Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Quality Account
1 April 2022 – 31 March 2023

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INTRODUCTION

The safety and quality of the care that we deliver at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is our highest priority. To support this, we undertake a review of the quality of our services on an annual basis and outline the progress we have made against our agreed quality priorities. As well as this we take the opportunity to acknowledge the challenges that we have faced in delivering care to the standard to which we aspire.

Each NHS Trust is required to produce an annual report on quality as outlined in the National Health Service (Quality Account) Regulations 2010. The quality account is the vehicle by which we, as providers, inform the public and ourselves about the quality of the services we provide. The quality account enables us to explain our progress to the public and allows leaders, clinicians, governors, and staff to demonstrate their commitment to continuous, evidence-based quality improvement.

Through increased patient choice and scrutiny of healthcare service, patients have rightfully come to expect a higher standard of care and accountability from the providers of NHS services. Therefore, a key part of the scrutiny process is the involvement of relevant stakeholders. To that end, one of the requirements for inclusion with the quality account is a statement of assurance from these key stakeholders and evidence of how the stakeholders have been engaged.

In addition, as NHS Foundation Trust we are required to follow the guidance set out by NHS Improvement regarding the quality account and for which there are several national targets set each year by the Department of Health and Social Care against which we monitor the quality of the services we provide.

Through this quality account, we aim to show how we have performed against these national targets. We will also report on locally set targets and describe how we intend to improve the quality and safety of our services moving forward.

Foreword from the Chief Nurse and Patient Safety Officer and the Chief Medical Officer

The Trust's aspiration is to provide world class care. With quality, safety, and patient experience sitting firmly at the core of this. During 2022-23 our focus has been the recovery and restoration of our services and tackling our waiting lists due to the Covid-19 pandemic.

Despite these challenges we continued with our aim to deliver outstanding patient care to every patient, every day. Our staff have adapted and continue to deliver the high level of care we are so proud of. This has been reflected in the feedback received from our patients.

18As we move into 2023-24 our focus will be to build on the significant improvements seen in previous years and to ensure that providing quality care remains at the heart of everything we do, every day.

Dr. Ruth Longfellow
Chief Medical Officer

Sara Ellis Anderson
Interim Chief Nurse and Patient Safety Officer
(August 2021- March 2023)

Paul Kavanagh Fields
Chief Nurse and Patient Safety Officer
(April 2023 - Present)

PART 1

Statement on Quality from the Chief Executive

It gives me great pleasure to introduce our annual Quality Account, sharing with you our achievements and celebrations over the past year, as well as the challenges and the improvements made. This Quality Account sets out our key achievements in 2022-23, as well as sharing our priorities for 2023-24.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has a clear vision statement – that we aspire to deliver world class patient care. This is an ambitious goal, but also an achievable one. It is supported by our Quality Strategy, which ensures that quality and patient safety are at the heart of everything we do.

It has been another proud year for the Trust as we continue to face the challenges presented to NHS services by the Covid-19 pandemic. Despite these challenges, our teams have continued to inspire us in the ways they have stepped up with great resilience, consistently delivering the high-quality patient care that we pride ourselves on.

While we are incredibly proud of this year's achievements, we continue our journey to be recognised as a Trust that continuously works to improve and deliver outstanding services to the communities we serve.

The Trust has this year, has had a significant focus on improvements regarding Infection Prevention and Control, Cleanliness, and investment into our estate, with many inpatient wards being refurbished and additional isolation/cohorting facilities being provided. With these improvements in mind, we have maintained low infection rates, with no MRSA bacteraemia since 2006. We ensure ongoing monitoring and surveillance of all infections, as well as regular monitoring of ward and department level practices.

Learning from all patient safety incidents is promoted throughout the Trust with examples of good practice shared at a variety of meetings. Over the last year the Trust has worked hard to enrich incident investigations by increasing the multi-disciplinary approach and this is evident in the robust action plans being developed and taken forward with oversight from the Trust's Quality and Safety Committee.

The National NHS Staff Survey which is undertaken by more than 300 NHS organisations again provided very positive feedback with 52% of staff completing the survey in 2022 and 91% of respondents saying they would be happy with the standard of care provided if a friend or relative needed treatment.

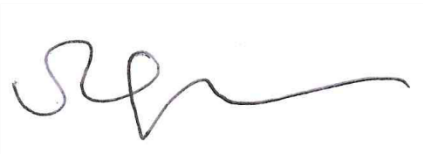
September 2022 saw the publication of the Care Quality Commission Adult Inpatient Survey 2021. Once again, we were delighted with the excellent feedback we received from our patients over the past year. Overall patient experience at RJAH was rated as the best in the country compared to other NHS Trusts. The same survey also saw the food we prepare and serve at

RJAH rated as the best in the country for the 16th time in 17 years, as well as the wards being highlighted as the cleanest in the country – for the second year running.

The Trust has been supporting staff through the ongoing cost-of-living crisis by introducing a series of cost-of-living schemes for staff. These included free breakfasts of porridge or toast, as well as discounted 'winter warmer' lunches. Free hot and cold drinks have also been made available to every department.

Quality is at the heart of every decision we take and, with the significant contribution of staff from across the hospital, we will strive to keep improving in 2023-24 to deliver ever higher levels of patient experience and care.

I confirm that to the best of my knowledge the information outlined in this document is true.



Stacey Keegan,
Chief Executive Officer
28 June 2023

PART 2

Priorities for improvement

Our Quality Improvement Priorities for 2023-24

Deciding on our quality priorities for the coming year

This part of the report describes the areas for improvement that the Trust identified for the year 2023-24. The quality priorities have been derived from a range of information sources. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire.

We also took account of the national landscape at the time and shaped our priorities to align with emerging national quality priorities.

Each of the quality priorities outlined below were monitored throughout the year via existing governance structures which will be described in more detail below.

Patient Safety

1. Reduction in inpatient falls

Objective: Reduce number of inpatient falls per 1000 bed days

Rationale: There were a total of 148 falls reported in 2022-23 and the Trust was above the target of 2.5 falls per 1000 bed days. Falls and fall-related injuries are a common and serious problem for older people. The human cost of falling includes distress, pain, injury, loss of confidence and loss of independence. Some falls in hospital can result in serious injuries, such as hip fracture and head injuries. There are no single or easily defined interventions which are shown to reduce falls. However, it is estimated that multiple interventions performed by the multidisciplinary team working collaboratively and tailored to the individual patient can reduce falls by as much as 25-30%.

Measures:

- Falls per 1000 bed days.
- Reduction in the number of falls resulting in harm.

Board Sponsors: Paul Kavanagh-Fields

Oversight Committee: Patient Safety Meeting with upward reporting to Quality and Safety Committee. Falls have also been identified as one of the organisation's Patient Safety Incident Response Framework (PSIRF) priorities.

2. Reduction in RJAH acquired pressure ulcers.

Objective: Reduce number of RJAH acquired pressure ulcers

Rationale: There were a total of 8 RJAH acquired pressure ulcers during 2022-23, one of which resulted in moderate harm and a serious incident investigation being completed. Pressure ulcers can result in longer lengths of stay in hospitals.

Measures:

- Improved compliance with pressure ulcer training and education
- Improved risk assessment documentation
- Implementation of standardised patient care round documentation

Board Sponsor: Paul Kavanagh-Fields

Oversight Committee: Patient Safety Meeting with upward reporting to Quality and Safety Committee.

3. Reduction in number of medication incidents resulting in harm.

Objective: Reduce the number of medication incidents resulting in harm

Rationale: There were a total of 239 medication incidents reported during 2022-23 of which 7 resulted in patient harm. Medication-related incidents remain one of the most frequently reported categories of patient safety incidents, accounting for about 10% of reported incidents nationally. The organisation has identified medication incidents as one of the priorities for PSIRF.

Measures:

- Reduction in number of medication incidents with harm
- Evidence of learning from incidents to identify areas for improvement.

Board Sponsor: Paul Kavanagh-Fields

Oversight Committee: Patient Safety Meeting and Quality and Safety Committee

Clinical Effectiveness

4. Reduction in delayed discharges.

This quality priority has been rolled over from 2022-23 to continue to embed and sustain the improvements seen.

Objective: Achieve the Trust KPI of less than 5.24% of all patients delayed

Rationale: Discharges from hospital are complex and can be a source of anxiety for patients if they are not being discharged to their homes and therefore improved communication around the discharge process will hopefully alleviate concerns and improve their overall experience. The work commenced in 2022-23 has seen improvements to the number of patients delayed within the organisation. The discharge rate peaked at 11.58% in December 2022 and has reduced in Quarter 4 ending at 4.31% in March 2023.

Measures:

- Achieve % improvements towards trust target of 5.24% delayed discharges.
- Reduced length of stay.
- Successful implementation of criteria led discharge.

Board Sponsor: Paul Kavanagh-Fields

Oversight Committee: Patient Safety Meeting and Quality and Safety Committee.

Patient Experience

5. End of Life Care and ReSPECT documentation

This quality priority has been rolled over from 2022-23 to continue to progress the work across the organisation.

Objective: Ensure patients receive high quality and safe care at the end of their life by ensuring staff have the correct skills and training.

Rationale: People with advanced life-threatening illnesses and their families should expect high quality, effective palliative and end of life care (PEoLC).

Measures:

- Increased % compliance levels of training.
- Increased quality of documentation on ReSPECT forms

Board Sponsor: Paul Kavanagh-Fields

Oversight Committee: Patient Experience Meeting with upward reporting to Quality and Safety Committee.

6. Enhancing the experience of patients with Learning Disabilities and Autism and Dementia who access our services.

This quality priority has been rolled over from 2022-23 and extended to include Dementia care.

Objective: Improve patient experience with patients with learning disabilities and autism and patients with dementia who access our services.

Rationale: Through stakeholder engagement the Trust recognised more could be done to improve the experience of our services for those with Learning Disabilities (LD) and Autism. Although awareness training and resources available for Learning Disabilities and Autism have improved in 2022-23 there are still improvements required in promoting the need for reasonable adjustments for our patients, the use of hospital passports and access to specialist LD nurses for advice and guidance. The 2022 PLACE inspection also highlighted areas for improvement within the environment in the domains disability and dementia.

Measures:

- Improved % with training compliance for dementia awareness.
- Improved scores in the disability and dementia domains on the PLACE audit for 2023
- Continued compliance with tier 1 LD and Autism awareness training and review of staff groups to undertake Oliver McGowan training.
- Increased feedback from patients with LD, Autism and Dementia
- Increased access to specialist advice for LD and Autism

Board Sponsor: Paul Kavanagh-Fields

Oversight Committee: Patient Experience Meeting with upward reports to Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined.

Statements of Assurance from the Board

In this section we report on matters relating to the quality of NHS services provided as stipulated in regulations. The content is common to all providers so that as can be compared across NHS Trusts.

