NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Quality Account 2024/2025

Author: Nicola Brockie, Chief Nurse & Director of IPC

Executive Sponsor: Matthew Hartland, Chief Executive Officer

Foreword from Chief Executive Officer

I am pleased to present the Quality Account for The Royal Orthopaedic Hospital for 2024/2025. 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.

We are proud to be 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 would 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.

Matthew Hartland
Chief Executive Officer

Contents **Page**

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 a 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 2024/25.
- 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 – The 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 2024/25

During 2024/2025 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 third sector partners to ensure the quality of care and access to services for our patients is of the highest quality.

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

Quality Priority		
1.	**Safe**	Reduction in surgical site infection
2.	**Caring**	Improve the quality of communication to our patients
3.	**Effectiveness**	Development and implementation of the Health Inequalities plan
4.	**Responsive**	Optimisation of patient's health prior to surgery
5.	**Well-led**	Introduction of Service Accreditation

Table 1. Quality Priorities 2024/25

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 2024/25 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 QP 2 & QP 4 required further work and scrutiny to ensure that they are embedded and achieve the goal, therefore the Committee recommended they would continue into 2025/26. This decision was supported by the Trust's Quality and Safety Committee.

2.1. Performance on 2024/25 Quality Priorities

Priority 1. Reduction in surgical site infection

Safe	**Reducing surgical site infection risk rates for knee replacement and spinal surgeries undertaken at ROH from 2024/25 onwards**
Leads	Victoria Clewer – Infection Prevention and Control Lead Nurse
Executive Lead	Nicola Brockie – Chief Nurse and Director of IPC (DIPC)
Why we chose this QP?	Reducing SSI risk rates for knee replacement and spinal surgeries at ROH has been selected as a Quality Priority for 2024/25 onwards due to incidences of 'higher outlier' status across the following quarters:

Quarter/Months/Year	Category	Risk	Benchmark	Status
Q1 – Jan-Mar 2024	Knee replacement	0.7%	0.2%	Higher outlier
	Spinal surgery	1.7%	0.9%	Higher outlier
Q3 – Jul – Sep 2023	Knee replacement	0.7%	0.2%	Higher outlier
	Spinal surgery	1.7%	0.9%	Higher outlier
Q1 – Jan – Mar 2023	Hip replacement	0.0%	0.3%	Lower outlier
Q3 – Jul – Sep 2022	Hip replacement	1.6%	0.3%	Higher outlier
	Spinal surgery	2.8%	0.9%	Higher outlier

Significant decrease and sustained reduction of SSI risk rate was observed in knee replacement surgeries following the initial creation and implementation of the 'Theatre Focus Group' which has since formed into the SSI Prevention Group. The main improvements brought about by the creation of this group was to reestablish an appropriate cleaning and decontamination regime within the theatre department as well as reinstating theatre etiquette and discipline, primarily with a review of the theatre 'red lines' denoting areas that require theatre attire and IPC practices to maintain cleanliness and sterility. The 2024/25 Quality Priority objective is to build upon this work and further address surgical practice, etiquette, and standards.

Actions identified

Four key actions were identified to address the increased risk rate for knee replacement and spinal surgeries. These further contribute to maintaining lower SSI risk rates for hip replacement surgeries and other surgeries for which surveillance is not currently undertaken.

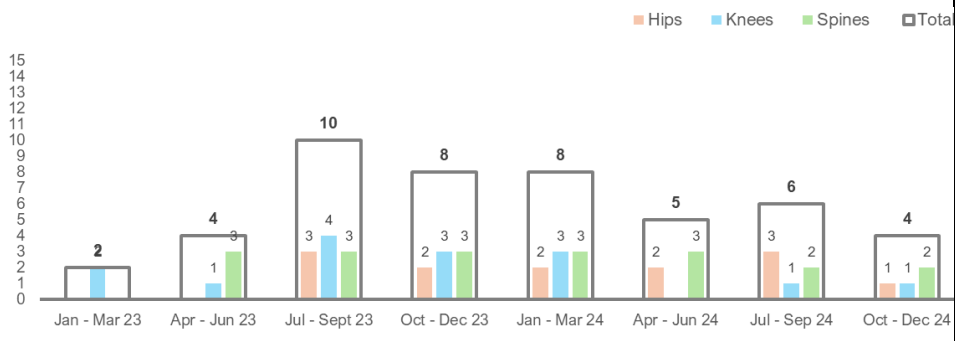
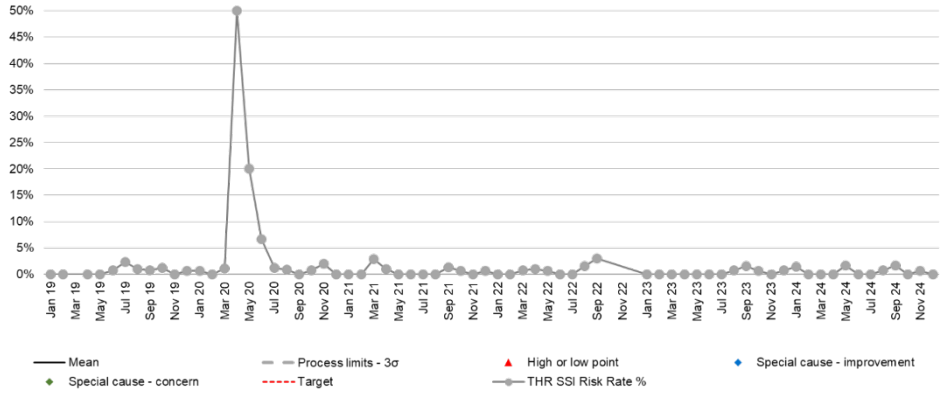
1. Creation and implementation of an ROH specific SSI prevention bundle.
2. Formalise the reporting and sharing of UKHSA SSI surveillance quarterly reports.
3. Create an orthopaedic IPC collaborative between The Royal Orthopaedic Hospital, The Robert Jones and Agnes Hunt Orthopaedic Hospital and The Royal National Orthopaedic Hospital.
4. Adopt a PSIRF approach to SSI reviews and utilise themes/feedback alongside an established formal audit process to inform future QI priorities and practice.

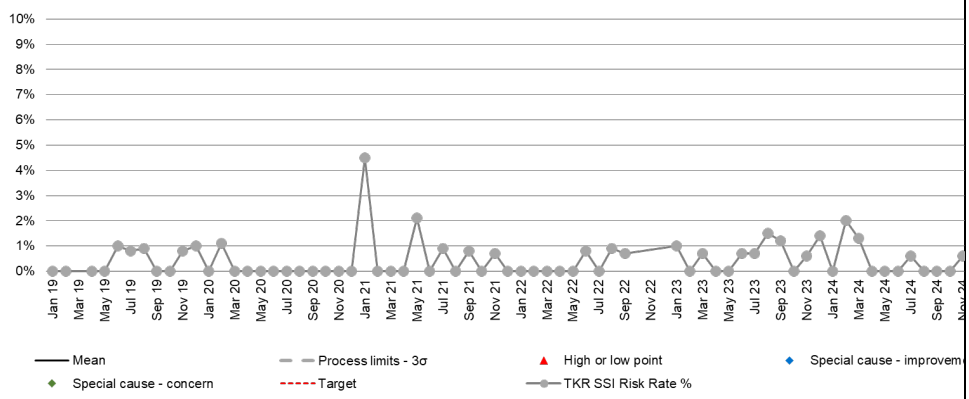
How have we evaluated success?

As part of the quality improvement work, use of statistical process control (SPC) charts has been implemented to monitor SSI risk rate, SSI incidence and plot interventions. In doing this we are able to monitor the work being undertaken and have a visual confirmation of its impact.

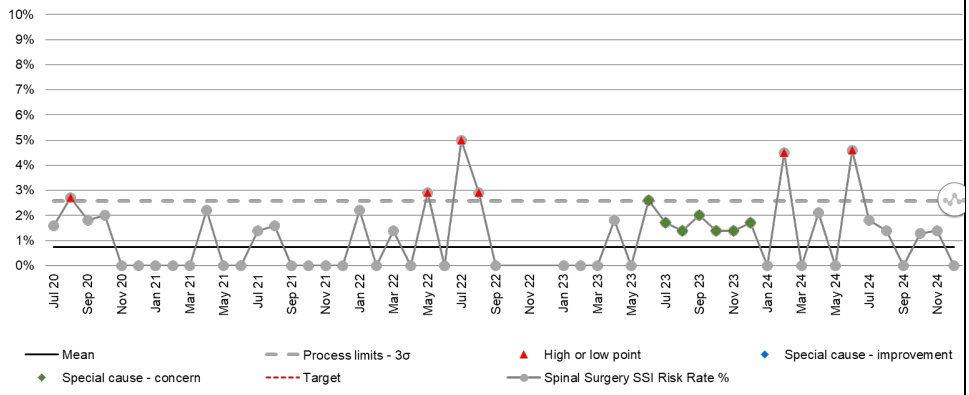
Success will be apparent if there is a sustained decrease in SSI risk for knee replacement and spinal surgeries and no further increase in SSI risk for hip replacement surgeries.

	What does success look like? • A sustained reduction in SSI risk rate for knee replacement and spinal surgeries. • Embedded evidence-based surgical practices and an improvement in theatre standards and etiquette. • Improved local benchmarked reporting and a collaborative approach to improvement.
Actions Completed	• ROH application and use of the UKHSA SSISS protocol has been reviewed to ensure an efficient service. Service provision and requirements have also been reviewed. Workforce capacity and capability to continue with existing surveillance programme has been confirmed. All staff who participate in the collection of data for the SSISS have undertaken UKHSA SSI training. • Process and timeframe for sharing SSI data has been reviewed and documented for future refence. IPCT attend speciality multi-disciplinary team meetings as requested/required to coincide with the release of quarterly SSI reports from UKHSA to facilitate discussion with surgeons. • To support the inclusion of clinical staff within the SSI prevention work an 'SSI dashboard' has been created and displayed within the theatre department to update all staff of the current SSI risk rates, improvement work and inform ways in which they are encouraged to get involved and support his work. • Collaboration between ROH and RJAH allows the free sharing of SSI risk rate data on a quarterly basis to allow benchmarking to take place. • ROH were early adopters of the PSIRF from an IPC perspective and much work has gone into continuously reviewing how SSIs are investigated. Work on reviewing this process for SSI reviews has been completed ensuring a meaningful thorough review of the data collected for all SSI reported. This includes the monitoring of compliance with 'One Together' practice standards as well as facilitating ease of use for trend monitoring and escalation. The updated process has created an SSI register which is used to gather data to inform thematic reviews should future 'higher outliers' be identified. This also allows real-time surveillance and monitoring of trends which will trigger further interventions such as targeted observations (One-Together audits) of surgical practice, theatre/ward environments etc.
Ongoing Actions	A multidisciplinary approach is being taken to develop and implement an ROH specific SSI prevention bundle. This is based on NICE guidance and informed by the 'One Together' SSI prevention bundle – both of which are evidence-based tools, specifying practices that are recognised to minimise the risk of SSI. This action will continue into 2025/26 – with

	the bundle ready for implementation by the end of quarter 1 (June 2025).
How has success been measured?	Awareness of the SSI surveillance process within the theatre environment has already had a positive impact, IPC continues to be discussed regularly and is high on the agenda and taken seriously by all within the department and across the Trust. Ongoing success will be influenced by the embedding of the ROH SSI prevention bundle and continued high standards of practice. This will be reflected by a reduced SSI risk rate. Interventions and effectiveness is monitored at monthly SSI Prevention Group meetings in which the ROH SSI prevention bundle leads provide upward reports and monthly action log updates. These meetings are minuted. An overall group action log is kept tracking additional actions as required.  Total hip replacement surgery risk rate % (inpatient & readmissions, includes primary & revision surgeries):  Total knee replacement surgery risk rate (inpatient & readmissions, includes primary & revision surgeries):



Spinal surgery risk rate per quarter (inpatient & readmissions, includes primary & revision surgeries):



2.2 Priority 2. Improve the quality of communication to our patients

Caring	**Improve the quality of communication to our patients**
Leads	Karen Hughes, Head of Nursing Division 1 Nasir Uddin, Associate Director of Operations Division 1
Executive Lead	Nicola Brockie, Chief Nurse
Why we choose this QP?	Medical and healthcare information can be complex, if people do not get clear and understandable information, they may make decisions that are not right for them or not be able to access services at all. Our Patient Advice & Liaison (PALS) contacts data highlights that for patients who contact us 'appointment' and 'communication' issues remain. 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. The MDT working group focused on these areas in 2024/25.

