes.

The ROH PSIRF Policy and PSIRF Response Plan set out the key responsibilities of the key internal and external stakeholders. The PSIRF Policy and Response Plan also set out clearly the governance structure for review and investigation of patient safety incidents under the new PSIRF.

A summary of the key roles and responsibilities are set out below:

Executive Director of Governance

The Director of Governance is responsible to the Trust Board and the Chief Executive in relation to patient safety incident management and the implementation of learning and improvement that stems from the investigation of patient safety events.

Executive Chief Nurse

The Executive Chief Nurse is responsible to the Trust Board and the Chief Executive and is the Executive Lead in relation to patient safety.

Assistant Director of Governance & Risk

The assistant Director of Governance & Risk, as well as the wider governance team, are responsible for:

- Oversight of the development and management of the PSIRP within the Trust
- Developing strategies, designing, and implementing systems to raise awareness of and improvement of incident reporting, risk assessment, risk registers, investigation processes including training in learning response tools.
- Organisation wide trend analysis to identify cross cutting themes including the identification of health inequalities.
- Ensuring that learning from adverse events and incidents is shared across the Trust and where relevant the health system.
- Ensuring appropriate notification of incidents to relevant internal and external stakeholders, agencies, and regulatory bodies.
- Notifying the Chief Executive, Executive Directors, Non-Executive Directors, and all other relevant stakeholders, of unexpected deaths or other serious incidents that may attract media attention.
- Providing appropriate advice and support to the Chief Nurse and Medical Director to enable the accurate identification, reporting and investigation of incidents.
- Ensuring an effective quality assurance process is in place to monitor the quality of investigations, associated reports, and action plans.
- Ensuring an effective tracking system is in place so that investigation and learning response data and progress against action plans can be monitored and reported on to the Trust Board and Sub Committees.
- Ensuring that evidence is collected and appropriately stored to validate the implementation of recommendations and actions arising from PSII's.
- Ensuring assurance evidence can be retrieved in a timely way when required by the Trust Board or other internal or external stakeholders, as appropriate.

Divisional Triumvirate & Governance Team

The respective Divisional Triumvirates and the governance team are responsible within their areas and remit for:

- Ensuring arrangements are in place at a ward or departmental level to enable appropriate and timely patient safety incident identification, reporting, management, and investigation for all areas within their responsibility.
- To inform the Governance team immediately of any serious incidents and ensure that an incident report is completed via the Trust's Local Incident Management System
- To make decisions on and undertake investigation into patient safety incidents by utilising and following the PSIRF Plan
- To produce a quality improvement plan outlining the required actions to be implemented to ensure lessons are learned.
- Sharing of any relevant patient safety incident response reports, quality improvement plans/action plans, and copies of any Duty of Candour correspondence with the patient / family.
- To feedback the outcome of patient safety incident responses to staff as appropriate.
- Governance team to provide assurance reports on patient safety incident responses to Divisional Management Board.
- Ensure that staff involved in patient safety incidents, or the management and investigation of patient safety incidents, receive appropriate support.
- Ensure that the patients, relatives, or carers are informed about the incident in a timely manner in accordance with the Duty of Candour and document this discussion on the Trust's LIMS.
- To support and formally monitor, at Division meetings, progress against quality improvement plans/action plans produced because of patient safety incident investigations and responses.

Additionally, the key internal ROH Board and Committee Responsibilities are as follows:

Board of Directors

The Board of Directors is responsible for ensuring that appropriate systems are in place to enable the organisation to deliver its objectives in relation to PSIRF. It delegates this responsibility to the Quality & Safety Committee.

Quality and Safety Committee

The Quality and Safety Committee is responsible for assuring the Board of Directors that:

- The Trust has a strong patient safety incident reporting culture in which patient safety incidents are promptly identified reported and investigated.
- PSIIs are being appropriately identified, managed, and investigated and any resulting actions and learning are being addressed and embedded.
- Trends in patient safety incidents are being reviewed and managed on a Trust-wide basis.
- Quality improvement and learning from patient safety incidents is being identified and implemented.

- In collaboration with the Divisions and the Governance Team, the Quality and Safety Committee will also ensure that divisions are:
    - Reporting, managing, and investigating patient safety incidents in line with this policy and the accompanying plan.
    - Ensuring implementation of recommendations and quality improvement plans from serious incident investigations.