Review of Services

During 2022-23, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided three NHS services, in Musculo-skeletal surgery, medicine and rehabilitation.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these health services.

The income generated by the relevant health services reviewed in 2022-23 represents 100% of the total income generated from the provision of NHS services by The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for 2022-23.

Participation in Clinical Audit

During 2022-23, 13 National clinical audits and 0 national confidential enquiries covered NHS services that the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

During that period, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in 9 out of 13 (69%) National Clinical Audits that it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in during 2022-23 were as follows:

- Mandatory Surveillance of HCAI
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Joint Registry (NJR)
- National Comparative Audit of Blood Transfusion programme
- Case Mix Programme
- British Spine Registry
- Elective Surgery (National PROMS Programme)
- Perioperative Quality Improvement Programme (PQIP)
- Surgical Site Infection Surveillance

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2022/23 are as follows:

- Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
- Mandatory Surveillance of HCAI

- National Early Inflammatory Arthritis Audit (NEIAA)
- National Joint Registry (NJR)
- National Comparative Audit of Blood Transfusion programme
- Case Mix Programme
- British Spine Registry
- National Diabetes Inpatient Audit
- Elective Surgery (National PROMS Programme)
- National Diabetes Audit - Adults
- Perioperative Quality Improvement Programme (PQIP)
- Surgical Site Infection Surveillance
- Falls and Fragility Fracture Audit Programme (FFFAP)

The reports of 21 local clinical audits were reviewed by the provider in 2022-23 and The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in below to improve the quality of healthcare provided.

	Project Number	**Project Title**	**Action Plans**
1	2122_013	Audit on compliance of recording ASIA & SCIM in the National Spinal Cord Injury Database	1. Consider using online ISNCSCI charts in Outpatient clinic; Admission, Discharge and the neurology records required for database at specific time points 2. Database Coordinator to highlight to the doctors / MDT (e.g., Goal Planning) when patients on the wards are due outcome measures. 3. If while updating to database ISNCSCI forms are found to be incomplete, Database Coordinator to return the form to person completing form to complete or alert respective consultant. 4. Doctors to ensure that complete International Standards for Neurological Classification of SCI (ISNCSCI) Worksheet is done. 5. To train Physiotherapists to do PR examinations so that they could do the complete ASIA examination.
2	2223_026	Re Audit of Pneumonia in Adults NICE CG 191.	1. All patients with CAP should have CURB-65 score documented - To discuss the findings at lunch time meeting ensuring all concerned are informed of action. Also, to send an email to all staff members (with a read receipt) stressing CURB-65 score to be documented on EPR for every patient. 2. All patients should continue with the present management of pneumonia with antibiotics as per the trust guidelines - To ensure all staff members are aware of the antibiotics Trust guidelines and they know the management of pneumonia and antibiotics. An email to be sent to all staff members (with a read receipt) concerned with attached Trust guidelines on management with antibiotics pneumonia. 3. Blood/Sputum Cultures should be sent for those who were indicated as per Trust`s Sepsis Policy/Guideline - To discuss the findings at lunch time meeting ensuring all concerned are informed of action. Also, to send an email with attached Trust Sepsis

			Policy Guidance to all staff members (with a read receipt) to ensure this will be compliant. Blood/Sputum Cultures (in those with indications) sent are to be documented on EPR for every patient.
3	2223_027	Compliance of the protocol for Non-Medical referrers to request clinical imaging	1. Ensure one printed copy of the current NMR procedure is printed and available to radiology staff, including names and signatures of authorised NMRs - Print current document and signatures. 2. Ensure protocols reflect current practice - Review current protocol and encourage referrers to draft new protocols that reflect the historic referral practices of NMRs for MRI examinations. 3. Provide MR safety training for referrers - Develop a training module for NMRs (and other referrers) regarding MRI safety 4. Develop a trust wide policy for non-medical referrers within the trust, to ensure a robust governance framework supports NMRs - Draft Policy
4	2021_046	Audit of BMI documentation in THR patient notes	1. Utilisation of Oxford hip score forms to document BMI - •Clinicians to ensure Oxford Hip Score forms completed for all new referrals •Make a note of the BMI and the radiological findings outlined at the bottom of the form. 2. Excluding high BMI in joint replacement - Ensure that we do not exclude people with osteoarthritis from referral for joint replacement because of overweight or obesity based on BMI following NICE Guidance NG226 published in Oct 2022.
5	2122_050	Reaudit on the Surgical Management of ACL Injuries	1. Documentation re non-op vs op treatment options - Design a patients ACL booklet which the surgeon can point to the patient to for further info and discussion of any questions 2. Documentation re discussion of pros and cons of various graft options - Design a patients ACL booklet which the surgeon can point to the patient to for further info and discussion of any questions 3. Local anaesthesia and type of block used documentation - Make surgeons and SpRs/Fellows aware of the need to include LA and block details on operative notes.
6	2122_043	Audit of reporting of Pre-operative Imaging	1. Clear indication that an x-ray request is pre-op - Redesign of referral forms to include tick box for pre-op, so not reliant on colour of referral form. 2. 100% compliance- images intended for pre-op planning are clearly indicated on form with accompanying Radiologist report - Review and repeat audit starting January 2023
7	2223_012	Monitoring the effectiveness of Serious Incident Action Plans	1. Monitoring of future incidents related to all SI's from June 2022 - Monthly Datix Incident search against

			completed and approved action plans. 2. Completion date of actions - Appropriate time to be allocated to ensure actions are completed on time. All actions following SI's and Never Events should be completed within 6 months. Actions to be completed in 6 months. Include overdue actions in Governance Unit Monthly Reports and Patient Safety and Quality and Safety Committee.
8	2122_038	Audit of intra-operative upper arm tourniquets in trauma surgery	1. Improve compliance with recommended TQ pressure Target adult TQ pressure to initial SBP + 50-100mmHg 2. Ensure TQ isolation to prevent seepage of skin prep fluids Use exclusion drape/similar method. 3. Record method of exsanguination Record if compressive exsanguination (+ how achieved) vs elevation used 4. Record skin condition of TQ site pre/post-procedure Ensure skin condition recorded.
9	2223_003	Adult corrective surgery within 90 days and 2 years	1. Discrepancy in 90-day data - Identify what the cause is whether it is with coding or with Data input 2. 90 day and 2-year return to theatre to identify cause of return to theatre - Case analysis.
10	2223_035	Compliance with RJAH IRMER procedures	1. IRMER practitioner recorded on all research exposures - new referral form for research study 2. Consistent recording of the IRMER practitioner - Additional information and learning provided to Radiographers 3. Improvement in compliance with IRMER procedure 4 - Repeat audit to include a larger sample of individuals of childbearing age.
11	2122_029	A re-audit of Paediatric Operative Notes to support Clinical Coding accuracy.	1. Improve integration between coding team and clinicians - Face to face meetings between coding and paediatric consultants to discuss coding queries. Teaching session for the Welsh weekend regional trainee teaching in relation to coding. 2. Continuing education of trainees - Further teaching session for orthopaedic trainees as part of regular educational programme 3. Ensuring key data is always captured in op note - Consider changes to the current standardized operative note template.
12	2223_020	Audit of practices of Post operative spinal antibiotics prescription	1. Local Protocol required for antibiotic usage in lumbar Spinal surgeries - 1) National Collaborative study of Survey of preference of Consultants, 2) Discussion in MDT with other consultants of RJAH

13	2021_027	An evaluation of antibiotic prophylaxis regimes used in primary lower limb arthroplasty.	1. Sharing findings with Pharmacy - Ensure the findings of this report is shared with pharmacy for information 2. More targeted education of theatre team regarding new dosage regime required - Provide education training to Theatre team.
14	2223_010	Reaudit IR(ME)R Procedures Audit: recording clinical evaluation for medical exposures.	1. Increase compliance with IR(ME)R procedure 10 - Share the results with relevant stakeholders 2. Increase knowledge of responsibilities of referrers under IR(ME)R - Promote the referrer 'Pause and check' poster within the trust 3. IRMER procedures to be a trust wide document 4. IRMER quick guide for referrers
15	2223_042	Pre-Operative Fasting Re-audit.	1. Reduce the pre-op fasting time for fluids to 2 hours - Discuss the audit findings and proposed recommendations at the next Anaesthetic Clinical Governance Meeting and to Baschurch ward staff 2. Reduce the pre-op fasting time for fluids to 2 hours - Anaesthetists to contact Baschurch ward staff in the morning of patients having surgery in the afternoon to adjust starvation times based on surgery wait times.
16	2021_039	Audit of clinical management of pts with DMD according to standard of care	1. Height/ulnar length of all DMD patients completed in clinic - Nurses/Physio responsible for ulnar length and weight measurements within clinic 2. MDT review for all patients every 4-6 months. Project group discussions with management team 3. Improved documentation of information given and discussions in clinic - Use of clinic proforma for DMD patients to prompt documentation. For upload to EPR 4. Restoration of spirometry testing in line with guidelines - Spirometry testing to recommence in clinic settings and introduction of additional tests. 5. Ongoing improvement regarding steroid emergency action plans and provision of emergency medication - Staff training by Birmingham Endocrine team. Parent/patient training sessions on administering IM steroids. Use of proforma for improved documentation. 6. Transition work evidenced with patients - Discussion with transition nurse once in post. Transition leaflets to be given. Ready steady go tools to be implemented. 7. Improvement in cardiac clinic/service to meet annual target - Ongoing management support to review current cardiac service.
17	2122_040	Causes of delayed discharge after total shoulder replacement surgery	1. Set the EDD of a standard primary TSR/TER to 1 day Contact pre-op assessment to let them know that primary TSR/TER EDD is to be set to 1 day post op 2. Delayed discharges due to physio/OT input -

			Discussion with physios/OT regarding delayed discharge
18	2223_013	Chartered Society of Physiotherapists Patient Notes Audit	1. Abbreviations list to be created for RJAH outpatients - All therapists to compile a list of extensively used abbreviations in their working area 2. To highlight the record keeping guidance to all outpatient therapists - Sharing the CSP, RCOT and HCPC guidance to all clinicians via email and at team meeting 3. Move to electronic notes in 2024 - Team to work closely with the physio EPR lead for the Trust
19	2122_027	Audit of ankle arthroplasty data collection process for the NJR	1. RJAH data provider in theatre – regarding both good results of this audit and the 2 discrepancies. Enquire re: who covers when on leave / back up process. 2. Coding of all theatre cases accurately (this has been done for most – apart from 2) Will discuss with coding and email copy of audit presentation if required 3. Addendum – was asked during presentation to clarify role of Inez Dunne for our understanding of the process. Discuss with Data Provider in Theatres 4. Highlight number of awards won by RJAH in this category. Check dates with Data Provider in Theatres 5. Error corrected – 2 of the procedures with missing forms were not on the same day but different days (slides 13,14, 16 updated). Check error with Data Provider in Theatres
20	2021_044	Documented Lower Back Pain in Primary THR Patients Audit	Purchasing of 2D/3D imaging system as NICE Recommendation - Discussion with Radiology department to see if this can be purchased
21	2122_006	Reaudit of Primary THR & TKR Length of Stay Audit	1. Share findings with the multidisciplinary team - Present at quality forum Present to orthopaedic therapies team Share findings to key stakeholders. 2. Protentional New Audit around transport - Share / liaise with key stakeholders 3. More specific delayed discharge categories to be utilised when patients go over EDD - Identify more specific categories for delayed discharge patients to improve the enhanced recovery programme 4. Future audit of looking at patients mobilising on day 0 to see if it has an impact on length of stay - Identify stakeholders and discuss a new audit 5. Communication between MDT and Physiotherapists - Continue to utilise and continually update the PSAG boards on all wards as a method of communication 6. Future audit of Enhanced Recovery programme once embedded - Identify key stakeholders and discuss a new audit of the programme and its efficiency.