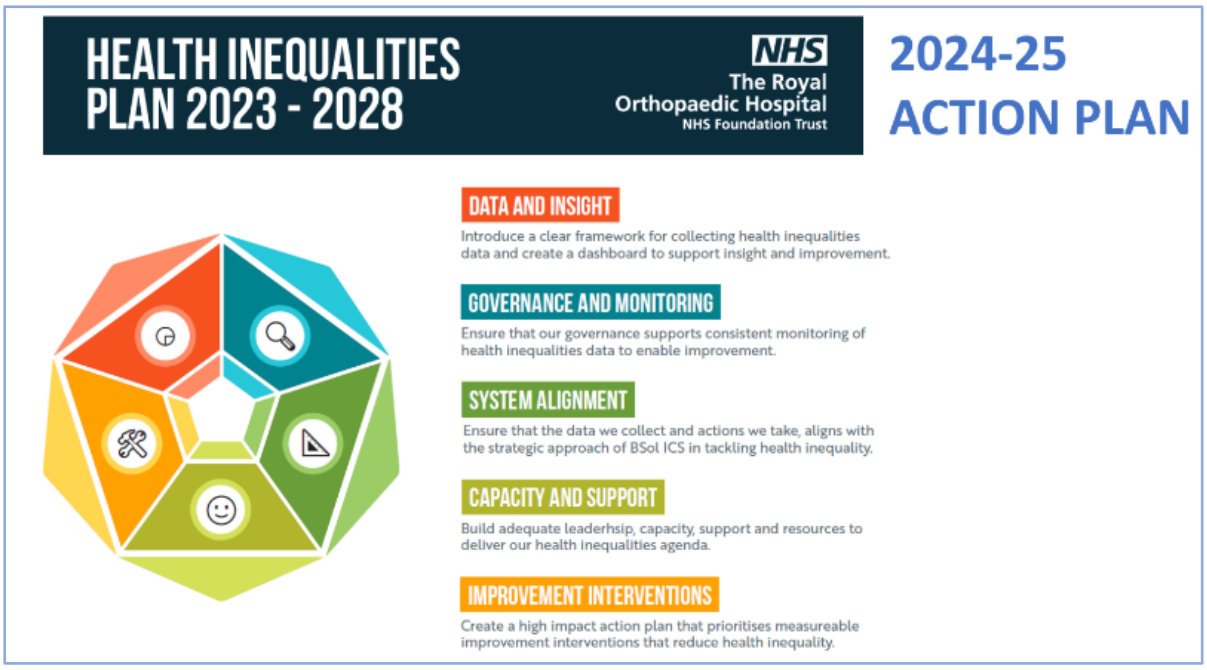
What actions have been taken?	• Review of process for enabling letter templates to be created/amended and added to PAS to ensure meet the patient information standards and are standardised where possible. • Review of all existing letter templates on PAS. • Review of text messaging process. • Review themes from patients' complaints/PALS which if addressed would improve patient experience. • Identify where this work can be maintained and monitored as 'business as usual'
How have we evaluated success?	• Review of complaints/ PALS data (relating to communication) • Approved letters on PAS meeting the required patient information standards. • Ongoing success will be influenced by the maintenance of this work and completion of the suggested outstanding actions.
Action completed	On-going monitoring of PALS/complaints and incidents relating to communication for themes/trends via Divisional Governance structures. • Established automated process to ensure any new/amendment letter template requests to IT for entry to PAS have been through Comms patient information process. • Review of all letter templates including for Therapies, ONKOS and CRIS and confirmed compliance against patient information standards and that they contained consistent up to date information. • Accessible Information Group re-established – chaired by Patient Access Clinical Service Manager who will continue this work. • Review of Appointments team staffing structure to ensure appropriate for number of calls received and other workload. • Review of Appointments SOPs to ensure processes for booking, changing and cancelling appointments are clear and include details of how this is communicated to patients. • Proposal paper was written for Operational Management Board regarding Trust use of 'easy read' format for all appointments, following engagement with key stakeholders. The planned agenda item of Business Planning was not discussed, therefore, a virtual decision requested. • Reduced number of letter templates currently on PAS (started with 235)-on-going piece of work.

On-going actions	• Develop active directory of 'live' letter templates which are reviewed annually at Accessible Information Group meeting • Progressing proposal to move to 'easy read' format for all appointment letters • Review of processes for patient text messaging as currently a free text option available. • Review of PAS manager access privilege to ensure only those who need for role have. • Archiving of all templates not required.
How has success been measured?	Themed complaints and PALS data was provided by the Patient Engagement Team. Overall based on the information available, concerns raised to PALS relating to communication have reduced from 82 in 23/24 to 50 in 24/25. Complaints have increased from 5 to 13. However, during this period there have been factors within operational teams and capacity which have impacted and were beyond the scope of this Quality Improvement, which have led to the increase in complaints relating to cancelled and rescheduled appointments, these are monitored in existing Governance and Operational forums. **Recommendations** • The 'easy read' proposal is formally reviewed and a decision made by Operational Management Board. • The completion of outstanding actions and on-going monitoring to be via the Accessible Information Group, to ensure this becomes business as usual.

2.3 **Priority 3. Implementation of the Health Inequalities plan**

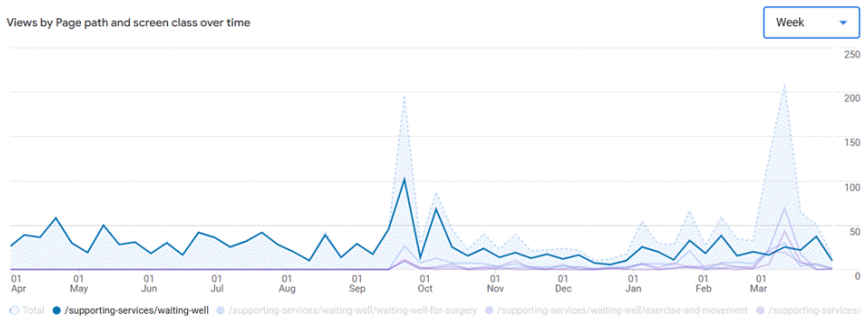
Effectiveness	**Develop and implement a Health Inequalities Plan with clear targets and objectives to improve patient access / experience and to meet the needs of our local population.**
Leads	Nicola Brockie Chief Nurse & Rebecca Lloyd Deputy Director of Strategy
Executive Lead	Matthew Hartland, Chief Executive Officer
Why we chose this QP?	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 (King's 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.
How have we evaluated success?	• Achieving the recommendations within the KPMG Health Inequalities report for FY 2023/24 • Development of a Trust Strategy
Actions completed	• Development and delivery of the Health Inequalities action plan • Health Inequalities has been incorporated into the refreshed Trust mid-term strategy. With clear metrics outlined. • Development of an annual improvement action plan to be presented to the Board. • There has been some deep dive into the data, but this remains difficult with work required in the coming year. • Alignment of the Trust to the FSH Health Inequalities work stream, networking and engagement with other FSH's. • Two Board members have undertaken the NHS Confederation Health Inequalities for Executive programme. • Governance is in place and alignment to the Board Assurance Framework has been undertaken. • Align with the Learning Disability & Autism strategy. With noted improvements in compliance of Oliver McGowan training. • Improvement engagement with Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHAR) work. • Variety of improvement initiatives undertaken including: Health Hacks, and Health Inequalities bus tour planned for April 2025.
On-going actions	• It was presented and agreed at Board in April 2025, that Health Inequalities would be monitored via the Trust Strategy. This would be supported by an annual action plan that feeds into the annual delivery plan for the Strategy.
How has success been achieved. will we evaluate success	• Approved mid-term Trust Strategy refresh. • Some improved data and understanding of our patient demographic affecting access and choice. • Improved governance and reporting routes. • Improved access for our local communities. • Improved engagement at system and national level.



2.4 Priority 4. Optimisation of patients' health prior to surgery

Responsive	**Optimisation of Patients' Health prior to Surgery**
Leads	Jennifer Pearson, Head of Nursing, Division 2
Executive Lead	Nicola Brockie, Chief Nurse
Why we choose this QP?	'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 patients' 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 were also keen to implement a digital solution that allows patients to share concerns about skin integrity prior to surgery, thereby reducing cancellations on the day.
What Actions have been taken?	• Developed a working group with aim to develop a pre-screening pathway working with divisional colleagues. The pathway has been

	signed off and agreed by stakeholders and training to implement this will begin in May 2025. • Worked 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 patients who are digitally excluded are considered and supported. This was launched in Feb 2025 using DrDoctor following agreement from surgeons and the implementation of a new nurse led criteria which allows autonomy of nurses to postpone patients if the criteria reveal infection or other which would be detrimental to surgery. This process is under review.
How have we evaluated success?	• Reduction in cancellations due to highlighting skin integrity issues. • It is highly encouraging that patients now have access to a range of 'Waiting Well' resources, and that staff across both OPD and POAC are demonstrating increased confidence and consistency in signposting patients to appropriate support and advice. • Analysis of the quantitative data suggests that uptake via QR codes remains limited. While website traffic shows some engagement, the number of visits remains relatively low in comparison to the volume of patients who have been provided with, or directed to, 'Waiting Well' information. Qualitive data from the Communications team has been collated (see below) in response to the limited digital/QR engagement, the Communications team has transitioned the 'Waiting Well' website to a 'business as usual' status. Moving forward, efforts will focus on enhancing outreach through short, engaging social media clips designed to more effectively capture patient interest and encourage wider access to key advice. Total views: • 1,410 page views • 762 unique users Views over time: 

Action completed	• POAC pathway project set up to review and develop preoperative pathways. • Launched the digital service which went live in Feb 2025 using DrDoctor and the agreed nurse criteria. Plan, Do, Study, Act (PDSA) process using QI methodology, review planned for May 2025. • Nursing competencies agreed by the group and Clinical Education team so that RAG ratings can commence in POAC and reduce the need for a clinician to 'clerk' some patients, date to be arranged for nurse training in May 2025. • National Orthopaedic Alliance (NOA) network meetings looking at pre-operative optimisation work and pathways nationally within orthopaedics – chaired by Head of Nursing for Division 2. • 'Waiting Well' advice live. The group are now recruiting patients to be part of the feedback regarding the 'Waiting Well' online health promotion information. Incentives for this include a £10 Amazon voucher. • Pre-operative information leaflet signed off by the Surgical Site Infection Prevention Group. The leaflet has been formatted by the Communications team. • Presentation to Consultants at audit meeting by Associate Medical Director and Head of Nursing for Division 2 in December 2024 regarding digital project – approval gained for project to be nurse led.
On-going actions	• Patient review of 'Waiting Well' 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. • Data being collected on cancellations. • Evaluation of work to date to be undertaken during quarter. This will include access reports from the Communications team in relation to 'Waiting Well' advice shared on the internet and direct patient feedback. • To strengthen the sign posting to health promotion 'Waiting Well' advice, the Communications team are currently putting short clip videos onto social media using ROH staff to deliver key messages. • As part of the Patient Information group – patient information is being reviewed and where and when appropriate 'waiting well' advice links are being added. • Patient feedback is being gathered via focus groups (incentives were used to encourage patient engagement) in relation to all patient information, but a specific question in relation to 'waiting well'

	advice has been included to ask patients – waiting feedback via the Accessible Information Group.
How has success been measured?	• PEEG group feedback. • Patient feedback using questionnaires. • Outcomes from POAC project group. • Impact of cancellations on the day following launch of digital project

2.5 **Priority 5. Introduction of Service Accreditation**

Well-led	**Introduction of Service Accreditation across all Clinical Areas**
Leads	Emma Steele, Deputy Chief Nurse
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we choose this QP?	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). Previously the Trust did 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 programme 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.
What actions have been taken?	• Established a Service Accreditation steering group using a QSIR methodology approach to the project. • Developed and followed road map. • Developed a set of standards against which to measure quality of care that demonstrates improvement. • Worked with AMaT to upload the standards and use the platform as a way of undertaking the review and displaying the results. • Created a core group of assessors and have met to review standards and plan the assessment to ensure standardisation.