They also have a role in the analysis of patient safety incident data, triangulating this information with other sources to identify trends and request assurance and improvement where required.

Executive Governance Meeting

The Executive Governance meeting is a forum for assurance and oversight as well as sign off on PSIIs and patient safety incidents and their responses that are deemed suitable for escalation to Executive Director level.

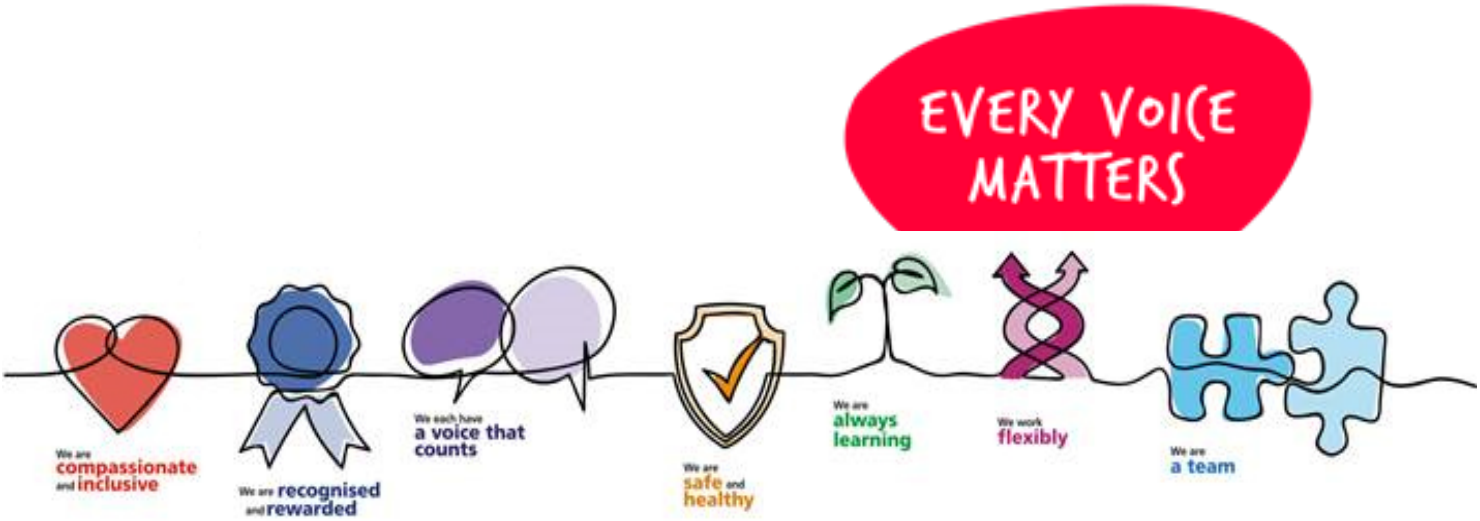
External oversight of ROH governance structures and processes, particularly in relation to PSIRF is provided by Birmingham and Solihull Integrated Care Board (BSOL ICB)

BSOL ICB seek assurance on PSIIs and any other patient safety incident matters and provides scrutiny and oversight via regular monthly contracting and patient safety oversight meetings.

6.1 National People Pulse Survey

The People Pulse survey is run three times a year in January, April and July. All staff have access to completing this survey. The survey provides a pulse check with staff member to throughout the year and enables a comparison against the National Staff survey (NSS). The nine staff engagement questions from the National Staff survey form the basis of the survey, which is administered for the ROH by IQVIA, an external partner.

Trust Level staff engagement	Q1 23/24	Q2 23/24	Q4 23/24	Improved?
Motivation	6.83	6.88	7.03	↑
Involvement	6.69	6.65	6.79	↑
Advocacy	7.53	7.67	7.74	↑
Overall staff engagement	**7.01**	**7.06**	**7.19**	↑



6.2 NHS Staff Survey

Each year, the ROH participates in the annual NHS Staff Survey. Staff who are employed by, or under contract to the ROH, 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, Staff survey launch day and other committees. Managers are 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 Annual Business Planning process.

In 2022, 1317 staff were asked to take part in the National Staff Survey with 60% (n=793) of staff responded using a mix mode of online and paper copy completions. The National response rate is 48%. The ROH is in the benchmarking group with 13 other Specialist Acute Trusts.