12 Service Evaluation projects reports were reviewed by the provider in 2022-23 as follows:

	Project Number	Project Title	Action Plans
1	2122_018	Spicaless Hip Reconstruction Surgery in Children with Cerebral Palsy	1. Disseminate to wider Paediatric Orthopaedic Network - Submit to BSCOS meeting 2. Determine if there are any unidentified problems post discharge as a result of no immobilization - Prospective study to include patient/career/ community physios' perspective of early postop experience.
2	2223_008	BOFAS Study: Outcomes of Foot and Ankle Surgery during COVID	1. Check timings of preoperative imaging - Imaging to be dated within 6-12 months of the planned surgery 2. Up to date imaging is available - To ensure up to date imaging is available.
3	2122_028	Reaudit of Botox Administration in Children with Cerebral Palsy	1. Consider role of standardised Botox risks sticker for consent forms 2. Ensure patient information leaflet are provided as part of the pre-op consultation 3. Use of the Botox proforma / explore potential to integrate this electronically into the new EPR system.
4	1920_018	Recording Effectiveness of Rehabilitation on Sheldon Ward	1. Elderly Mobility scale and mobility descriptors should be recorded weekly to establish when patients 6+potential was achieved - Discussion with all concerned 2. Elderly Mobility scale and mobility descriptors should be recorded weekly to establish when patients 6+potential was achieved - Set up a new audit of Rehabilitation on Sheldon Ward. 3. Monitoring of patients or rehab potential - Continue to monitor patients for rehab potential and

			continue to accept patients who have rehab potential to utilise the ward resources and improve LOS 4. Recording of carers to improve functionally during a period of rehabilitation - Set up a new audit of Rehabilitation on Sheldon ward.
5	2223_011	Evaluation on surgical drapes in spinal surgery	1. To start using back table covers instead of large patient drapes - Inform all theatre staff including scrub nurses working in Spines about implementing change
6	2223_018	Post Lumbar Surgery Drain Usage Evaluation	Protocol required for Drain usage in lumbar Spinal surgeries: 1) National Collaborative study of Survey of preference of Consultants, 2) Discussion in MDT with other consultants of RJAH
7	2223_019	learning curve, clinical outcomes, and complications with Endoscopic spine surgery	1. The inter-laminar Endoscopy approach has a learning curve for all three groups described here - Although anatomy is familiar to spinal surgeons, the presence of a learning curve implies a careful and measured approach to the take up of this technique in clinical practice, despite its clinical safety in our series. Discuss within Spinal Disorders Speciality Meeting to use inter-laminar Endoscopy approach going forward. Discussed at Regional Spinal Network Meeting for West Midlands 2. To optimise utilisation of this technique - Trust should be able to organise all scheduled day case surgery lists using endoscopy.
8	2223_002	Signing off Investigations on EPR	1. Inclusion of signing off investigations on MCSI junior doctors' induction - Update of the MCSI junior doctors' induction

			2. Audit trail access - Contact EPR Team
9	1718_073	Outcomes of thumb CMC joint replacement evaluation	No Action Plan required.
10	2021_043	Retrospective review of patellofemoral outcomes in patients with high BMI	No Action Plan required.
11	2122_037	Reaudit of lumbar discectomy length of stay	Awareness of same day discharge - Create awareness for patients and ward staff that it is safe for patients to be discharged on the same day of their operation if the surgical team are happy
12	2122_014	Standardising and Rationalising Post-operative Blood Tests at RJAH	1. Only do bloods when necessary - Agree with anaesthetist at sign out about whether bloods required (depends on EBL in addition to the other factors mentioned previously) 2. Work into upcoming enhanced recovery protocol - When the new enhanced recovery protocol being designed, rationalising blood tests will be part of this.

Participation in Clinical Research

Research at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continues to flourish. The total number of studies active at the Trust during 2022-23 was 67, of which 43 were adopted onto the National Institute for Health research (NIHR) portfolio. These studies fall into the Clinical Research Network speciality areas (Cancer, Children's, Genetics and Congenital Disorders, Inflammatory and Immune diseases, Musculoskeletal, Anaesthesia, Peri-operative Medicine and Pain Management, and Surgery). They include commercial, academic, and RJAH-sponsored studies.

The number of participants that were enrolled in research eligible for inclusion in the NIHR portfolio was 448. This figure represents a 52% increase on the previous year's (293) performance of recruitment to clinical research studies.

CQUIN framework

During 2022-23 The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in six objectives of the CQUIN (Commissioning for Quality and Innovation) payment. framework, as to which five were fully achieved. No income was conditional on achieving quality improvement and innovation goals agreed between the Trust and its Commissioners through the CQUIN.

CQC registration

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2022-23.

During December 2018, the CQC carried out an inspection of the Trust and at this time, the Trust was given an overall rating of 'Good' with care found to be 'Outstanding', with the breakdown of ratings show in the table below:

Ratings for The Robert Jones and Agnes Hunt Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Surgery	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Critical care	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019
Services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Outpatients	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Diagnostic imaging	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall*	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

The full CQC inspection report can be found at the following link: https://www.cqc.org.uk/provider/RL1/services

In response to the inspection report from February 2019, the Trust put in place and completed a robust action plan to address the areas for improvement highlighted by the CQC. A further inspection was planned during 2020 however this continues to be deferred by the CQC due to the COVID-19 pandemic.

The Trust hosted a pilot Medicines Optimisation CQC inspection on the 9th and 10th of August 2022. This was the first inspection in the pilot and included all the CQC key lines of enquiry (KLOE's). The CQC visited clinical areas including the Pharmacy and Homecare, Theatres and Day surgery unit, six wards, Outpatients, radiology, and the High Dependency Unit. The inspection team spoke with 28 staff in clinical areas and 19 staff via focus groups and interviews. We spoke with 8 patients and relatives. The inspectors observed a ward round, patient consultations both face to face and via telephone; tracked a patient's journey through theatres and observed medicine preparation and administration. There was also an opportunity to review 17 sets of medical records and/or related prescription charts.

The Medicines Optimisation Pilot Rating across all KLOES was GOOD.

Secondary Uses Service Submission

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2022-23 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:

- 99.96% for admitted patients care.
- 100% for outpatient care

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

- 99.85% for admitted patients care.
- 99.93% for outpatient care

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Raise the awareness and profile of data quality, developing within the Trust a positive culture, through encouraging best practise and promoting new processes, and ensuring that all staff recognise that they have a responsibility for ensuring a high standard of data quality.
- Maintain a robust Audit framework that provides assurance for key performance indicators as reported in the Trust's Integrated Performance Report (IPR).
- To monitor and review a set of data quality KPI's focussing on any areas of concern.
- Improve the Data Quality in relation to referral to treatment time (RTT) through audit, validation, and education of both clinical and non-clinical teams, providing support and advice when needed.
- To ensure compliance with all data quality standards as specified within the Data Security and Protection Toolkit.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information. The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the Trust, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The Trust has an established information governance management framework and continues to develop information governance processes and procedures in line with the information governance toolkit. The Trust`s Information Governance status is the subject of ongoing review by the Information Governance Committee which is responsible for reviewing policy and monitoring compliance with Department of Health and Social Care Guidelines. This

process is overseen by the Audit and Risk Committee which also has a role in ensuring that all serious data governance risks or incidents are brought to the attention of the appropriate Board Committee. The Trust has in place the Chief Medical Officer as the Caldicott Guardian, and the Director of Digital as the Senior Information Risk Owner (SIRO). Further, the Assistant CEO is the Data Protection Officer.

The requirements of the Data Security and Protection Toolkit (DSPT) are designed to encompass the National Data Guardian review's 10 data security standards.

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2022-23 has not yet been determined as the final submission date is 30 June 2023.

For 2021-22 the Trust's score was STANDARDS MET.

During 2022-23 the Trust identified and reported no serious IG breaches.

Clinical coding error rate

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was not subject to the Audit Commission's Payment by Results clinical coding audit during 2022-23.

An internal audit was conducted with the results as outlined below:

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
98%	93.23%	98.92%	99.03%

Seven Day Working

The seven-day services programme has been designed to ensure patients receive high quality consistent care across all seven days of the week. As an elective centre, the Trust does not receive emergency admissions in the same way as an acute hospital, being aware of emergency admissions in advance which enable the Trust to ensure appropriate multidisciplinary teams are in place. The Trust offers several seven-day services appropriate to the service requirements of an orthopaedic elective centre. This is regularly reviewed based upon patient requirements and feedback, to ensure our services reflect the needs of our patients.

NHS Outcomes Framework: Review of performance against mandated indicators

The NHS Outcomes Framework sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been chosen to measure these outcomes and stipulates the methodology to be used in order to enable accurate benchmarking.

An overview of the indicators is provided in the table below and the data provided has been calculated using the specified methodology. It is important to note that, whilst these indicators must be included in the Quality Accounts, the most recent available national data for the reporting period is not always for the most recent financial year. Where this is the case, an * is included next to the indicator. The following data has been taken from the HSIC website and is based on the most up to date data available at the time of writing.

Mortality

The Trust has a Learning from Deaths Policy in place in line with national requirements. This policy ensures that the Trust reviews all deaths in line with the NHSE framework and supports the requirements of the new Medical Examiner Service. We record all our expected and unexpected deaths, and all have a mortality review completed. These results are reviewed through the Trust Mortality and Resus Meeting. We have a lead consultant who chairs this committee and reports to the Patient Safety Meeting. A quarterly Learning from Deaths report is presented at Trust Board.