	• Pilot of 2 services completed in September 2024.
Actions completed	Accreditation awarded to all departments in Phase 1 at a celebration event on Tuesday 3rd December 2024 attended by Nicola Brockie, Executive Chief Nurse and Interim CEO Matthew Hartland. • Ward 1 – Silver • Ward 2 – Silver • Ward 3 – Silver • Ward 4 – Gold • Ward 12 – Gold • ADCU – Gold Presented progress to Quality and Safety Committee in September 2024 and Trust Board in October 2024.
On-going actions	• Engage with other departments/staff groups to plan Accreditation for services • Invite AHP colleagues to join Assessor group • Phase 2 standards are progressing well. Areas include POAC, OPD, Discharge lounge, College Green and ROCS. • Assessors training has taken place and the leaders for the areas have been briefed. Phase 2 assessments will commence week beginning 28th April 2025. • New Quality and Safety walkabout process is underway and evaluating well.
How has success been measured?	• 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. • Ability to review results on AMaT. • Taking on board feedback and altering standards accordingly.

3.0 Our Quality Priorities for 2025/26

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 2025. Five specific areas to focus our attention in 2025/26 were identified.

	Quality Priority	Operational Lead	Executive lead
1. Safe (roll over)	Reduction in surgical site infection.	Victoria Clewer, Head of IPC, TV, and Deputy DIPC	Nicola Brockie, Chief Nurse
2. Caring	Art for Health – a holistic approach to managing patient pain.	Liza Tharakan & Chronic Pain team	Nicola Brockie, Chief Nurse
3. Effectiveness	Minimising the risks and potential impact of medical neglect among children and young people with limited engagement	Rebecca Furnival, Interim Lead for Safeguarding and Vulnerabilities	Nicola Brockie, Chief Nurse

	in health services due to existing health-related barriers.		
4. Responsive	Reduction in length of time for patients to wait for access to the Spinal Service.	Michelle Hubbard, Deputy Chief Operating Officer	Marie Peplow, Chief Operating Officer
5. Well-led (roll over)	Year 2 of the roll out of Service Accreditation.	Emma Steele, Deputy Chief Nurse	Nicola Brockie, Chief Nurse

Table 2: Quality Priorities for 2025/26

Priority 1. Safe

Safe	**Reducing Surgical Site Infection (SSI) risk rates for total knee replacement (TKR) and spinal surgeries undertaken at The Royal Orthopaedic Hospital (ROH) from 2024/25 onwards. (Rollover – year 2)**
Leads	Victoria Clewer, Head of IPC, TV and Deputy DIPC
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we chose this QP?	Reducing the risk of surgical site infections (SSI) at ROH was identified as a quality priority for 2024/25, following consecutive years (2022–2024) of 'higher outlier' status in total knee replacement (TKR) and spinal surgery categories. Although SSI risk rates have improved across all monitored categories, this priority has been extended into 2025/26 to support the continued development and implementation of a bespoke ROH-specific SSI prevention bundle and a robust ongoing surveillance programme.
How will we evaluate success?	As part of our ongoing quality improvement initiatives, Statistical Process Control (SPC) charts are being utilised to monitor SSI risk rates, SSI incidence, and to track the timing and impact of implemented interventions. This approach enables real-time visualisation of progress and facilitates data-driven evaluation of the improvement work. Success will be defined by a sustained reduction in SSI risk for total knee replacement and spinal surgeries, as well as the prevention of any further increase in SSI risk for total hip replacement procedures. Definition of Success:

	• Demonstrable and sustained reduction in SSI risk rates across total hip replacement, total knee replacement, and spinal surgeries. • Consistent implementation of evidence-based surgical practices, alongside enhanced theatre standards and professional conduct. • Improved local benchmarking and reporting processes, supported by a collaborative, multidisciplinary approach to continuous improvement.
Actions planned	The 2024/25 Quality Priority centred on critically reviewing the evidence base for SSI reduction interventions, with the aim of collaboratively identifying those most relevant to orthopaedic surgery. This work supported the development of a bespoke SSI prevention bundle tailored to the needs of ROH. For 2025/26, the focus will shift to the implementation and evaluation of this bundle alongside the enhancement of our SSI surveillance processes. The key objectives for this period are: 1. Finalisation and rollout of the ROH-specific SSI prevention bundle. 2. Development and deployment of an audit framework to ensure consistent and appropriate application of the bundle. 3. Integration of bundle compliance metrics into local and national SSI surveillance reporting. Anticipated outcomes include: • Embedding of evidence-based surgical practices and the promotion of enhanced theatre standards and professional etiquette. • Strengthened local benchmarking and surveillance reporting, fostering a collaborative, data-informed approach to continuous improvement.

Priority 2. Caring

Caring	**Art for health – Holistic approach to managing patient's pain**
Leads	Dr Liza Tharakan & Chronic Pain team
Executive Lead	Nicola Brockie, Chief Nurse
Why we choose this QP?	Prioritising Art for Health can be a transformative approach to improving patient outcomes, particularly for chronic and long-term care patients. Art therapy fosters emotional expression, reducing

	stress and anxiety while enhancing overall well-being. Studies have shown that engaging with creative activities aids in pain management by shifting focus away from discomfort and promoting relaxation. For patients facing extended treatment journeys, integrating art into holistic care offers a non-invasive, therapeutic tool that complements traditional medical interventions. Whether through painting, music, or storytelling, art fosters a sense of control and connection, empowering individuals to actively participate in their healing process. By making art a Quality Priority in healthcare, we cultivate a more compassionate, person-centred system that acknowledges the profound impact of creativity on recovery and resilience.
How will we evaluate success?	Measuring success in prioritising art for health requires a blend of qualitative and quantitative methods that capture the real impact on patients lived experiences. Here are keyways to assess progress: • Patient-reported outcomes: We will undertake surveys and gain insight during medical reviews. Patients can provide feedback on how creative engagement influences their daily life. • Daily activity improvements: Observing changes in routine functioning, mobility, and engagement in social or recreational activities can indicate enhanced quality of life. • Pain management effectiveness: Monitoring pain perception before and after art interventions can help evaluate its therapeutic impact. • Healthcare utilisation: A decline in hospital visits or medication reliance may suggest that holistic approaches are complementing traditional care effectively. • Clinical observations: Doctors, nurses, and therapists can provide insights on patient responsiveness, adherence to treatment, and overall emotional resilience. Success is not just about numbers—it is about witnessing patients feeling empowered, engaged, and supported in their healing journeys.
Actions planned	• Further roll-out of Art for Health sessions: Expanding accessibility through hospitals, community centres, and online platforms to engage more patients. • Building relationships with Birmingham City University for music options: Partnering with music therapists and researchers to incorporate sound-based interventions into healthcare settings.

	• Exploring a charity post for coordination: Creating a dedicated role to oversee logistics, outreach, and program development. • Seeking national charity funding: Identifying grant opportunities and philanthropic support to ensure long-term sustainability.

Priority 3. Effectiveness

Effectiveness	**Delivering Safe, Effective and Inclusive Care -** Minimising the risks and potential impact of medical neglect among children and young people with limited engagement in health services due to existing health-related barriers.
Leads	Rebecca Furnival, Interim Head of Safeguarding and Vulnerabilities
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we choose this QP?	Effective care relies on a strong safeguarding framework that places the protection and empowerment of vulnerable individuals at its core. In accordance with Care Quality Commission (CQC) standards, safeguarding must be integrated throughout all levels of care delivery, underpinned by a clear understanding of the diverse and often complex needs of at-risk groups — including children and young people involved with social care, care leavers, those experiencing mental health challenges, individuals transitioning to adult services, and those with care and support needs such as learning disabilities and/or autism. Addressing health inequalities is a fundamental part of this commitment. A proactive, person-centred approach is essential to identify and remove barriers that prevent equitable access to safe, high-quality care. This includes recognising and responding to social, cultural, and economic factors that impact peoples' ability to receive the care they need. Collaboration is central to achieving this vision. We will work together with individuals, families, communities, and other professionals to provide joined-up care that focuses on what matters most to the people we support.
How will we evaluate success?	• Case study examples to be provided to the Safeguarding Committee and Children and Young Persons Group. • Conduct a monthly review of cases involving multiple 'Was Not Brought' and DNA (Did Not Attend) appointments to encourage patient engagement with health services and reduce potential health risks associated with non-attendance. Additionally, carry

	out an annual audit in accordance with internal 'Was Not Brought' and DNA guidelines to ensure compliance and inform service improvements. • Encourage feedback and involvement: Set up systems to collect regular feedback from patients and their families, using this input to enhance services and ensure they are meeting the needs of the community. Feedback collected using Ulysses and PALS.
Actions planned	• Promote a safe and effective culture: Cultivate a culture of vigilance, accountability, and shared responsibility, ensuring safeguarding is embedded throughout all levels of care delivery. • Develop individualised care plans: Ensure that all care plans are tailored to the needs, preferences, and circumstances of everyone, with active involvement from the person receiving care and their family. • Empower children and young people through shared decision-making: Ensure children and young people and their families are involved in their care choices, leading to improved engagement and satisfaction. • Provide education and support: Offer training to staff and resources to patients, carers and families to help them make informed decisions about care. • Tailor services to meet needs: Adapt services to be more accessible and responsive to the unique needs of disadvantaged or at-risk populations, using a multi-disciplinary approach. • Multi-Disciplinary Team (MDT) meetings: Facilitate collaboration among healthcare professionals, safeguarding and vulnerabilities teams, and community workers to ensure care plans are coordinated.

Priority 4. Responsive

Responsive	**Reduction in length of time for patients to wait for access to the Spinal Service**
Leads	Michelle Hubbard, Deputy Chief Operating Officer Supported by Sue Kelsall, Clinical Service Manager
Executive Lead	Marie Peplow, Executive Chief Operating Officer
Why we choose this QP?	The Spinal Service waits nationally are challenged and are longer than clinically desired. This national issue is represented locally at the ROH, as the speciality is an outlier in comparison to all other

	ROH services. Rising waits lead to an increase in PALS concerns and complaints and potential patient harm due to delays in care. There are opportunities to increase innovative ways of working to reduce the long waiters within the Spinal Service.
How will we evaluate success?	• Elimination of 65 weeks. • A reduction in waiting times. • Achievement of the National imperatives for waiting times for the Trust in line with the Annual Plan. • A reduction in PALS concerns and complaints regarding waiting times.
Actions planned	Demand and capacity review detailed significant consultant capacity gap. This has led to the increase in consultant capacity which will come into effect in Q1 of 2025/26. Other initiatives to improve productivity also include implementation of the 'go further faster' GIRFT templates for outpatient clinics. The service is also developing a pilot of triage clinics for new patients and super discharge clinics (3 consultants reviewing any consultants long waiting follow ups). Monitored through a small task and finish group chaired by the Deputy Chief Operating Officer and the daily Patient Tracking List (PTL) meetings. The intention is to have the 1st clinics in May 2025 to support patients that will breach 65 weeks in June, July and August 2025. After the pilot the frequency of these clinics will be determined and job planned.

Priority 5. Well Lead

Responsive	**Year 2 of the roll out of Service accreditation**
Leads	Emma Steele, Deputy Chief Nurse
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we choose this QP?	Carrying on with the roll out of Service Accreditation throughout wards and departments at ROH.
How will we evaluate success?	Successful Accreditation Programme completed and then embedded.
Actions planned	• Phase 1 complete and Phase 2 underway, Phase 3 will be developed and completed by the end of 2025/26. • New Quality and Safety Walkabout process developed and rolled out. • Continual engagement with Service Accreditation assessors to review standards and plan next phase.

	• Develop bespoke standards for Phase 3 which includes Theatres, Recovery and Critical Care Services.