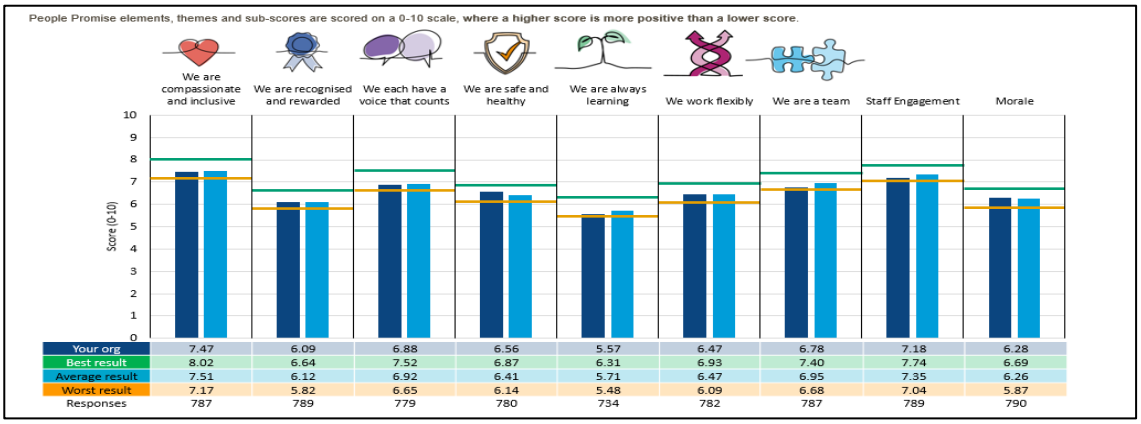


Figure 29: People Promise Elements and themes, overview.

*Data source Survey Coordination Centre NHS

7.0 Achievement in year

GIRFT accreditation

We achieved GIRFT accreditation as an elective surgical hub. This recognises our exceptional quality and enables us to support more patients to access treatment.

Continuous improvement

We have focussed on continuous improvement, refining our approach through introducing improvement huddles and supportive governance.

New facilities

We have continued to develop our site, introducing new rest facilities, a new cafe and food offering, a new oncology complex and wellbeing pods.

Staff survey results

We achieved a higher engagement rate than ever before and we score highly across the majority of domains. This indicates that our team is mostly positive about their experience at work.

Awards and recognition

We have been shortlisted in a range of awards for the work we do including the NOA and HSJ Awards for our osseointegration work and from Inclusive companies on our inclusion work.

New strategy and plans

We developed a new strategy and range of supporting plans. They are ambitious and will help us develop in the coming years aligned with the needs of our patients.

Leading specialties

Our Oncology Consultants hosted the inaugural BOOM conference this year, a global consensus meeting which considered Chondrosarcoma and Infected Oncology Reconstructions.

Research and innovation

We have continued to pioneer new research and lead innovative studies. For example, trials like MICA Biosystems focussed on remote-controlled cell technology.

Wellbeing and inclusion

We have continued to prioritise team wellbeing through initiatives like the hardship fund. We also continued our inclusion journey through initiatives like our 'Many Cultures, One ROH' exhibition.

Improving pathways

We have continued to optimise surgical pathways, for example, increasing the number of day care procedures we offer which helps patients return home within 24 hours.

Teaching and learning

We continued to advance our teaching and learning programmes. For example, we partnered with implantcast, to offer medical education to professionals through surgery observation.

Veteran Aware

We are accredited as Veteran Aware. This accreditation means we, along with other healthcare partners, are committed to support the needs of the Armed Forces community.

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Royal Orthopaedic Hospital
Quality Account 2023/24

Statement of Assurance from NHS Birmingham and Solihull Integrated Care Board June 2024

1.1 Birmingham and Solihull Integrated Care Board (ICB) as coordinating commissioner for Royal Orthopaedic Hospital, welcomes the opportunity to provide this statement for inclusion in the Trusts 2023/24 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 14th June 2024 and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that Royal Orthopaedic Hospital provides. The report demonstrates the progress made by the Trust against the 2023/24 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2024/25.

1.4 We have worked closely with Royal Orthopaedic Hospital over the course of 2023/24, working collaboratively to review the organisations' progress in implementing its quality improvement initiatives. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2024/25.

Yours sincerely

Helen Kelly
Chief Nursing Officer – Interim
NHS Birmingham and Solihull Integrated Care Board