Because of the low numbers of deaths across the organisation the HSMR and SHIMI are not monitored by the Trust. Further, the standardised mortality rates for hospitals, produced nationally by Dr Foster are not applicable to small specialist Trusts like The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, again because the numbers of deaths that occur are too small for change to be statistically significant. However, there is ongoing monitoring of all deaths which occur within the Trust with oversight by the Quality and Safety Committee and reporting to the Board.

During 2022-23 twelve patients of Robert Jones and Agnes Hunt Orthopaedic Hospital died. This comprised the following number of deaths which occurred in each quarter of that reporting period: three in the first quarter; three in the second quarter; two in the third quarter and four in the fourth quarter.

By 31 March 2023, nine case record reviews and three coroner's investigations have been carried out (coroner outstanding in one case) in relation to the twelve deaths.

In no cases was a death subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: three in the first quarter; three in the second quarter; two in the third quarter and four in the fourth quarter.

No patient deaths, representing 0% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

Due to the low number of deaths that occur in the hospital, it is possible for every death to be tracked and reviewed and the data provided above is therefore accurate.

In 2022-23 the trust had one death where COVID appeared on the death certificate. This was not attributable as RJAH acquired.

Through the case record reviews and investigations the Trust identified an opportunity to improve liaison between the wards and critical care around the planning of limits for treatment this has prompted discussion between the MCSI lead and HDU lead for providing opinion on treatment limits planned. A newly formed working group has reviewed the end-of-life care process and improving both training and links with local hospice.

There is work ongoing with our local acute trust for us to become a satellite of their Medical Examiner service, which will further improve the process of bereavement and the liaison with families. This is due to start on the 1st of June 2023.

There were no case record reviews and no investigations completed which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the structured judgement review methodology in the last quarter and the Trust's serious incident process or learning from deaths review method before that.

0 representing 0% of the patient deaths during 2022-23 are judged to be more likely than not to have been due to problems in the patient care.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Due to the small numbers of death that occur at the hospital it is possible for every death to be reviewed in detail.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has continued with the implementation of the ongoing Learning from Deaths Policy including Medical Examiner Service introduced during 2022.

Helping people recover from episodes of ill health or following injury.

Readmission Rates

During 2022-23 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0% and for 16+ years old it was 0.42%.

Activity	NO. OF READMISSIONS	% READMISSIONS
01/04/2022	2	0.52%
01/05/2022	1	0.18%
01/06/2022	1	0.18%
01/07/2022	1	0.16%
01/08/2022	2	0.35%
01/09/2022	3	0.56%
01/10/2022	2	0.34%
01/11/2022	5	0.80%
01/12/2022	3	0.58%
01/01/2023	1	0.20%
01/02/2023	5	0.93%
01/03/2023	1	0.19%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- No comparative data is now available.
- Data is submitted and checked monthly as part of regular performance reporting.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust will take action to improve this percentage by:

- Improving understanding of readmission rates linked to infection.
- Continuing discharge planning at pre-operative appointments

Quality Outcomes

The Trust contributes to the National Registries to collect outcomes data. Currently these include:

- British Spine Registry (BSR)
- National Ligament Registry
- UK Hand Registry
- Foot and Ankle Registry (BOFAS)
- British Hip Registry (NAHR)
- National Joint Registry (NJR)

RJAH continues to be awarded the 'NJR Quality Data Provider' award. This scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets.

The Trust also collects large volumes of PROMs (patient reported outcome measures) for total hip and knee procedures to submit to the national PROMS programme. The programme led by NHS England mainly focuses on those specific procedures. Over the past year work has taken place to expand our outcomes collection throughout the organisation and ensure that these measures are collected and analysed across all procedures and treatment taking place in the trust. Electronic data collection has allowed us to further expand to all teams within the organisation and any services that patients may require along the pathway. Regular data collection is now evolving for all teams and services that are listed below. We continue to work with other areas to ensure the work supports outcomes monitoring for all areas.

- Hip and Knee Arthroplasty
- Upper Limb
- Sports Injuries
- Foot and Ankle
- Spinal Disorders
- Shropshire Orthopaedic Outreach Service (SOOS)
- Physiotherapy
- Anaesthetics

Outcomes data is being used regularly in the organisation to monitor patients pain scores and quality of life while on the waiting list and following surgery/treatment. Data collected will support identifying areas of improvement for patient care and services. Patient Reported Outcome Measures (PROMS) measures health gain in patients undergoing hip replacement and knee replacement surgery in England, based on responses to a questionnaire before and after surgery.

This report shows the NHS Digital data presented to the public and is based on the improvement seen in joint replacement six months after the operation. The data is currently published quarterly and shows where NHS England have both pre-operative and 6-month follow-up scores available, so this does mean that the number of modelled records is less than the number of procedures actually carried out in that period. Four areas are reported on by NHS England, Primary Hip replacements, Revision Hip replacements, Primary Knee replacements and Revision Knee replacements.

The Trust's data published in February 2021 shows that the Trust achieves good outcomes for its patients, particularly given the complex nature of the procedures it carries out. There is no national comparative data available beyond 2019/20.

The data below provides the National Average for all NHS trust involved in the National NHS PROMs programme in England, along with the Highest Score achieved and the Lowest Score. Against the score The Robert Jones and Agnes Hunt Hospital achieved overall for each labelled procedure. Over the years the trust continues to achieve higher than lowest score across England and exceeding, or meeting, the National Average over many of the financial years noted below.

The date shows the scores for all the Trusts involved in the NHS PROMS programme in England, for patients having Total Knee Replacement, Total Hip Replacement, Revision Total Knee Replacement and Revision Total Hip Replacement.

The Oxford Hip Score (OHS) and Oxford Knee Scores (OKS) are joint specific Patient Reported Outcome Measures, designed to assess disability in patients undergoing THR and TKR.

These scores are post-op scores, out of 48, the higher the score the better the outcome. – OHS and OKS are a short 12-item questionnaire that are developed and designed specifically to assess patients function and pain. Each question can have a score of 0-4 and the overall total can provide a score from 0-48, the higher the score resulting in the best possible outcome.

The EQ5D is a quality of life score and is not specific to orthopaedics. The score is between 0 and 1, and the higher the number the better the score.

The data is collected through self-completed questionnaires and the patient are asked to complete these within a 12-week timeframe before their operation and 6-9months following their surgery.

Primary Hip Replacement

	EQ5D Index					Oxford Score				
	2016/17	2017/18	2018/19	2019/20	2020/21	2016/17	2017/18	2018/19	2019/20	2020/21
National Average	0.445	0.468	0.465	0.459	0.472	21.8	22.68	22.68	22.687	22.981
Highest Score	0.537	0.566	0.557	0.539	0.574	25.123	26.299	25.376	25.547	25.702
Lowest Score	0.310	0.376	0.348	0.352	0.393	16.428	18.871	18.752	17.059	17.335
Robert Jones and Agnes Hunt	0.453	0.489	0.496	0.468	0.470	22.211	23.574	24.429	24.135	24.129

Revision Hip Replacement

	EQ5D Index					Oxford Score				
	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21
National Average	0.290	0.289	0.287	0.307	0.336	13.512	13.901	13.864	14.065	15.445
Highest Score	0.362	0.322	0.396	0.38	0.413	16.504	17.664	18.961	16.130	17.328
Lowest Score	0.239	0.142	0.206	0.238	0.253	10.253	10.735	7.853	10.648	13.338
Robert Jones and Agnes Hunt	0.334	0.298	0.248	0.297	*	13.719	15.912	10.387	14.177	*

Primary Knee Replacement

	EQ5D Index					Oxford Score				
	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21
National Average	0.325	0.338	0.338	0.335	0.315	16.546	17.259	17.330	17.486	16.886
Highest Score	0.404	0.417	0.405	0.419	0.403	19.884	20.635	20.011	20.688	20.25
Lowest Score	0.242	0.234	0.266	0.215	0.181	12.335	13.156	13.774	12.622	11.916
Robert Jones and Agnes Hunt	0.318	0.354	0.361	0.364	0.358	17.843	18.541	17.74	19.188	19.681

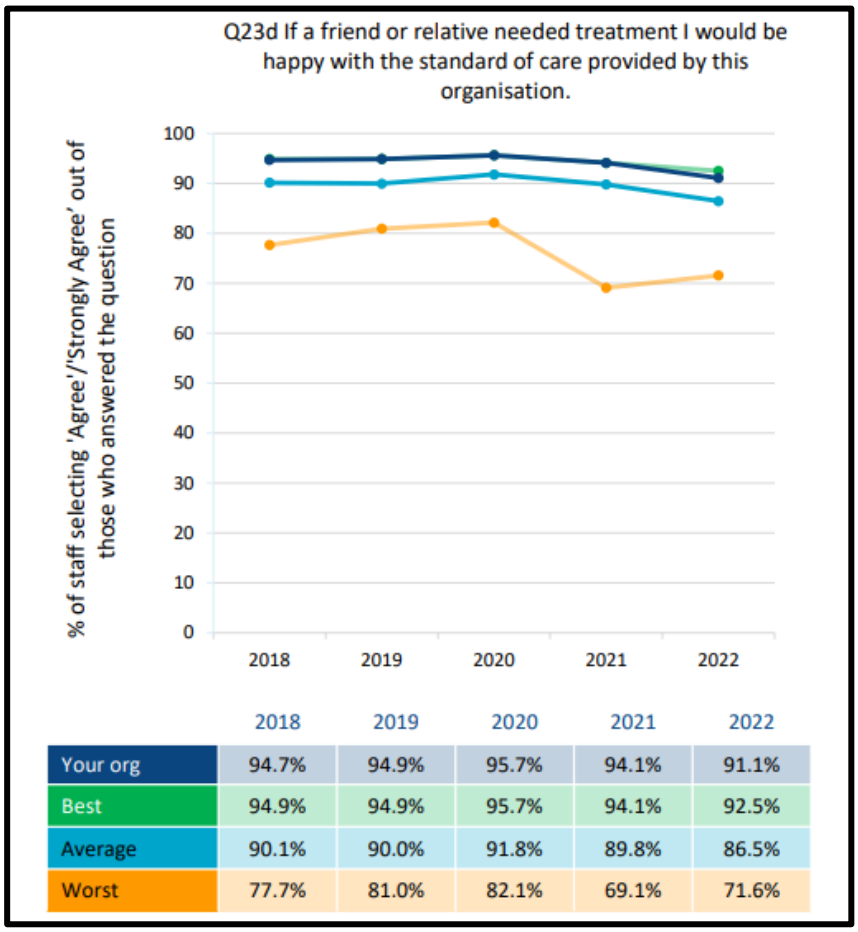
Revision Knee Replacement

	EQ5D Index					Oxford Score				
	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21
National Average	0.273	0.292	0.288	0.295	0.299	12.346	13.124	13.598	13.840	13.499
Highest Score	0.296	0.328	0.297	0.394	0.230	13.781	15.444	15.784	16.384	12.425
Lowest Score	0.156	0.196	0.196	0.168	0.207	8.602	9.374	9.014	8.650	8.701
Robert Jones and Agnes Hunt	0.251	0.328	0.279	0.326	*	10.946	14.392	15.113	12.439	*

Staff Survey

The principal aim of the staff survey is to gather information which will help the Trust to improve the working lives of our staff and so help to provide better care for patients. The staff survey provides the Trust with a wealth of information detailing staff views about working at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

In 2022 the staff survey is aligned with the NHS People Plan, and the People Promise. The data has been benchmarked against each of the seven elements of the People Promise, plus two further themes – staff engagement and morale. 52% of staff completed the survey in 2022 and 91% of respondents said they would be happy with the standard of care provided if a friend or relative needed treatment.