4.0 Statements of Assurance

4.1. Priorities for improvement and statements of assurance

During 2024/2025 the ROH had 14 relevant health services. The ROH has reviewed and 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 2024/25 the ROH provided and or subcontracted £140,636,098 of relevant health services.

The income generated by these health services reviewed in 2024/25 represents 93.5% 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 1st April 2023. Aligned payment and incentive contracts form the main payment mechanism under the NHSPS.

In 2024/25 API contracts contain both a fixed and variable element. In 2024/25 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 2024/25, the ROH participated in 5 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 2024/25 are listed below.

4.3.1. National audits

Governing Body	Project Title	Team	Lead	Progress
NHS DIGITAL	Elective Surgery National PROM'S Programme	Arthroplasty	Mr Y Agrawal	Hip Q1 compliance 100% Knee Q1 Compliance 100% Hip Q2 Compliance 98% Knee Q2 Compliance 99%
HQIP/QA	National Joint Registry (NJR)	Arthroplasty	Mr D Dunlop	100% latest audit compliance 97% Consent rate
BTA	Bedside transfusion audit	Trust wide	Mrs K Hughes	Submission of minimum data set completed

UK FATE	Venous thromboembolism in foot and ankle surgery.	Foot & ankle	Mr H Rajgot / Mr B Budiar	Data submitted. Report published – 97% compliance
NAP 7	NAP 7 - Perioperative Cardiac Arrest	Anaesthetics	Dr B Smith	Report sent to Dr B Smith for review of any actions. Trust compliance 98%

4.3.2. **National audits Cont.…**

Speciality	Brief description of audit/Improvements
Arthroplasty PROMS	There is a hold due to the changes with NHS digital we are not getting reports at this time however the team keep a monthly rolling ROH in house figure of the compliance on data collections. • 98.7% of hip replacements reported improvements, from Oxford Hip score. • 97.6% knee replacements reported improvements in health from Oxford Hip score. • 98.1% of hip participation rate post-operative questionnaire. • 96.4% of knee participation rate post-operative questionnaire. 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%. **Current participation rate at ROH** • 98% participation rate - 1165 primary hip procedures and 138 revisions have been completed 2024/25. • 97% participation rate – 1219 knee procedures and 143 revisions have been completed 2023/24. • PROMS data us reviewed at both AQILA and Quality and Safety Committee.
National Joint Registry (NJR)	All primary and revised arthroplasty is registered on the NJR system. In 2022/23 the audit compliance was 97% and 2023-24 100%. 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.
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.

	A recommendation was that we apply to get the HES data on the patients that we are adding to the FATE audit, or ask The Queen Elizabeth Hospital for data, or check the patients notes, or ask the patients directly. Confirmed that this is in place at The ROH by Mr McKenzie.
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 shows the Trust as compliant.

Table 4: National Audits

4.4. **Local Audits**

A sample of completed audits for the last three months. All audits are scheduled to present at either AQILA / Clinical Audit meeting or both.

Speciality	Title	Summary/Actions
Small Joints	Audit of non-medical prescriber activity in the foot and ankle department.	This audit has demonstrated competency of all non-medical prescribers within the foot and ankle service and that they meet the standards of proficiency set out by the Royal College of Podiatry. Non-medical prescribers within the foot and ankle team provide a safe and efficient service to patients, benefitting the foot and ankle team by providing an autonomous prescribing service within the team, therefore streamlining patients' care pathways. This audit showed that 100% of prescriptions were appropriate and indicated to treat the presenting complaint. All drugs prescribed were within scope of practice for an advanced podiatrist. 100% of prescriptions were well written with all necessary demographic and drug information included. They were all signed and dated appropriately, and no prescriptions were returned or queried. 100% pf patients received a consultation with the prescribing practitioner prior to receiving the prescription to ensure there were no contraindications and to discuss potential side effects as well as the dosing regime, in accordance with Royal Pharmaceutical Society guidelines for non-medical prescribers.

		Where required, advice was sought from the multidisciplinary team (i.e. Microbiology / Bone Infection Service / Consultant in charge of care) to ensure the drug prescribed was appropriate and any necessary adjunct drug monitoring occurred during treatment. This ensured patient safety, appropriate use of antibiotics and made certain that clinicians adhered to local and national guidelines on antimicrobial stewardship.
Trust Wide	Sepsis 6 compliance	The sepsis audit is a rolling audit due to it not meeting the criteria of the Sepsis 6. Various actions have been implemented but the Trust still require extra training on the recognition and management of sepsis. Once antibiotics were prescribed administration occurred promptly however not all patients received the antibiotics within the one hour as per guidelines. Actions have been implemented for all nurses to undertake AIM, all wards to have a sepsis link nurse champion. New Antimicrobial Prescribing Guidelines are waiting to be signed off and will be launched via comms and to staff. This will be re-audited June.
Arthroplasty	Adequacy of consent for TKR	An apparent variability in the consenting process at the ROH has been noted, with much variability in terms of the risks being quoted to patient. we would therefore like to review the current standards regarding the consenting process for total knee replacements against National Standards/Guidelines. 1. Identify prevalence of 2-stage consent process. 2. Identify areas of variability. 3. Identify areas for improvements. We looked at 98 patients and the 95% compliance with the two-stage consent process is commendable and indicates that most patients are receiving a thorough explanation of the procedure and its risks. This is critical for ensuring that patients are making informed decisions about their healthcare. However, the gaps identified in the communication of risks suggest that there is room for improvement in ensuring that all relevant risks are consistently covered during the consent process.

		The findings of this audit highlight the need for a more structured approach to the consent process, with a checklist or standardised template that ensures all necessary risks, both general and specific, are discussed. This would help prevent any critical information from being inadvertently overlooked and ensure that the consent process meets the highest standards of care. The following actions have now been implemented. => Pre-printed consent forms. => Education standardised practice to consultants. We aim to carry out this audit again to see if the implementation of the above actions ensures that we have 100% compliance. If the preprinted consent form is effective, we need to look at other procedures and if we can implement this practice Trust wide.
Trust Wide	Wrist band	Completion of wrist band audit across all wards in line with NHS England guidance. All wards were 100% compliant. Small adjustments were made ensuring the band was not too tight however every patient had an accurate wristband in situ.
Imaging	Review of MRI imaging in young adult hip patients	• The outsourced MR scans failed to comply with set standards in this audit. Although the reports attempted to address clinical questions in majority of cases, high rates of missing data; example particularly missing assessments of version (53%), Cam/Pincers (80%) and Lateral structures (33%). • 30% of reports contained contrast statements stating that value of MR scan limited without contrast. • High rates of discrepancy vs in-house reporting with 26.7% classed as Major discrepancy (8 missed labral tears). • We advocate for in-house MSK reporting for complex MR scans.

4.5. Audit Overview

Below is the annual breakdown of the clinical audits registered for 2024/25 and the audits that are outstanding or require re-auditing. The Trust currently participates in five 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 2024/25	Audits outstanding	Audits requiring re-audit
1	43	53	12
2	35	26	8
Trust wide	8	6	4
TOTAL	86	85	24

4.6. Priorities for audits 2025/26

The Audit team are continuing to embed 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 the Heads 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 ward and area audits are currently showing a compliance of 98% and a total of 409 actions have been completed which has improved the compliance.

The proposed 2025/26 plan is shown below.

Project Title	Team	Lead	Latest Report	Progress
Elective Surgery: National PROM'S Programme	Arthroplasty	Mr K Moholkar / Lijun Wen	Awaiting report	Hip Q1 compliance 100% Knee Q1 compliance 100% Hip Q2 compliance 97% Knee Q2 compliance 97%
National Joint Registry (NJR)	Arthroplasty	Mr D Dunlop / Deb Wright	Gold Quality provider award	100% latest audit compliance

Bedside transfusion Audit	National	Karen Hughes	Not yet published	Submission of minimum data set completed
Service Accreditation	Trust wide	Emma Steele	In progress	Phase 1 of the delivering outstanding care accreditation silver and gold awards were awarded to ADCU, Woodlands, Wards 1,2,3 and 12, the aim of the OCET is to celebrate good practices, create a culture of sustainable continuous improvement, improve patient experience, staff morale and unit/ward efficiency. Phase 2 is now in progress to include POAC, outpatients, phlebotomy, and Topography.
Glucose Audit	Division 2	Jennifer Pearson		
Pre-operative Temperature Audit	Division 2	Jennifer Pearson	YES	An audit was carried out in accordance with NICE standards of reducing SSI by monitoring of patients' temperatures intraoperatively and post-operatively. The audit determined that patients are normothermic pre-operatively and over 90% of patients were

				relatively warm, however the documentation and recording was not evidenced in all patients. Actions have therefore been put in place and on completion a further audit is to be completed.
Divisional medicine management Controlled drug audits – safe and secure handling of medicine	Division 2	S Begum	Rolling Monthly reports	These audits provide assurance to the CQC that the organisation is managing and handling controlled drugs and other medications in line with regulations. Actions derived from the audits are shared with department managers and collaborative work is completed between pharmacy and departments to achieve better compliance across all areas. The results and actions are discussed in relevant meetings such as CDAO group and Medicines Safety Group.
NAP 7 - Perioperative Cardiac Arrest	Anaesthetist	Dr Siddaiah	Awaiting latest report	Report sent to Dr B Smith for review 20/11/2023

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 and we currently have nine pieces of guidance that require baselines.

Given the restricted time limitations for some clinicians the audit team will continue to offer pro-former building, analysis and support with action planning as well as offering data input from our audit nurse 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 2024/25 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 orthopaedic and musculoskeletal (MSK) research, from basic science to clinical studies, demonstrating fully our 'bench to bedside' philosophy.

The ROH prioritises the opening of, and recruitment to new studies, as outlined by the West Midlands Research Delivery Network (RDN). However, the ROH experienced a 42% decrease in the number of patient participants recruited to research studies over 2024/25, compared to 2023/24. This is largely due to external factors and is similar to other organisations, as the Midlands region has experienced a 47% drop off in the number of participants recruited to MSK and orthopaedic studies, stemming from a national reduction in the number of large, funded research studies in the specialty.

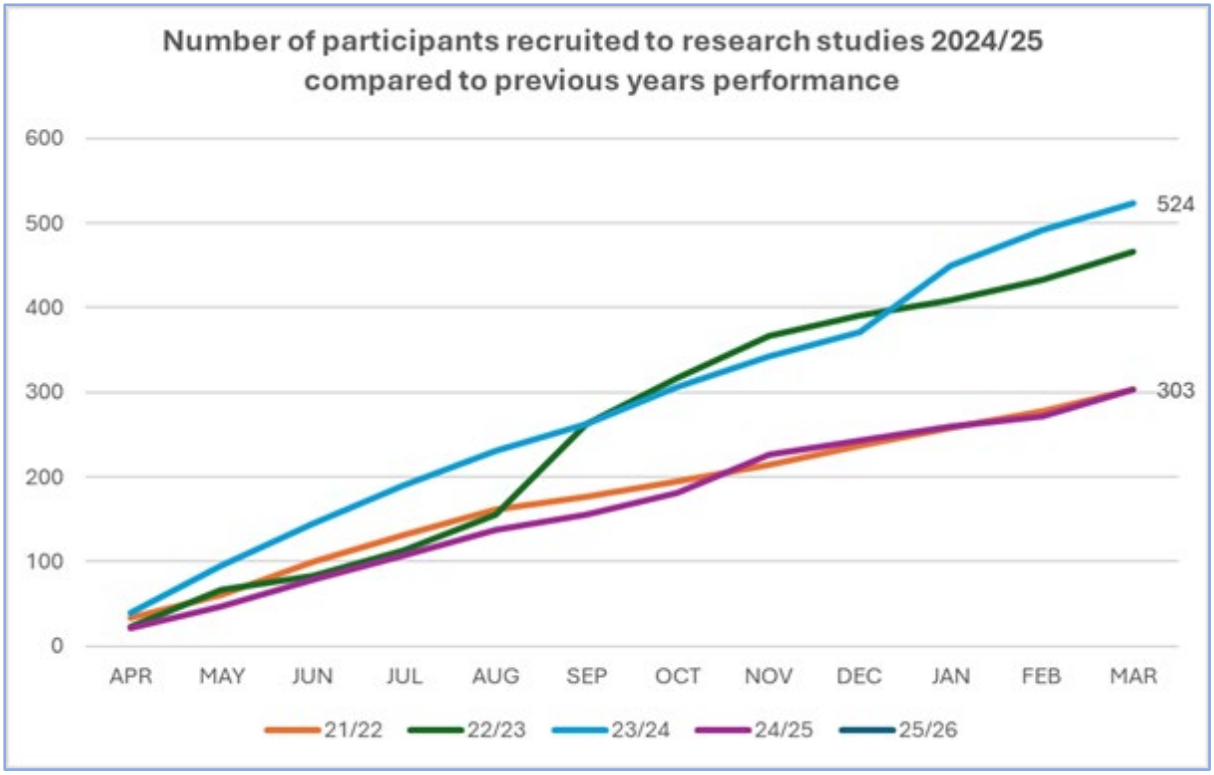


Figure 7: Total recruitment- All ROH research studies 2024/25, compared to previous years

During financial year 2024/25, 303 participants were recruited to research studies. Of these, 215 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 88 were recruited into non-NIHR portfolio studies.

The department continues to generate significant research activity via its Research Tissue Bank (RTB), stored at Arden. Studies approved via the RTB are not currently eligible for NIHR portfolio adoption, but account for 56 of the 88 non-portfolio recruits.

The number of participants recruited into commercially sponsored studies has decreased from six, in 2023/24 to one in 2024/25. Improving our commercial performance will be a key focus for the next few years. The Trust will be an active participant in the new West Midlands Commercial Research Delivery Centre, established at Birmingham Women's and Children's Hospital. The Trust played an active role in supporting the successful bid to establish this centre. Furthermore, the Trust has 2 commercial studies currently open for 2024/25 and is on track to see a significant uplift in recruits to commercial studies for 2024/25.

The Research & Development department has worked hard to create more capacity for research within the organisation. This is demonstrated by the recruitment of eight full time research fellows in the Trust, working across clinical specialties including spinal, oncology, arthroplasty, arthroscopy and anaesthetics.

This year has also seen ROH members of staff awarded more than £6 million of research grant funding. This will result in 3 large, randomised trials opening at ROH over 2025/26, including MEDAL (pharmacological management of acute low back pain and sciatica), PORTRAIT (evaluating the effectiveness of radiotherapy in those undergoing surgical fixation of spinal metastases) and BACPACS (evaluating the effectiveness of local nerve blocks following total knee replacement).

During this period 14 new studies were opened, and 8 studies were closed to recruitment. At the end of 2024/25, the department is delivering 49 open research studies: 19 interventional studies and 30 observational. Thirty-one of these studies are NIHR portfolio adopted studies, and 18, are non-portfolio adopted.

4.9. **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 2024/25.
- 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

Figure 8: November 2019

4.10. Information on the quality of data

The ROH submitted records during 2024/25 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 patient valid General Medical Practice Codes were:

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

4.11. 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 Toolkit (DSPT). In September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. The DSPT is split into a number of contributing outcomes, each of which are supported by indicators of good practice grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

The 'Health and Care CAF' presented in the DSPT consists of 47 contributing outcomes. At the interim baseline submission in December 2024, ROH was able to demonstrate

compliance for 35 of the 47 outcomes. We have less assurance around disaster recovery and business continuity planning. The Trust is working towards full compliance by the June 2025 final 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.

4.12. **Payment by results Clinical Coding audit**

The ROH was not subject to the payment by results clinical coding audit during 2024/25.

4.13. **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.

4.14. **Medical Rota Gaps**

Our postgraduate workforce continues to be resilient. 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 a 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 Handbook is provided and regularly updated.

There are monthly Postgraduate Doctors' Forum meetings to listen to and improve our doctors' 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.

4.15. **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 Incidents that resulted in severe harm
2024/25	3845	4	0.10%

Table 8: Patient Safety Incidents 2024/25

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 organisations 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.
- 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.

- Both internal and external review and audit of the implementation of PSIRF shows good implementation of the policy.

4.16. **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.

Where there are opportunities to review and improve care, a separate review can be undertaken in accordance with the Patient Safety Incident Response Framework (PSIRF).

During 2024/25 there were:

- 6 x inpatient deaths
- 16 x deaths within 30 days post discharge

Whilst the Learning from Death process has raised no concerns regarding ROH care or avoidability, actions have been undertaken as part of ongoing improvement work. These include;
- Changes to training and resuscitation simulations to include use of the EZIO system.
- Improved access to Stat Lock devices for patients with a PICC line who are confused/mobile.
- In order to better assist the Coroner with future investigations and inquests, in addition to the standard disclosure of statements, an overarching position statement will also be included.

4.17. **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.

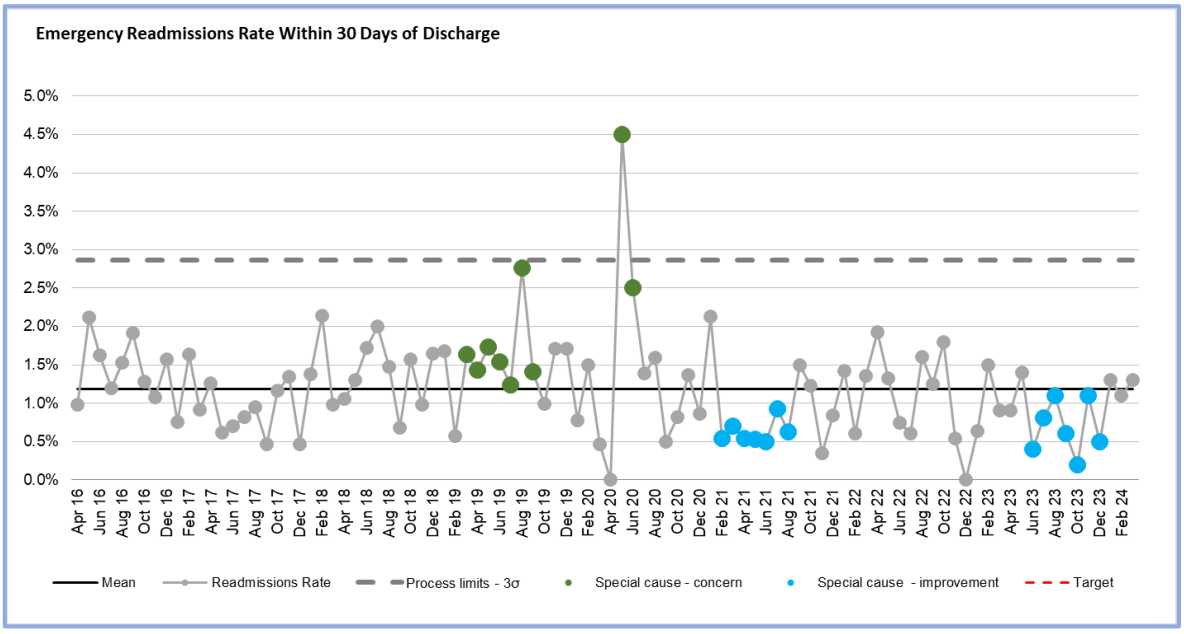


Figure 11: SPC Chart – Emergency admission rate within 30 days April 2016 to February 2024

4.18. **Response to personal needs**

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

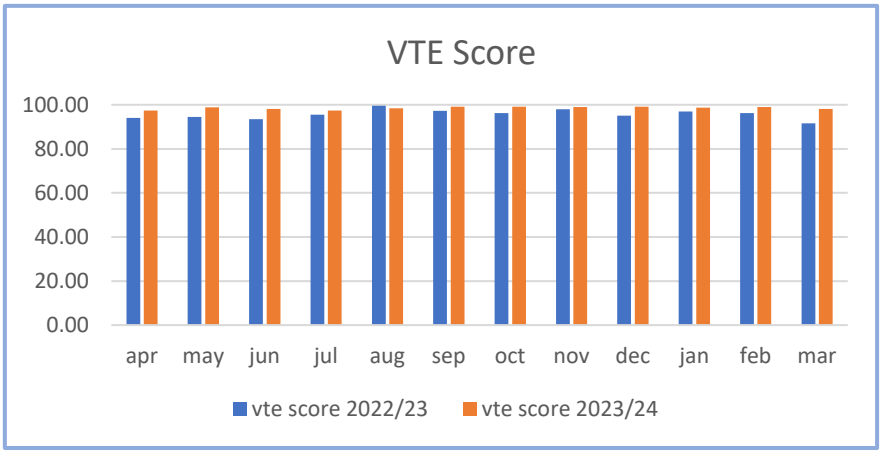
- Were you as involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about the medication 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 published in 2024 by patients receiving care in November 2023. The results have been reviewed and an action plan developed.

The response to the Health and Social Care statistical outputs consultation were updated in February 2025 and have now been published (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2025). The latest NHS OF publication updates the five 'Hospital episode statistics'-based indicators that have been approved to be published as part of the annual NHS OF publication. The 'NHS OF Data Source Links' document has been updated as part of the latest publication refresh. It provides a list of links for all the NHS OF indicators to the underlying source data, as well as links to alternative data sources where available.

4.19. **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
September	97.23	99.06
October	96.26	99.20
November	97.94	99.04
December	95.06	99.11
January	97.02	98.72
February	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 assessment 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 1st April 2023 to 31st March 2024.
- All reported suspected or proven Hospital Acquired VTEs are reviewed in accordance with Governance process. These have been aligned to PSIRF methodology.
- No potentially avoidable VTEs identified in year.

4.20. *Clostridioides difficile* Infection (CDI)

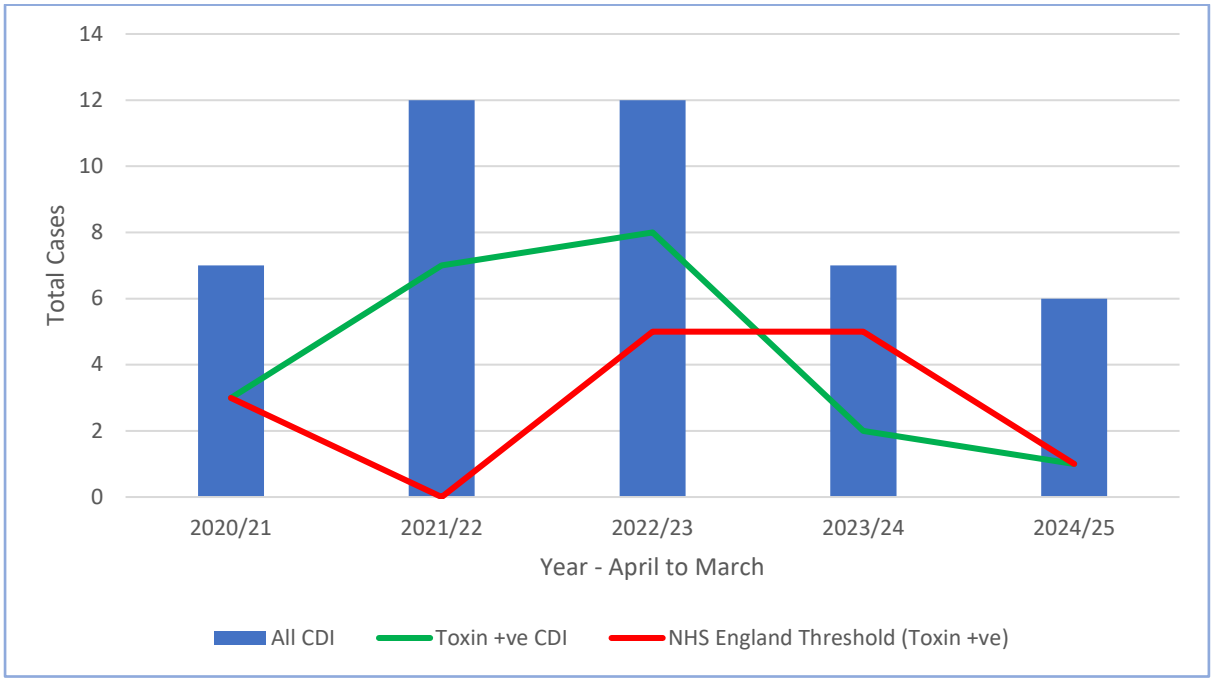


Figure 13: *Clostridioides difficile* cases reported by ROH between 2020/21 to 2024/25

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

- ✓ *Clostridioides difficile* infections are monitored and reported monthly, with an IPC 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 2024/25, there has been one case of reportable (toxin +ve) CDI. Which is one case 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.