	2018	2019	2020	2021	2022
Your org	94.7%	94.9%	95.7%	94.1%	91.1%
Best	94.9%	94.9%	95.7%	94.1%	92.5%
Average	90.1%	90.0%	91.8%	89.8%	86.5%
Worst	77.7%	81.0%	82.1%	69.1%	71.6%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust continues to participate and improve the Staff survey results.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by

- Participating in Quarterly Pulse Surveys for regular data collection
- Implementation of the people plan.

Ensuring that people have a positive experience of care.

Responsiveness to Inpatient's Personal Needs

The table below presents patient experience measured by scoring the results of a selection of questions from the National Inpatient Survey focussing on the responsiveness to personal needs.

	2016/17	2017/18	2018/19	2019/20	2020/21	
National Average	68.1	68.6	67.2	67.1	74.5	No national data available from 21/22 onwards
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	82.5	81.7	83.8	83.1	85.4	
Highest	85.2	85.0	85	84.2	85.4	
Lowest	60.0	60.5	58.9	59.5	67.3	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has a robust patient experience programme in place that facilitates learning and implementing changes based on patient experience.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve its performance:

- Renewal of the Patient Experience Strategy
- Continued use of real time feedback on patient experiences
- Improved patient involvement in the investigation of its incidents
- The production and completion of action plans in response to complaints

Patient Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Patients are asked to answer the following question: "How likely are you to recommend our organisation to friends and family if they needed similar care or treatment" on the day of discharge or after they have had a clinic appointment. They are invited to respond to the question by choosing one of six options, ranging from "extremely likely" to "extremely unlikely".

	2018/19	2019/20	2020/21	2021/22	2022/23
National Average	96%	96%	94%	94%	94%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	76%	73%	65%	64%	73%*
The Robert Jones and Agnes Hunt	99%	99%	98%	98%	98%

*for 2022/23 national data includes up to Jan 23

Treating and caring for people in a safe environment and protecting them from avoidable harm

VTE Assessment

Our patients often have difficulties mobilising which places them at an increased risk DVT or PE and as such the Trust's VTE assessment is of utmost importance to ensure that patient's do not suffer avoidable DVT or PE.

The Trust has in place a robust system of audit to measure compliance with the VTE assessment process. Further, any incidence of DVT or PE is subject to a full incident analysis review to ensure that learning is taken. The Quality and Safety Committee receives regular reports on the Trust's work on VTE prevention.

The chart below outlines the percentage compliance for VTE assessments for the year (up to March 2023), there is no national data for comparison published since 2020/21.:

	2017-18	2018-19	2020-21	2021-22	2022-23
Average	95.3%	95.6%	95.5%		
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	99.9%	99.9%	99.9%	99.72%	99.80%
HIGHEST	100%	100%	100%		
LOWEST	64.3%	63.2%	67.5%		

RJAH has maintained the required percentage of VTE assessments completed. The Trust monitors this through the monthly performance reports and the Trust VTE Group.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has in place a clinical lead for VTE who champions the VTE process amongst the clinical staff.
- Regular audits are undertaken to check compliance with follow up actions where required.
- The Quality and Safety Committee receives regular reports on compliance with VTE assessments.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

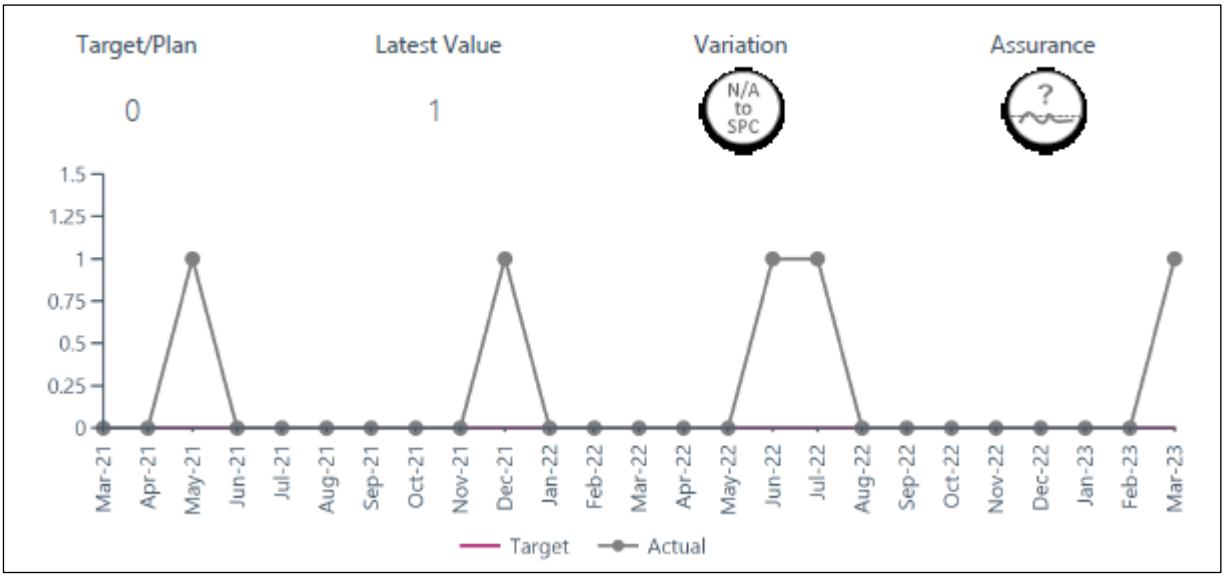
- RCA toolkit reviewed and updated to ensure all contributory factors are being explored.
- RCAs completed for each incident to monitor for themes and trends.

Clostridioides Difficile Infections (CDI)

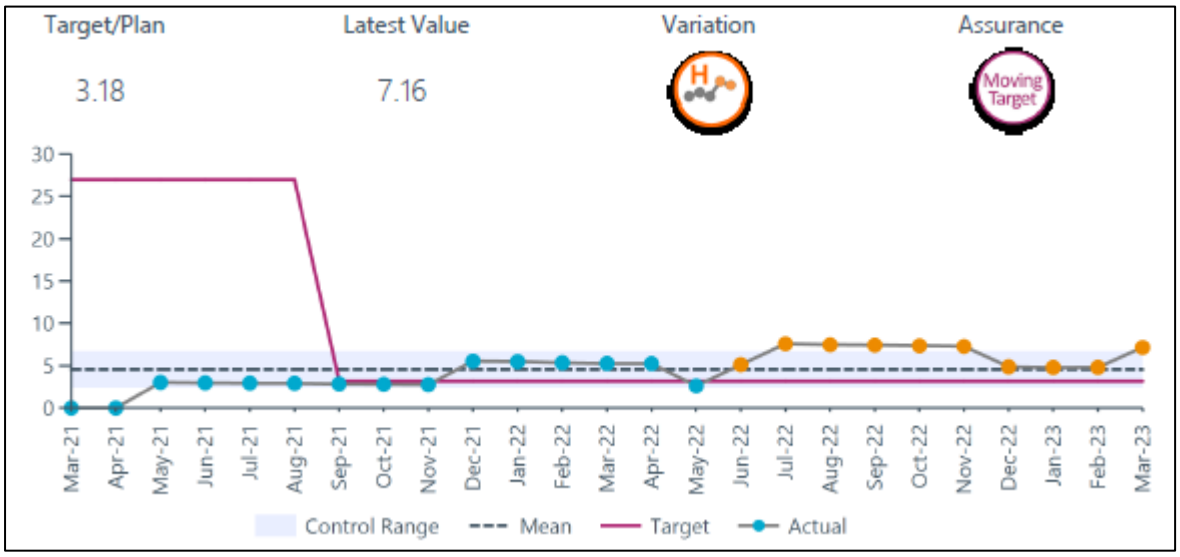
The Trust measures infection control performance as a rate of Trust apportioned cases per 100,000 bed days of cases amongst patients.

The Trust has had three attributable cases of CDI for the year 2022-23. This was against a target of two.

Number of RJAH Acquired CDI



CDI Rates Per 100,000 Bed Days



	2017-18	2018-19	2020-21	2021-22	2022-23
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	2.2	6.2	0	8.3	Awaiting data to be published
HIGHEST	91.0	39.8	*	*	*
LOWEST	0.0	0.0	*	*	*

* Benchmark data not yet available

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is reported and monitored monthly.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Continuing to carry out after action revies on all hospital acquired infections to ensure lessons are learnt.

Number of patient safety incidents and % resulting in severe harm/death

The hospital has a robust and established incident management process in place. The Trust utilises an electronic reporting system which enables all incidents to be tracked from the point of reporting and on-going monitoring until closure of an incident, therefore promoting timely response to serious incidents.

The tables below show the number of patient safety incidents reported each month during the reporting period and a breakdown by severity grading for these, including the proportion of incidents resulting in severe harm or death.

Patient Safety Incidents Reported per 1000 Bed Days

Period of Coverage	Rate of incidents	Number of incidents
Oct 22 - Mar 23	44.9	1176
Apr 22 - Sep 22	42.5	1119
Oct 21 - Mar 22	42.6	1116
Apr 21 - Sep 21	41.4	1092
Oct 20 - Mar 21	27.3	716
Apr 20 – Sep 20	26	685
Oct 19 – Mar 20	37.5	884

Patient Safety - Severe Harm / Death

Period of Coverage	Rate of incidents	Number of incidents	Comments
Oct 22 - Mar 23	0.31	8	6 deaths (1 unexpected and 5 expected) and 2 severe harm incidents
Apr 22 - Sep 22	0.23	6	6 Deaths (3 unexpected and 3 expected) and 0 severe harm incidents
Oct 21 - Mar 22	0.38	10	10 Deaths (1 unexpected, 9 expected) and 0 severe harm incidents
Apr 21 - Sep 21	0.04	1	1 Deaths (1 expected) and 0 severe harm
Oct 20 - Mar 21	0.34	9	6 Deaths (1 unexpected, 5 expected) and 3 severe harm incidents
Apr 20 – Sep 20	0.42	11	10 Deaths (1 unexpected, 9 expected) and 1 severe harm incidents
Oct 19 – Mar 20	0	0	

Footnote: Definition of Severe Harm/Death:
Severe Harm: Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.
Death: Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Serious Incidents

In 2022-23 the Trust reported three serious incidents as defined by the NHS England Serious Incident Framework. All these incidents have had Root Cause Analysis completed and reports prepared for presentation and agreement at Quality and Safety Committee. In addition, all our serious incidents have been reviewed by the Integrated Care System to ensure they are in line with the NHSE Framework.