4.21. **Compliance with national targets and regulatory requirements**

4.21.1 **Referral to Treatment (RTT)**

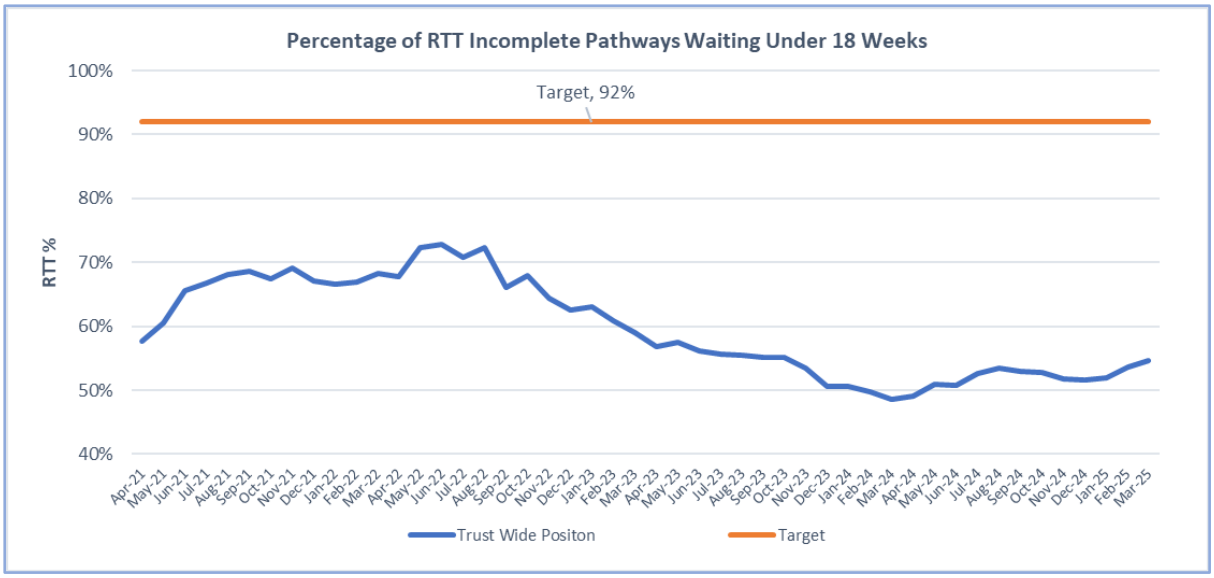
The ROH like many other NHS providers have seen constitutional targets such as RTT profoundly affected due to the national backlog of patients waiting for treatment. All Constitutional targets continue to be presented and discussed at the monthly Trust's Finance and Performance Committee Meeting, Trust 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.

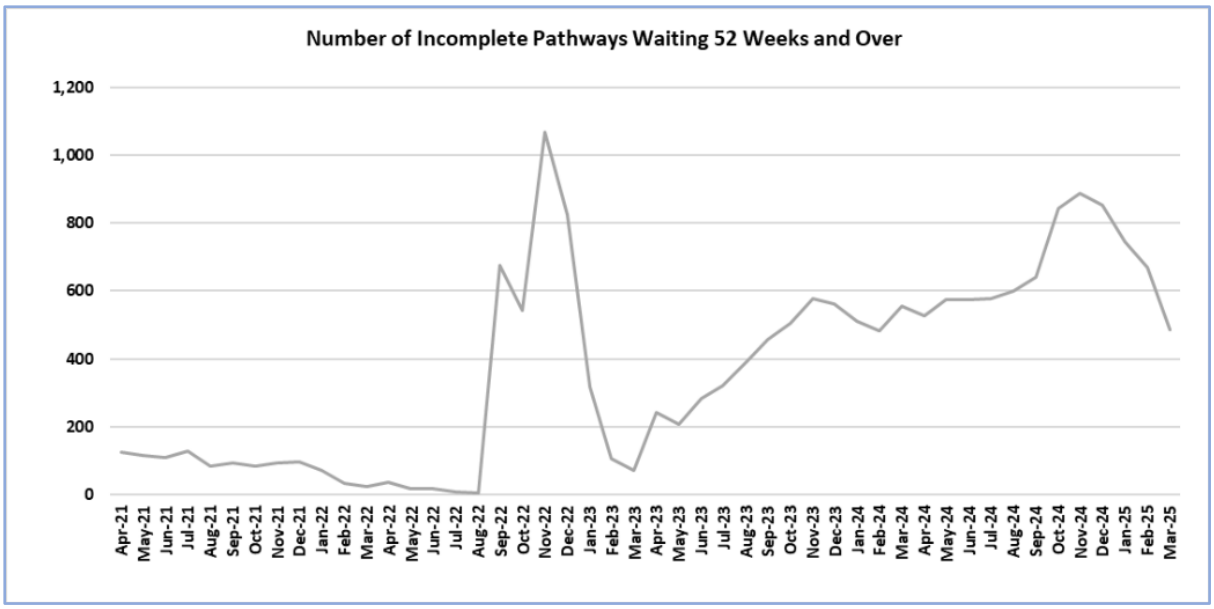
Operational performance metrics are monitored internally at weekly/daily patient tracking list (PTL) Meetings, Theatre Planning, Theatre Lookback Meetings and Divisional Management Board in order to provide full assurance that all admitted and non-admitted waiting lists are being actively managed. These oversight meetings aim to reduce the number of patients waiting over 18, 52 and 65 weeks. Additional PTL meetings are scheduled at the discretion of the Deputy Chief Operating Officer should the number of long waiters increase.

During 2024/25, 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 2025 ended at 54.66% 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 2024/25:





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 has been achieved in Arthroplasty, Foot and Ankle, Oncology and Oncology Arthroplasty.

4.22. Cancer treatment targets

Cancer standards

The table below represents the performance against cancer targets:

Performance Indicators: Cancer Services 2024/25	Target	Q1	Q2	Q3	Predicted Q4 (March 2025 position not validated)
% patients receiving subsequent treatment within 31 days (surgery)	96%	100%	100%	100%	100%
% cancer patients treated within 62 days of referral	70%	76.4%	89.4%	88.2%	76.5%
Faster Diagnostic standard (FDS)	77%	79%	83.6%	82.6%	80.1%

The Trust has seen a significant improvement in the delivery of cancer standards and continues to meet all national targets despite challenges with late tertiary referrals and shortages in Histopathologists.

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.

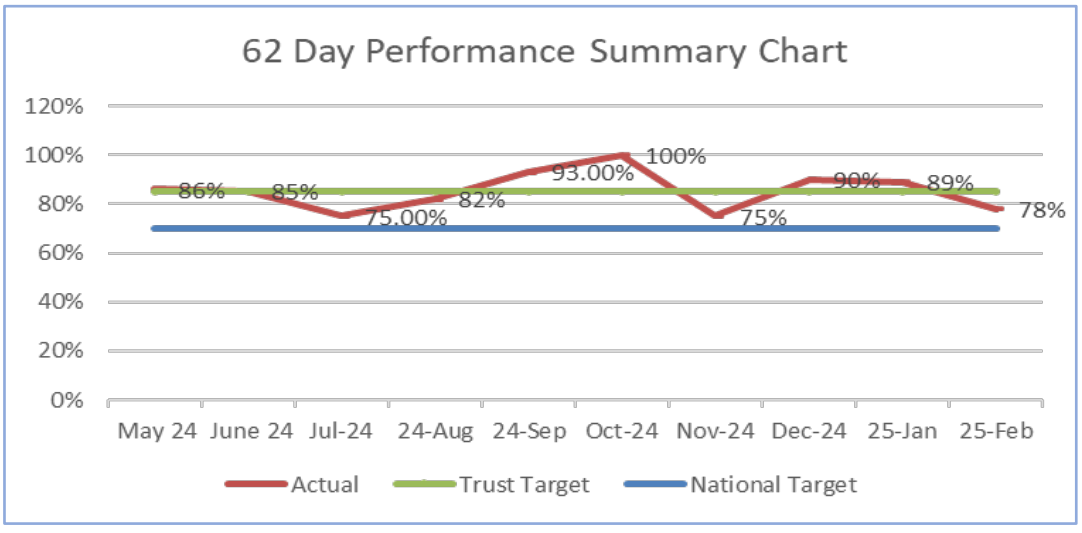


Figure 18: 62 Day Standard Performance 2024/25

The graph below 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 the 28 days have passed due to the rarity of the disease. Despite this, from May 2024 the ROH exceeded the target for most months except for October 24.

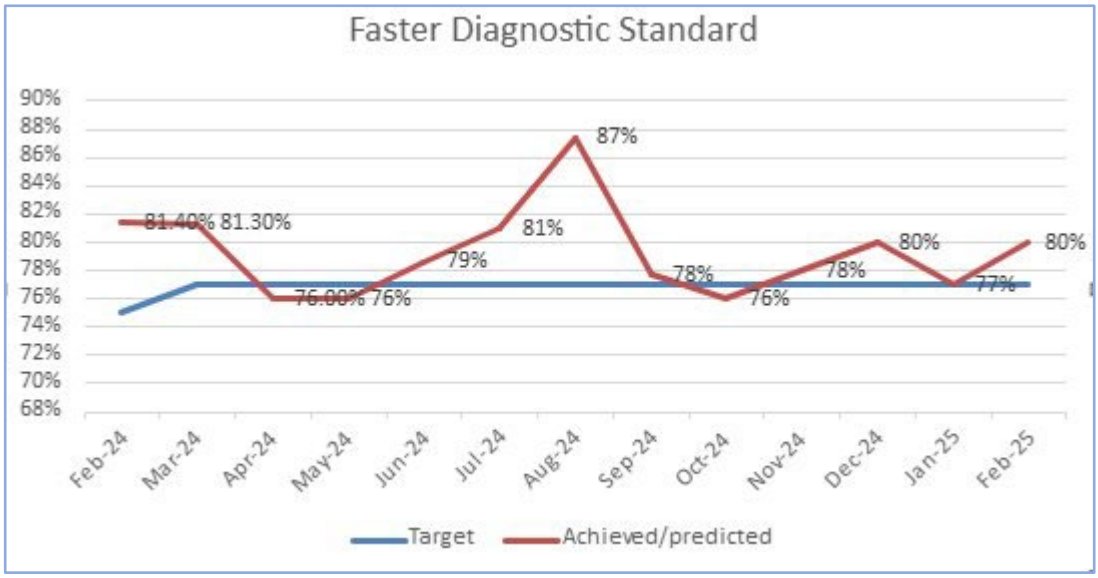


Figure 20: 28-day Faster Diagnosis Performance 2024/25

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.

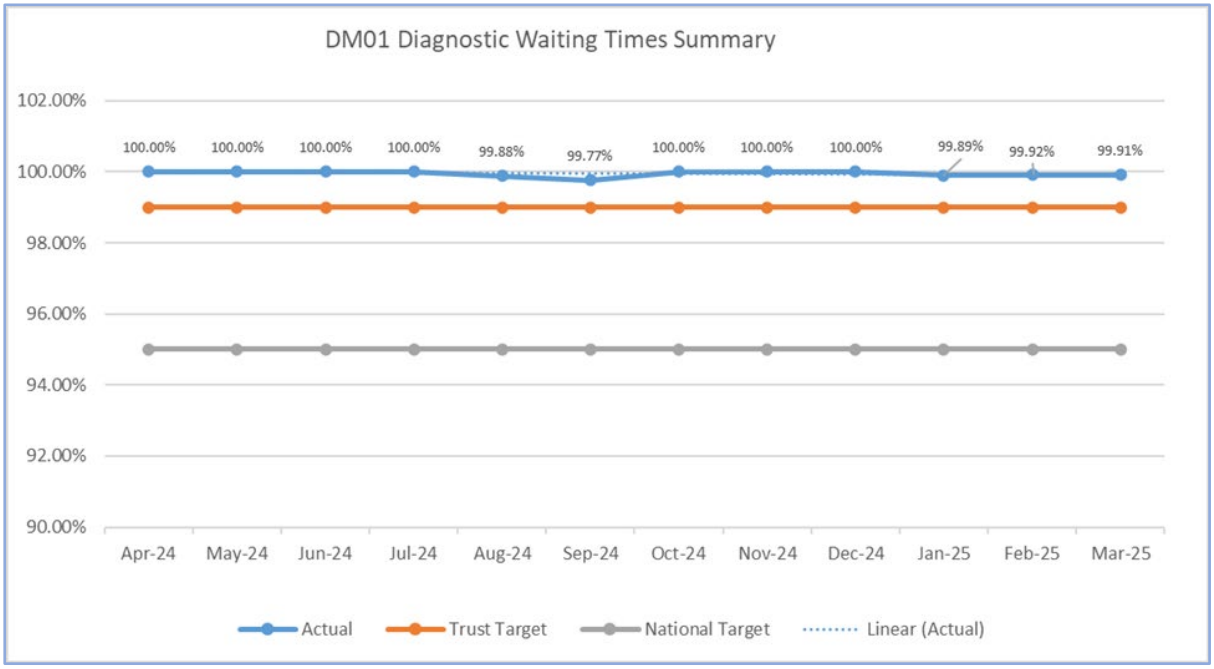
The ROH is one of only five specialist metastatic bone and sarcoma centres in the United Kingdom and receives referrals from a wide geographical spread. Some of the patients have been referred to the Trust after a prolonged pathway and are of high complexity which makes treatment within 62-days challenging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

4.23. **Diagnostics within 6 weeks**

Diagnostic performance

2024/25 the Imaging team consistently achieved the diagnostic standards target with the service performing over 99% throughout the year.

This 2024/25 diagnostic performance is demonstrated in the graph below:



The Imaging service also continues to provide system partners, Birmingham Women's Hospital 2 MRI sessions per week to support patient waiting times.

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.

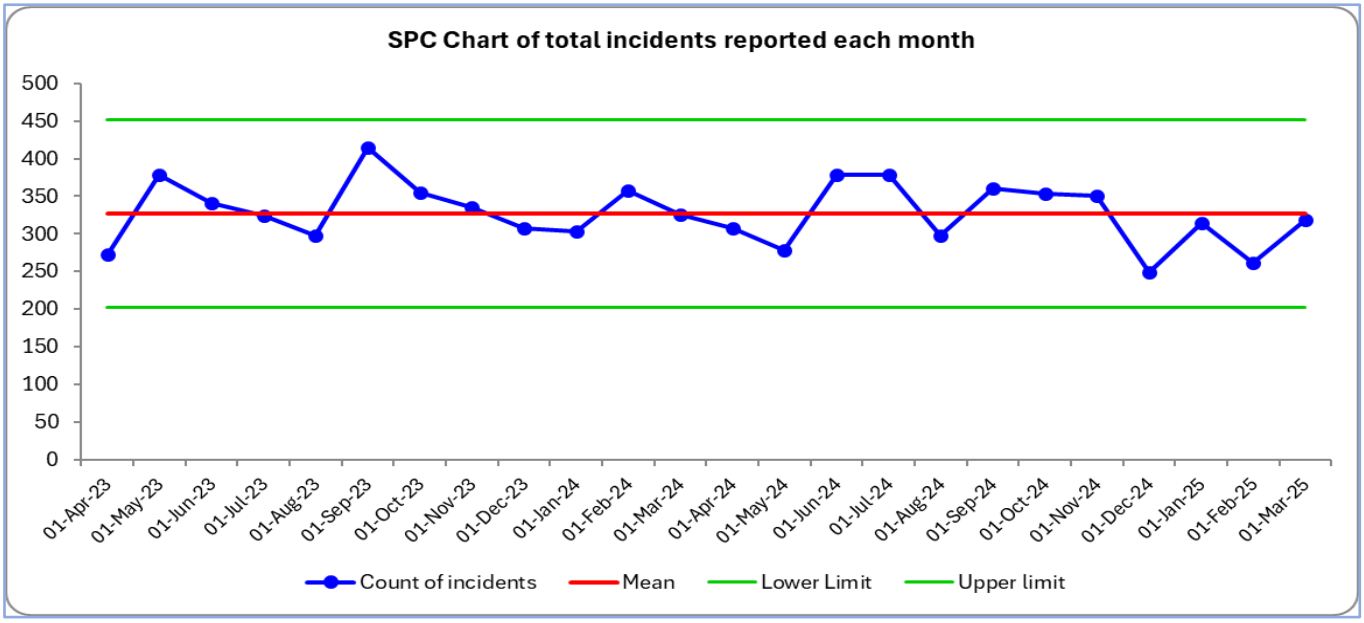


Figure 21: Incidents by Harm 2023/24

There is not a 'correct' number of incident reports as a 'low' reporting rate should not be interpreted as a safe organisation as it may represent underreporting, nor should a 'high' reporting rate be interpreted as 'unsafe' as it may represent a culture of openness. It is generally regarded as better to have a high rate with the majority being of no or low harm. A no blame culture is encouraged at ROH, and this is reflected in a high rate of reporting with the majority being incidents of low or no harm.

5.1.1 Serious Incidents

The implementation of the Patient Safety Incident Response Framework (PSIRF) has enabled a move toward a proportionate response focused on opportunities to learn. One of the key principles within PSIRF, is that safety incidents are caused by multiple, interacting contributory factors. This means that actions need to make changes on a systems level, in addition to provision of learning opportunities for staff. A review of the actions demonstrates 3 key themes – actions resulting in systems change, information sharing to improve knowledge and sharing of good practice.

1. **Systems based actions**

Systems based actions focus on making fundamental changes to the way work is done and are particularly effective in creating the conditions for sustained long term impact. These types of actions require greater resources so are utilised on priority areas. Some examples of these include a new standard operating procedure for referral triage and an update to the training to remind staff of the location of the EZIO system utilised during resuscitation incidents.

2. **Information sharing to improve knowledge**

PSIRF promotes a proportionate approach by ensuring resources are allocated where there are opportunities for learning. The report formats have been designed to draw

out the learning and ensure the information is accessible. Feedback from staff has been positive regarding the accessibility and usefulness of the new formats.

3. **Sharing of good practice**

There is a growing body of evidence, that learning is not just about adding something which is not there, but also recognising, reinforcing and refining what already is. There is an increasing role for learning from excellence. Some of the reviews have reinforced excellent practice, including the Orthotics and Tissue Viability Team responding to the immediate health needs of a patient attending for an outpatient appointment and arranging transfer to A&E, the exemplary and timely response of all staff to the sudden onset of difficulty in speaking in a patient ending with quick assessment by the Stroke team and a member of theatre staff noting an error on the consent form and speaking up until the error was addressed and surgery could continue.

5.2. Our patient experience

At the ROH, we are committed to creating an environment where patients and families experience exceptional care, where continuous improvement is a priority, and where community involvement shapes the future of our services. We believe that the most effective way to enhance our care is by actively listening to patients' thoughts, feelings, and experiences throughout their healthcare journey.

Our approach places patient feedback at the core of service improvement, ensuring it directly informs and inspires positive change. We have established a proven track record in gathering and acting on feedback through various channels, including:

- **National and local surveys** – such as the Care Quality Commission (CQC) In-Patient Survey and our bespoke in-patient and outpatient surveys.
- **Friends and Family Tests (FFT)** – offering insights into how likely patients are to recommend our services.
- **Compliments** – which celebrate excellence and boost staff morale.
- **Patient Advice and Liaison Service (PALS) cases and formal complaints** – highlighting areas for growth and refinement.
- **Healthwatch Birmingham comments and social media feedback** – providing real-time, unfiltered perspectives on patient experiences.

By leveraging this wealth of information, we proactively address challenges, identify patterns, and enhance practices that uplift the patient experience. Our partnership with Healthwatch Birmingham exemplifies this commitment, with their members regularly liaising with the Head of Patient Experience, participating in our Patient Engagement & Experience Group, and relaying community feedback. These collaborations ensure that our patients, carers, and families benefit from an independent and meaningful voice in shaping our services.

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**

Between 1st April 2024, and 31st March 2025, the Trust received 84 new formal complaints. Of these, one was withdrawn after being resolved outside of the formal complaints process.

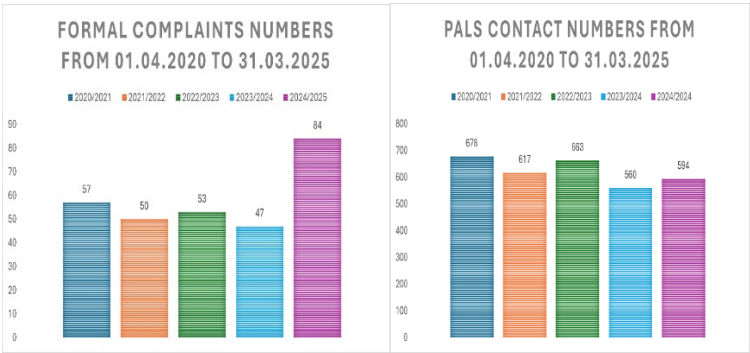
An important measure of quality in complaint management is the number of cases reopened due to concerns not being fully addressed or requiring further assurance. During this period, the Trust received seven requests from patients and their families to reopen complaints. These were resolved through resolution meetings with the Patient Experience Team and the Leads who had investigated the initial complaints or by providing further details in response to the initial questions to clarify the information provided. This practice aligns with PHSO guidance and is encouraged at all stages of the complaints process.

In 2024/2025, the total number of formal complaints received—including withdrawn complaints and requests for reopening—rose by 202% compared to 2023/2024. To address this significant increase, several ongoing initiatives have been undertaken, focusing on identifying trends and themes and resolving systemic issues that have directly impacted patient satisfaction.

The Complaints Department remains proactive in managing incoming complaints. Investigation timeframes vary based on complexity, but we strive to resolve issues within thirty working days. If additional time is needed for a thorough review, we maintain close communication with patients and complainants around time scales to ensure that they receive a comprehensive response.

Resolution meetings are increasingly utilised to enhance communication and achieve successful outcomes and the Trust adheres to the PHSO Principles of Remedy when addressing formal complaints.

The Annual Complaints and Patient Experience Report 2024/2025 will offer more detailed insights into PALS, Complaints, and Patient Experience and will be shared here [Royal Orthopaedic Hospital - Patient experience].



Figures: 2023 and 2024 PALS and complaints numbers for last 5 years

Number of Complaints and PALS Contacts from 2020/2021 to 2024/2025

*Data source: Patient Experience Department/ Ulysses system

The top three themes identified from the complaints in 2024/2025 were:

- ✓ Clinical Query: including delays in diagnosis or treatment, inability to access treatment, adverse outcome to treatment and lack of clinical information provided.
- ✓ Communication: including lack of communication with other providers also involved in the patients care, failure to communicate effectively interdepartmentally and lack of communication with the patient which impacted on patient care.
- ✓ Values and behaviours; including attitude of nursing, medical and administrative staff.

In 2024/2025 142 individual action plans were created for PALS and formal complaints. This is an increase of 42% on the numbers from 2023/2024.

All complainants are offered the opportunity to provide feedback on the outcome of the process both verbally and via satisfaction surveys.

5.2.2. **Patient Advice and Liaison Services**

During 2024/2025 the Trust has received 594 PALS contacts from patients and relatives. This is a 6% increase in the PALS contacts compared with 2023/2024. 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.