Incidents that have been reported and investigated relate to the following areas:

- Pressure Ulcers (2)
- Indwelling device issue (1)

In comparison, during 2021-22 the Trust reported seven serious incidents.

Never Events

These are defined as serious, largely preventable patient safety incidents. All never events have a Root Cause Analysis completed which is presented and agreed at the Quality and Safety Committee as per the Trust's Serious Incident Management Policy.

In 2022-23 there were 3 never events reported.
Incidents that have been reported and investigated relate to the following areas:

- Retained foreign object (2)
- Wrong sided block (1)

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has continued to undertake reconfiguration work on Datix to ensure more accurate capture of themes and trends in the categories of incident.
- The Trust introduced Quality Reports to provide an overview of incident management within its Units.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Benchmarking of incident reporting against other Specialist Trusts
- Continuing to promote a no blame culture to encourage incident reporting.
- Inclusion of patient safety incidents in the Multi-Disciplinary Clinical Audit Meeting attending by a cross section of clinical staff

PART 3

Review of Quality

Summary of Performance Status for Quality Priorities Set for 2022-23

In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders, the Trust identified the following key priorities for 2022-23:

- Patient Safety: End of Life Care and the ReSPECT process
- Patient Safety: VTE prevention and management
- Clinical Effectiveness: Enhanced Recovery – supporting patients to eat, drink and mobilise after surgery.
- Clinical Effectiveness: Reduction in delayed discharges
- Patient Experience: Waiting well initiative.
- Patient Experience: Progress against NHS Learning Disability standards

Progress made for quality priorities 2022-23

The following table gives an overview of the progress we have made for each of the quality priority areas and how the improvement work will be maintained in the coming year or continued.

It is important to remember that even though some priorities may be retired, this is not to say that the work ceases, but rather that the processes and systems for continued management of the improvement goal are well established and can be maintained outside of the Quality Account process.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
PATIENT SAFETY				
1. End of Life Care and the ReSPECT Process	Ensure patients receive good quality and safe care at the end of their life by ensuring staff have the correct skills and training	• Increased levels of training • Increased quality of documentation on ReSPECT forms • Organisational lead in place • Increased availability of resources.	• Organisational Lead for End-of-Life care identified. • Working group established with clear objectives. • Training needs analysis completed, and links established with local hospice to deliver bespoke training in 23-24. • Gap analysis competed against NICE guidance. • SWAN scheme resources for end-of-life packs agreed for use and implementation at RJAH. • Feedback on end-of-life care incorporated into mortality review by Learning from Death Lead.	Partially achieved. Working group to continue to meet and ongoing monitoring through patient experience meeting.
2. VTE – Prevention and management	Ensure compliance against Trust VTE policy to reduce risk of VTE incidence	• Improved compliance with VTE policy • Evidence of shared learning • Establish multi-disciplinary VTE group to monitor themes and trends.	• VTE multi-disciplinary working group established, and Trust clinical lead appointed. • Engagement with clinical specialties to understand reason for deviation from policy. • RCA toolkit reviewed and updated to ensure all contributory factors are being explored. • RCAs completed for each incident to monitor for themes and trends. • VTE masterclass being arranged for 23-24 • VTE incidents agreed to form part of PSIRF priorities for 23-24. • Policy format being updated to include quick reference guides.	Partially achieved. RJAH acquired VTE incidents peaked at 18 for Q3 reducing to 11 for Q4. VTE incidents will continue to be monitored at the working group reporting to Patient Safety meeting and has been identified as one of the Trust PSIRF priorities for ongoing monitoring.
CLINICAL EFECTIVENESS				
3. Enhanced Recovery – supporting patients to eat drink and mobilise after surgery	Decrease length of stay in primary arthroplasty surgery.	• Reduced Length of Stay • Increased positive patient experience scores. • Implementation of Enhanced Recovery team.	• Enhanced recovery business case approved. • Enhanced recovery roles recruited to, and new pathways implemented from April 2023. • CQUIN target achieved – quarterly audits demonstrated at least 70% of surgical inpatients are	Partially achieved. Average inpatient surgical length of stay has remained > 3 days.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
			supported to drink, eat, and mobilise within 24 hours of surgery ending.	Ongoing monitoring through Trust Performance Group.

4. Reduction in delayed discharges	Achieve the Trust KPI of less than 5.24% of all patients delayed	• Achieve % improvements towards trust target of 5.24% delayed discharges.
		• Increased positive patient experience scores.
		• Development of new roles within the MDT to support discharge processes.
			• Mini MADE (Multi Agency Discharge Event) on Sheldon ward May 2022
			• Criteria Led discharge (CLD) point prevalence audit conducted in June and October 2022.
			• Working group established across MSK and Specialist units.
			• Introduction of all delays being captured on Datix to review any level of harm associated with delay.
			• Standardised discharge checklist including CLD piloted in Q4.
			• New roles developed and implemented:
			  ○ Discharge co-ordinator role on Sheldon
			  ○ Resettlement team (MCSI) service review and introduction of discharge co-ordinator role to support wider team.
			• 100-day discharge challenge – 10 best practice initiatives reviewed. Business case in draft for seven-day therapy services on MCSI.
				Fully achieved.
				
				Delayed discharge rate peaked at 11.58% in December 22 and has reduced in Q4 ending at 4.31% in March 2023.
				
				Working group will continue to meet and IPR metric monitored at Quality and Safety Committee.

PATIENT EXPERIENCE				
5. Waiting well initiative	Ensure patients are communicated with effectively whilst on the waiting list	• Reduced patient contact/complaints relating to waiting times. • Increased communication with patients using My Recovery app • Ensuring robust clinical prioritisation and harms review process is in place.	• Harms review and clinical prioritisation process in place for MSK and Specialist Units. • My Recovery app completed automated testing period in Q3. • My Recovery app soft launch September 2022. • Phased approach to add specialties to My Recovery.	Fully achieved. My Recovery app will continue roll out across all specialties.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
			• Patient Access Manager is exploring the use of a 'Acknowledgement of Referral Letter' to send to a patient on receipt of a referral and to advise of our waiting times.	
6. Progress against NHS Learning Disability standards	Improve patient experience with patients with learning disabilities and autism who access our services	• Improved % with training compliance. • Increased patient satisfaction • Increased access to resources for staff caring for patients with LD and autism. • Increased access to resources for patients accessing RJAH services.	• LD and Autism tier 1 awareness training rolled out and now achieving >90% compliance trust wide. • NHS Benchmarking audit completed for 2022-23 • Patient video 'What to expect when visiting the hospital' filmed and available to patients accessing RJAH services on Trust Internet. • Links established with the Intensive Health Outreach Team (IHOT) from MPFT for additional support – service details and how to contact the team available on Percy intranet page.	Fully achieved. LD working group to be re-established in 2023-24 for implementation of Oliver McGowan training. Ongoing monitoring through Patient Experience Meeting.

Local Quality Indicators

In addition to the Quality Priorities for 2022-23 the Trust has selected a number of local quality indicators that have continued to be monitored throughout the year and continued to embed the national Patient Safety Strategy.

Safety

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is committed to continuously improve patient safety and delivering the NHS Patient Safety Strategy.

The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. RJAH have three members of staff who adopt the role of patient safety specialist, allowing them to oversee and support patient safety activities across our organisation. The patient safety specialists help to embed the strategy providing dynamic, senior leadership, visibility, and expert support to the patient safety work at RJAH. The aim of the patient safety specialists is to support the development of a patient safety culture and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.

A Patient Safety Meeting forms part of the quality governance framework and is led by the Chief Nurse and Patient Safety Officer; this is a multi-disciplinary meeting which monitors patient safety improvement action plans, risks, and associated policies. The Patient Safety Meeting receives upward reports from the Patient Harms Group which conducts deep dive analysis on patient safety incidents to determine themes, trends, and areas for improvement.

A key focus for the patient safety specialists this year has to been to prepare the organisation for the implementation of the new NHS England Patient Safety Incident Response Framework, which is due to launch in Autumn 2023, replacing the current NHS England Serious Incident Framework.

Patient Harm reviews

At the end of March 2023 there were 22,110 patients on our waiting list with 271 waiting over 78 weeks. We know lengthy waiting times can potentially negatively impact on patient ‘s health and wellbeing and the Trust have recognised the importance of staying in contact with our patients establishing a robust harms review and clinical prioritisation process for our patients waiting over 52 weeks. A harms review is required when the Trust has not been able to provide care and treatment within the expected timeframes as specified by national guidance. The outcomes of the harms reviews conducted are monitored at Quality and Safety Committee.

Safeguarding

At RJAH we take our safeguarding responsibilities very seriously and discharge our duties fully in complying with national and local legislation, policy, and guidance. Our work is underpinned by the Children’s Act (2004), Working Together to Safeguard Children Statutory Guidance (2006,

2015 and 2018) and the Care Act (2014) in relation to safeguarding adults. We contribute to a range of performance and quality measures as required by CQC, Shropshire Safeguarding Community Partnership (SSCP) and our local ICS. Improvements were seen within the Trust safeguarding priorities for 2022/23 with improved compliance with level 3 adult safeguarding training, improved pre-op pathway communication to identify safeguarding concerns and monitoring of our 'was not brought' policy for children.

Infection Prevention and Control

A key focus area for the Trust in 2022-23 was the delivery of the Infection, Prevention and Control Improvement plan. Following an MRSA outbreak* during the Summer 2021, the Trust continued to work hard to implement changes outlined by NHSE. Unfortunately, following a visit in February the Trust were in discussions with the regulators regarding a potential breach of licence. In May 2022 the breach of license was confirmed, and Trust were to be moved to segment 3 on the single oversight framework (SOF3).

In response to meet the exit criteria and undertakings an IPC improvement plan was developed to ensure actions were embedded trust wide and improvements sustained. This improvement plan was led by the Chief Nurse and Director of Infection Prevention and Control (DIPC) and managed through IPC Committee with monthly exception reporting to the IPC Quality assurance committee and Trust Board. The Trust welcomed support from NHSE and the ICS to support the rapid improvements made across the organisation for the benefits of our patients.

The Trust has now moved to GREEN on the NHSE Infection Prevention and Control escalation matrix and formal undertakings have been met with a follow up assurance visit in December 2022 continued to demonstrate sustained improvements.

The improvements made could not have been achieved without engagement and commitment from staff across all disciplines across the organisation; some of the key improvements are listed below:

- Improved communication and engagement strategies via various means including managers briefings, a fortnightly IPC bulletin from the medical director and chief nurse.
- Shared learning and dissemination of trust wide changes have been a key focus to ensure improvements are made across the organisation – this has been supported by after action review posters.
- Significant improvements in IPC training compliance have been seen, this training has been supported by the introduction of a Health Care support worker within the IPC team and the IPC champions across the Trust.
- Investment in estate refurbishment. Collaboration and links with estates, IPC and the operational teams have enabled works to be scheduled with minimal disruption to our patients.
- Introduction of new housekeeper role and successful recruitment of 15 housekeepers
- Appointment of a logistics stores assistant who is responsible for maintenance of stock rooms in clinical areas.
- IPC dashboard has been developed to give live data on HCAIs, SSIs, outbreaks, IPC audit and training data.
- Re-launch of BBE campaign and Uniform Policy

- Increased capacity and resource within the IPC team including appointment of Deputy DIPC
- Introduction of IPC Quality Walks and improvement of audit process.

The IPC team have developed their IPC strategy striving for excellence in IPC practice, through integrated working, education, digital technology, and enhanced engagement. This was launched 30th of January 2023 at the IPC summit.

Footnote: *outbreak NHS definition *'An outbreak is any two or more cases of an infection of the same type, where a common link can be established. A hospital outbreak simply reflects a link with the hospital'*

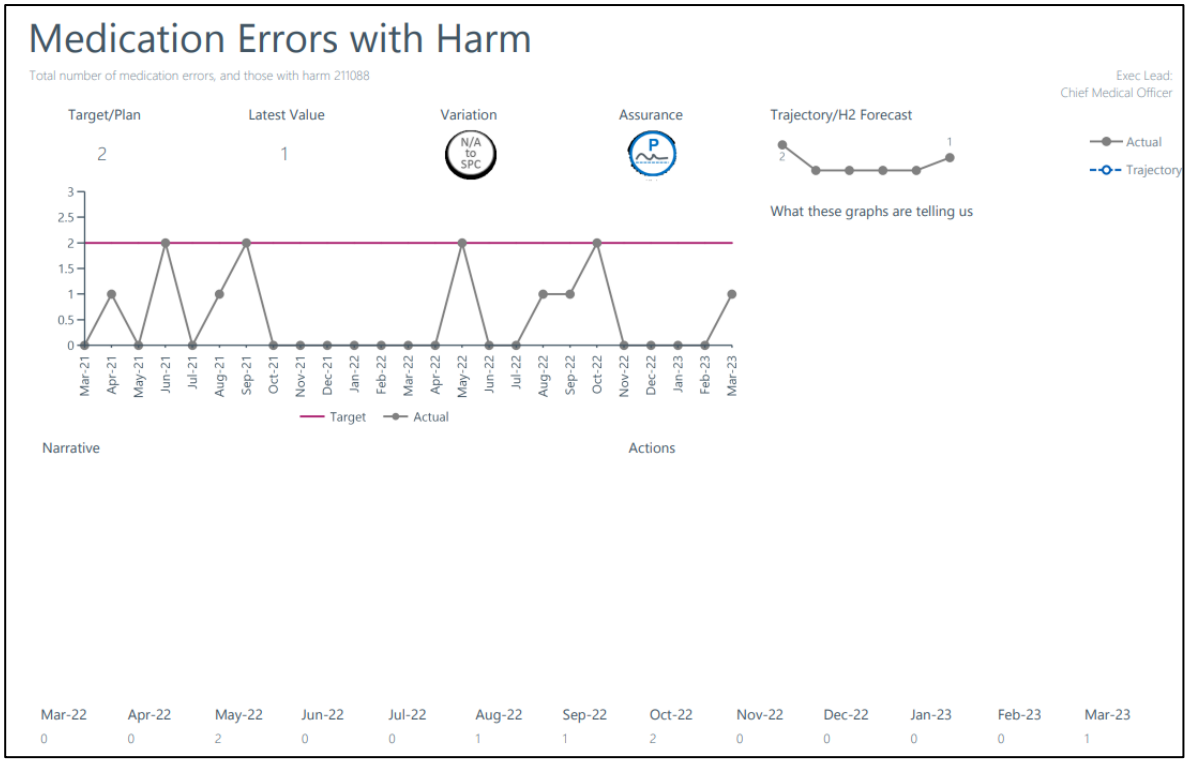
Medication Incidents

Medication incidents are any patient's safety incidents (PSIs) where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring, or providing advice on medicines. Within the Trust there is an open dialogue and reporting culture relating to medication incidents. A repot is produced monthly detailing any harms, number of incidents, key incident themes, and sharing of identified learning. This is shared across the Trust.

As the Trust move towards implementation of the Patient Safety Incident Response Framework (PSIRF) medicine incidents will be one of the top chosen categories of focus. In preparation for this we have commenced analysis of our medication incidents in terms of thematic reviews, using a systems framework for analysis, SEIPS alongside our monthly reports. Learning is then shared at Medicines Safety Committee, Patient Harms and Patient safety groups.

The Trust benchmark and share medicines safety themes through the Shropshire Telford and Wrekin ICB Medicines Safety Group, the regional Medicines Safety Officer Group and the CD Lin with the Chief Pharmacist network having oversight of all groups.

The chart below tracks our progress across twenty-four months in relation to the number of medication errors with harm.



Learning Lessons from incidents

- Serious incident reports and learning from the investigations are shared widely across the Trust via relevant meetings such as the Patient Safety meeting and at all Unit Governance meetings ensuring that shared leaning and awareness of issues is cascaded across all areas. These are also discussed at band 6 training days with a review of each SI presented to promote learning amongst our nursing staff.
- The Trust continues to involve patients in serious incident investigations with a nominated Patient/Family Liaison person for each investigation. The investigation reports are shared with patients and where applicable their families and opportunities are provided for the investigation to be discussed with clinical and governance staff.
- The Trust holds serious incident debrief meetings with relevant teams and support from the Governance Team in which the reports are shared with the staff involved. These are conducted in a blame-free way with the focus being on the learning. Areas of good practice are also highlighted during this process.
- The introduction of a Datix category that reports the area that incident originate from has been implemented and the Governance Team are raising these incidents alongside incidents that are reported with the Unit for learning and improvement. This also provides opportunity for learning to be shared across the Units.
- Over the last year there has been an increased focus on improving the quality of the incident investigations and a of review closed incidents is being undertaken by the Governance Lead external to the reporting Units each month. Findings of these reviews are reported back to Patient Safety meeting, this includes both good practice and areas that require improvement.
- After Action Review posters are produced to disseminate learning throughout the organisation. These are shared at unit governance, patient safety, and senior nursing meetings.

Implementation of Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy. The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

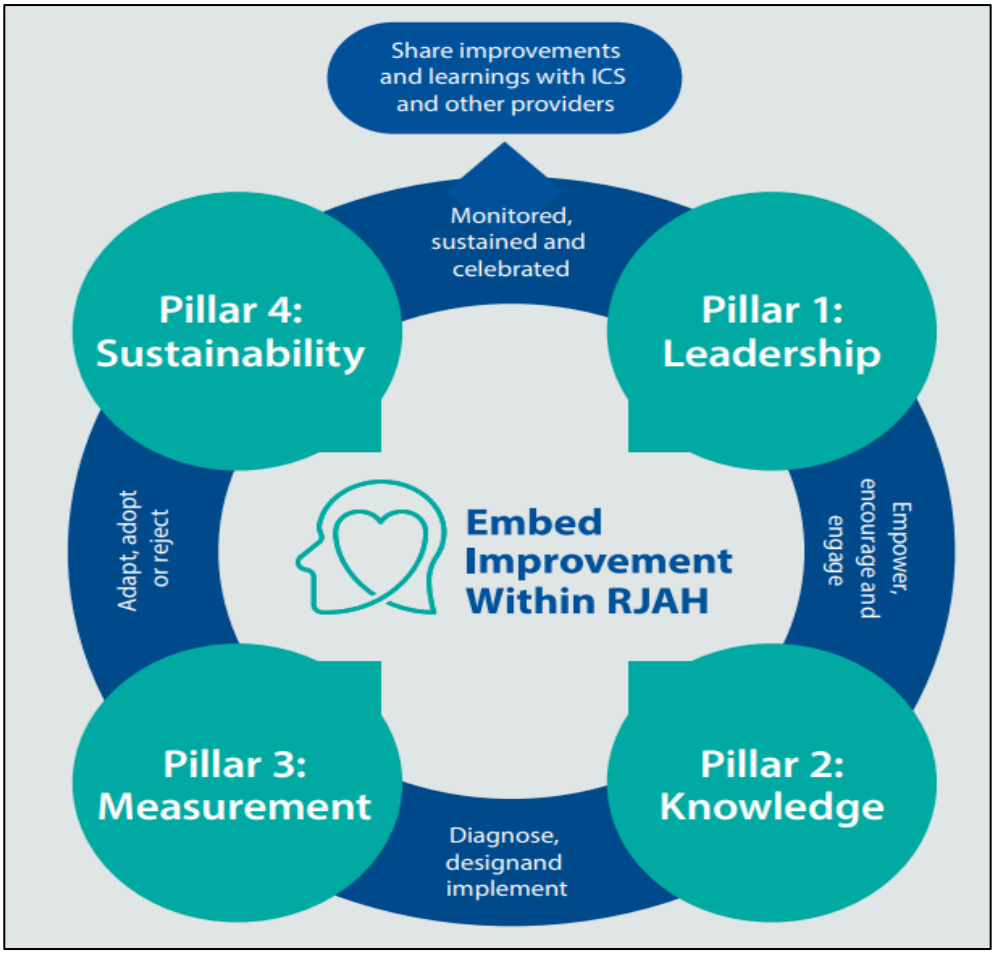
1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

RJAH has established a PSIRF implementation group to transition to the new framework and activities have included identifying PSIRF local priorities, identifying learning response leads and roll out of level one and two patient safety training as part of the national patient safety syllabus.

Quality Improvement

We are proud to announce the newly established Quality Improvement (QI) Framework which we will adopt to support embedding improvement within our organisation. The Trust's ambition is to develop and evolve improvement-led delivery through effective leadership behaviours and by building capabilities. Ultimately this will improve the quality, safety, and experience of our patients and workforce.

The QI framework launches the RJAH approach to improvement which highlights four instrumental pillars to support the embedment:



- **Leadership** – Developing our leaders to understand and champion improvement.
- **Knowledge** – Developing our staff's knowledge on improvement.
- **Measurement** – Evidence driven improvements utilising quantitative and qualitative intelligence.
- **Sustainability** – Learn, share, and celebrate our improvements whilst continually checking changes are still having the desired effect.