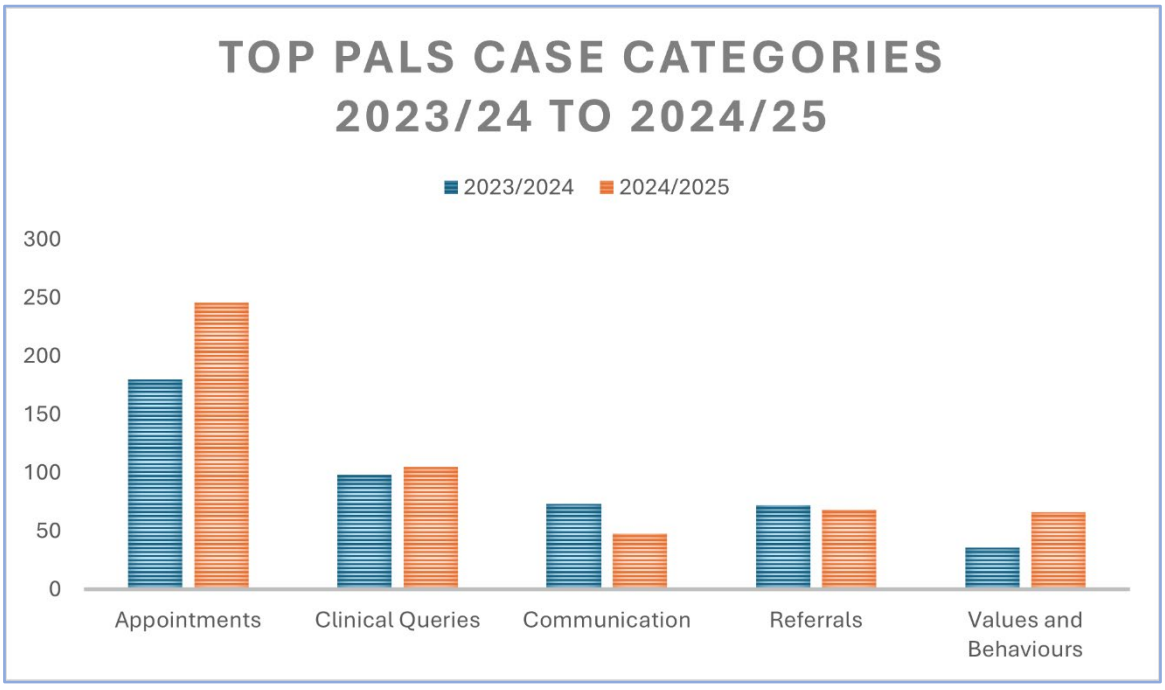


Figure 25: PALS Case Themes

The PALS team have continued to deliver a responsive service throughout 2024/25 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 including waiting times, referrals and cancellations
- Clinical queries
- Communication

5.2.3. **Patient Experience Surveys**

The ROH is committed to delivering exceptional patient care, founded on quality, compassion, and excellence in specialised elective services. A key pillar of maintaining and elevating these standards is the hospital's dedication to gathering, analysing, and responding to patient experience feedback. This feedback is not merely collected—it is actively used to refine and enhance the care and services provided, ensuring that patient needs remain central to every decision.

To further strengthen this commitment, we conduct a variety of surveys throughout the year. These surveys are essential tools in improving patient experience, allowing us to listen attentively to the thoughts and feedback of our patients and visitors. By valuing their insights, we continue to evolve our services, demonstrating our unwavering dedication to patient-centred care.

We are proud that we have a plethora of surveys and events that run throughout the year, and these include but are not limited to:

- 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
- Inpatient catering survey
- Synopsis and digital app survey

5.2.4. **Friends and Family Test (FFT)**

We believe that the best way to improve our services is by truly listening to the thoughts, feelings, and experiences of individuals throughout their journey. We highly value feedback from patients and their families, as it provides essential insights into both exceptional care and areas for growth.

Recognising staff who go the extra mile helps to foster a culture of appreciation and motivation, strengthening our commitment to high-quality service. 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.

Similarly, feedback highlighting concerns helps us identify trends and develop meaningful quality improvement programs. By learning from both positive experiences and challenges, we continue to enhance the care we provide and ensure that every patient's voice drives meaningful change.

During the last twelve-month period, we have received 14,943 responses from patients and carers via our Friends and Family Test on their care and experience which is an increase of 149% on last year. In 2024/2025 the Trust decommissioned the use of the "Smiley Faces" devices as a means of collating feedback and expanded the departments that utilise the FFT feedback thus enabling 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 November 2023, the Annual CQC inpatient survey was conducted. A total of 1250 patients from the ROH were invited to participate and 734 responded (60%), this is an increase on the previous year (57%) and is above the national average response rate for all Trusts which is 42%.

The survey identified:

Where patient experience is best:

- Overall view of inpatient services 9.0 / 10.0 – *Much better than expected*.
- Admission to hospital 8.0 / 10.0 – *Much better than expected*.
- Doctors 9.3 / 10.0 – *Much better than expected*.
- Leaving hospital 7.7 / 10.0 – *Much better than expected*.

Where patient experience could improve:

- lf you brought medication with you to hospital, were you able to take it when you needed to? 8.1 / 10.
- During your period in hospital, did you get enough to drink? 9.6 / 10.

- Thinking about any medication you were given to take home were you given any of the following? - Written Information about your medicine. 5.1 / 10

It should be recognised that although these were our points to improve as our scores had decreased since last year, the ROH continued to score above the National average for all of these questions.

The 2024 National Inpatient Survey was commenced in December 2024 utilising November 2024 data and the results will be expected to be published in August 2025.

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 PSIIs.
- 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 (PPS) 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 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 by the National NHS Team. Staff can access the survey via a link or QR code.

Trust level staff engagement	Q1 24/25	Q2 24/25	Q4 24/25	Improved?
Motivation	7.10	6.91	7.44	↑
Involvement	5.38	7.37	7.17	↑
Advocacy	7.34	7.92	8.04	↑
Overall staff engagement	**6.76**	**7.40**	**7.55**	↑

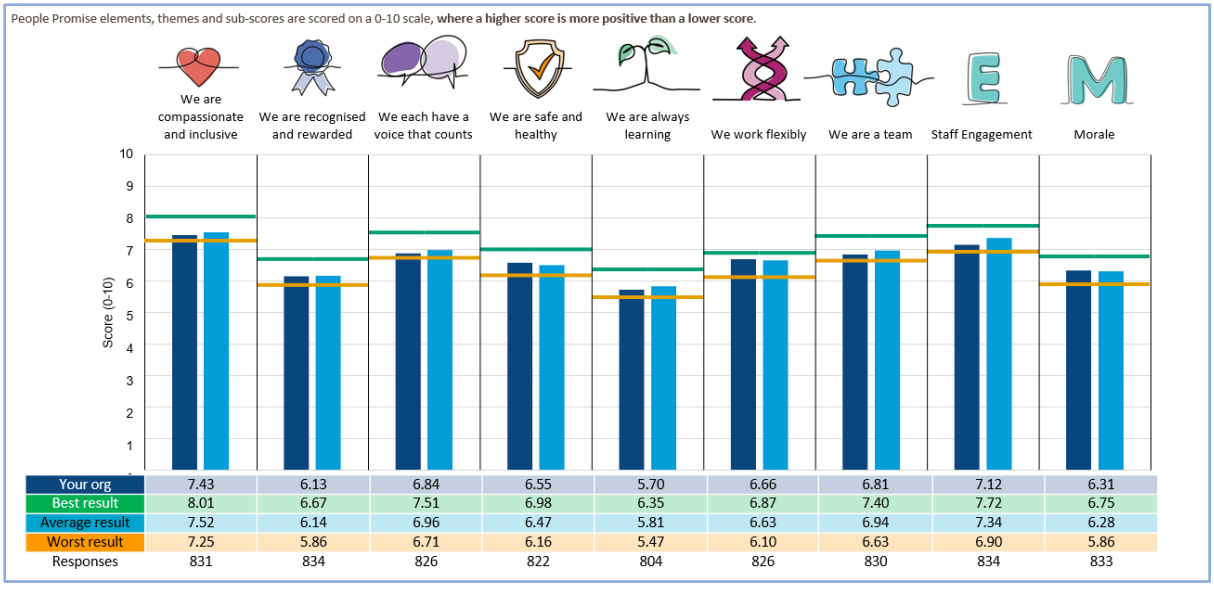
Figure: National People Pulse Survey in ROH**

6.2 NHS Staff Survey

Each year, the ROH participates in the annual NHS Staff Survey (NSS). Staff who are employed by, or under contract to the ROH, are asked to complete the survey. Bank staff members are also asked to complete a survey and have a separate set of results.

The findings are shared with staff members through communication channels, at directorate level, focus groups, team meetings, as well as the range of management meetings, including Executive Directors, Trust Board, and other committees. There are also staff survey awareness stands to share the information. Managers are given departmental information (where numbers of responses allow) and this detail is used in ongoing staff survey action planning, a 'You Said, We Did' campaign, staff appraisals, team development, and to support the Annual Business Planning process.

In 2024, 1396 staff were asked to take part in the National Staff Survey with 59% (n=823) of staff responded using a mix mode of online and paper copy completions. The National response rate was 50%. The ROH is in the benchmarking group with 12 other specialist acute trusts.



Your org	7.43	6.13	6.84	6.55	5.70	6.66	6.81	7.12	6.31
Best result	8.01	6.67	7.51	6.98	6.35	6.87	7.40	7.72	6.75
Average result	7.52	6.14	6.96	6.47	5.81	6.63	6.94	7.34	6.28
Worst result	7.25	5.86	6.71	6.16	5.47	6.10	6.63	6.90	5.86
Responses	831	834	826	822	804	826	830	834	833

Figure 29: People Promise elements and themes, overview

*Data source Survey Coordination Centre NHS

7.0. Achievement in year

Global recognition: ROH was ranked 60th among the world's top 125 orthopaedic hospitals by Newsweek, highlighting its excellence in orthopaedic care.

HSJ Digital Awards shortlist: The hospital was shortlisted in the 'Driving Prevention and Early Intervention through Digital' category for its work with the GetUBetter app, enhancing MSK patient care.

NOA Awards finalist: ROH secured three nominations at the National Orthopaedic Alliance 'Excellence in Orthopaedics' Awards 2025, recognizing innovations in patient care and workforce initiatives.

Inclusive Employer ranking: Ranked 8th in the 2024/25 Inclusive Top 50 UK Employers List, ROH was acknowledged for its commitment to diversity and inclusion.
roh.nhs.uk

Cancer treatment advancement: The Dubrowsky Lab at ROH secured a £110k grant to develop an injectable paste with anticancer and bone regenerative properties, aiming to improve treatments for bone tumours.

Robotic surgery milestone: ROH completed its 100th knee replacement surgery using the ROSA robotic system, enhancing precision in surgical procedures.

Staff Survey insights: The latest NHS Staff Survey results highlighted ROH's dedicated and compassionate workforce, reflecting the hospital's commitment to providing high-quality care.

Supporting research: ROH has successfully supported a bid to establish one of the UK's new NIHR Commercial Research Delivery Centres (CRDCs) to expand access to innovative clinical trials and deliver life-changing treatments.

Supporting sexual safety: ROH introduced a Domestic Abuse and Sexual Violence Advocate role and a Trust-wide Sexual Safety Charter to reduce abuse and support patients and staff.

Community care outreach: We held our first Community Appointment Day helping local people access expert advice on joint and muscle pain, bringing our care closer to the community.

Inclusive communication: Our Learning Disability and Autism Team developed a new communications toolkit to help patients better understand their care, making our services more accessible and supportive for everyone.

Advancing patient care: Denosumab, a treatment initially used in clinical trials, is now part of our standard care—marking a major step forward in improving outcomes for our patients.

8.0. Quality Account Statement

Birmingham and Solihull Integrated Care System
Caring about healthier lives

NHS
Birmingham and Solihull

NHS Birmingham and Solihull Integrated Care Board
Alpha Tower, 8th Floor
Suffolk Street
Queensway
Birmingham
B1 1TT
Telephone: 0121 203 3300
www.birminghamandsolihullicb.nhs.uk

Royal Orthopaedic Hospital NHS Foundation Trust

Quality Account 2024/25

Statement of Assurance from NHS Birmingham and Solihull Integrated Care Board

May 2025

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 2024/25 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 26th May 2025 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 2024/25 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 2025/26

1.4 We have worked closely with Royal Orthopaedic Hospital over the course of 2024/25, 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 2025/26.

Yours Sincerely,

NHS Birmingham and Solihull Integrated Care Board Chief Nursing Officer