Patient Safety Walkabouts

The programme provides an opportunity for members of the Trust Board to engage with patients, relatives, and staff through regular visits to clinical areas. The purpose of the visits is to provide visible leadership by the Board on quality and safety and to talk to patients, families, and staff about their experience of care in the Trust. In 2022-23 a total of 15 areas were visited.

Leadership walk rounds are recognised nationally as a critical leadership intervention, as described by the Institute of Health Improvements (IHI). Regular walk rounds are a sign of the Trust's safety culture and approach to improving quality in the organisation. This has provided members of the Board with the opportunity to talk to staff specifically about quality, safety, and improvement programmes and to get feedback to help achieve these improvements across the organisation. The walk round programme provides Non-executive Directors and Governors with

the opportunity to engage with patients, relatives, and staff and to discuss standards relating to quality and safety with clinicians and managers during the visits.

The purpose is:

- Demonstrate commitment to safety.
- Fuel culture for change pertaining to patient safety
- Provide opportunities for senior executives to learn about patient safety.
- Identify opportunities for improving safety.
- Establish lines of communication about patient safety among employees, executives, managers, and employees
- Establish a plan for the rapid testing of safety-based improvements.

There are five key lines of enquiry the walkabout investigates which mirror Care Quality Commission (CQC) questions; safe, effective, caring, responsive, well led. Staff of all grades are asked what is going well in their opinion and areas which require a more sustained focus of improvement. An action plan has been created and completion of actions and feedback is provided to various committees and boards for assurance purposes. This is coupled with feedback to the clinical area of actions undertaken and completed to ensure a ward to board to ward approach.

Effectiveness

The National Institute for Health & Clinical Excellence (NICE) guidance

All published NICE guidance was reviewed monthly by Clinical Audit Quality Lead and the Consultant Lead for NICE Guidance. A total of 152 guidelines were reviewed, as to which a 143 were deemed not applicable to the services provided to RJAH. Nine of the guidelines were applicable, of which four required audit activity to assess compliance.

Clinical Audits that are being carried out or have been carried out in 2022-23 in relation to NICE guidance include:

- 1819_001 National Rheumatology Audit - NICE CG79 and QS33
- 2223_001 An audit to determine whether the sepsis 6 pathway is being implemented and adhered to – NICE NG 51
- 2223_016 Pre-operative Patient Warming Audit – NICE CG 65
- 2223_026 Reaudit of Pneumonia in Adults – NICE CG 191
- 2223_028 Temperature Monitoring under Anaesthesia – NICE CG 65
- 2223_042 Reaudit of Pre-operative Fasting
- 2223_056 Reaudit of Acute Kidney Injury among In-patients – NICE CG169
- 2122_028 Reaudit of Botox Administration in Children with Cerebral Palsy (CG 145)

List of NICE Guidance received and considered “applicable to RJAH:”

Date Issued	Guideline No	Title	Outcome
26/05/2022	NG216	Social work with adults experiencing complex needs	Evidence of assurance required - Discharge Policy requires updating in line with NICE recommendations
29/06/2022	NG18	UPDATED: Diabetes (type 1 and type 2) in children and young people: diagnosis and management	Following review - guidance considered not to be applicable.
13/07/2022	TA803	Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs.	Following review - guidance Approved for use at RJAH.
09/11/2022	NG227	Advocacy services for adults with health and social care needs	Following review concluded NICE Guidance is covered in current RJAH policy with regards to this policy or practice

List of NICE Guidance received in 2022-23 and audits planned:

Date Issued	Guideline No	Title	Outcome
09/06/2022	NG219	Gout: diagnosis and management	2223_025 audit in progress - awaiting report and action plan.
07/07/2022	CG191	Pneumonia in adults: diagnosis and management	Re audit 2223_026 in progress and at Action Plan completion stage
24/08/2022	IPG734	Focal resurfacing implants to treat articular cartilage damage in the knee	Project Lead identified
18/01/2023	CG103	Delirium: prevention, diagnosis and management in hospital and long-term care	Audit has been completed 1920_032 and concluded: • Confusion/dementia screen was done in the majority of the patients= 75 years especially for patients from medical ward, which is an improvement compared to previous audit in 2017. • All patients suspicious of having an infection were screened for any possible infection /sepsis. • Documentation was inadequate regarding drug chart check in many patients. • The cognition for the majority of patients improved to baseline on discharge. The patients who did not attain baseline either died in hospital or were transferred to RSH or community hospital. Anticipated reaudit date has been moved to 01/04/2024.

Health and Safety

Health and Safety incidents were monitored on an ongoing basis throughout the year. All incidents were investigated, and remedial actions taken to prevent or reduce the likelihood of reoccurrence.

Those incidents reported involving specified injuries, dangerous occurrences or resulting in a member of staff taking more than seven days off work because of a work-related accident were also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). During 2022-23 there were seven incidents reported to the HSE under the requirements of the RIDDOR regulations. No regulatory action or sanction was received in respect of the reported incidents.

The Chief Finance and Planning Officer retained Board-level responsibility for health and safety. The Trust employed a 0.5 WTE Health and Safety Manager, with support from a 0.5 WTE Health and Safety Advisor, to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

A Health and Safety Meeting met bi-monthly, chaired by the Director of Estates and Facilities, and included health and safety representatives from staff side unions in compliance with the Safety Representatives and Safety Committees Regulations, 1977.

Experience

Listening to Patients and Carers

Collecting Patient experience data is an important part of monitoring the quality of care provided at the RJAH and helps promote an open learning culture by identifying and sharing examples of good complaints practice and learning that was identified through patient feedback.

The table below shows overall patient feedback in 2022-23 compared to 2021-22:

Feedback	2021-22	2022-23	Diff from 2021-22 to 2022-23	% Change
Complaints	115	113	-2	-1.7%
Local resolution	19	29	10	52.6%
PALS concerns	206	303	97	47.1%
PALS enquiries	3667	4006	339	9.2%
Compliments	6281	10684	4403	70.1%
FFT	98%	98%		

Learning from Patient Feedback

In 2021-2022, the Patient Experience and Engagement Strategy 2021-2024 was refreshed and outlines the Trust's commitments to provide patients, carers, their relatives with world class care.

We know that a positive experience during a care episode promotes a positive clinical outcome. If a patient feels listened to and involved in their care they will respond better to medical, nursing and therapy interventions and be better able to manage their own journey of care.

During 2022-23 the Trust has been working towards achievement of the commitments to provide the best experience of care at each phase of the patient pathways and interaction with our staff to put patient experience at the heart of everything we do.

Our commitments are:

1. We will work in partnership with our patients and actively involve them in decisions about their care.
2. We will communicate to our patients in a manner that is accessible and appropriate to their own individual needs whilst listening to our patients about their priority of care and what matters most to them.
3. We will involve our patients and services users and the public generally in decisions regarding the way we deliver services and any future developments.
4. We will engage with our patients to facilitate patients to manage their own health conditions and get the best out of their wellbeing.
5. We will further develop the role of volunteers to ensure we maximise their input to enhance patient experience.

The Trust uses Patient feedback as a key measure of monitoring the quality of care, this is an important "health check" for the services we provide as well as promoting a strong culture of listening to patients to help improve services.

The Trust offers many opportunities for patients and carers to give their feedback including Trust email, Twitter and Facebook, local and national patient feedback surveys, Friends and Family Test (FFT) survey, patient stories, patient forums, Trust Governor forums and comments received direct. All feedback is shared with the clinical areas and is responded to by the Communications Team or the Patient Advice and Liaison Service (PALS) Team.

In addition, the Trust has robust processes in place which enables patients to raise their concerns formally via the Complaints process and informally via the Patient Advice and Liaison Service (PALS). These concerns are all investigated in line with the Trust's complaints policy and action plans put in place, where applicable, to ensure learning and improvement.

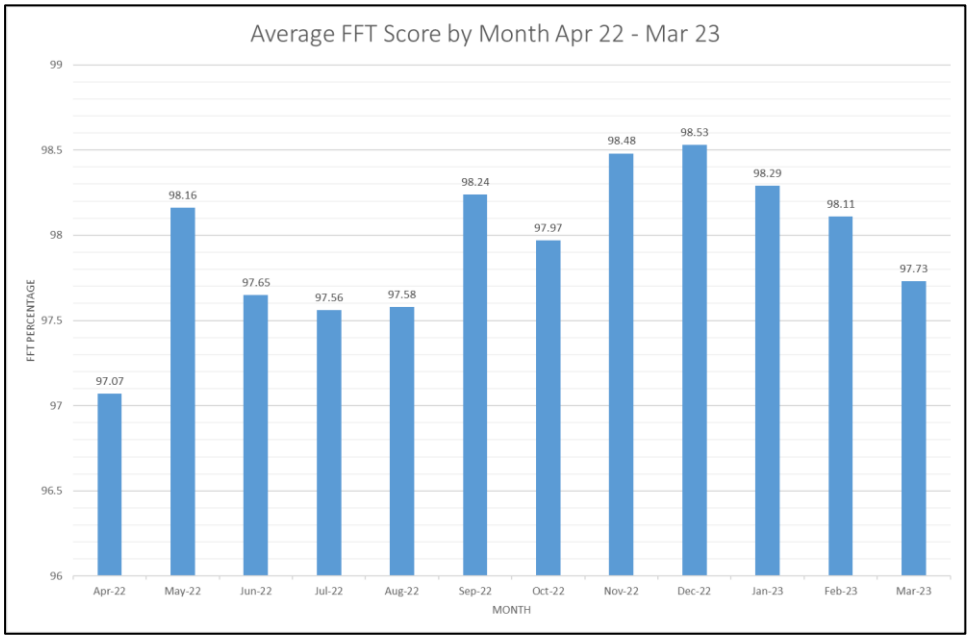
Patient Friends and Family Test

The NHS Friends and Family Test (FFT) “Overall, how was your experience of our service” was created to help Trusts understand whether patients are happy with the service provided, or to provide suggestions on any improvements needed. It's a quick and simple way for patients to give their views after receiving NHS care or treatment.

The results from FFT provides insights into how we can improve or celebrate the positive patient feedback received with the staff delivering the services. FFT data is collected in real time using the IQVIA patient feedback system and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment).

For 2022-23, 21,543 patients completed a FFT survey and 97.7% of patients (inpatients and outpatients) said they would rate their experience as good or very good.

The chart below shows the average FFT score per month against a target of 95%:



The Trust is committed to improving the percentage of patients who would rate their experience as good or very good.

Staff are sent an email alert in real time as soon as a low FFT score is received, and comments are immediately uploaded into IQVIA for staff to respond to within department. The FFT results are shared in Unit, department, and Speciality level Governance Quality reports with trends of low scores monitored on a monthly basis.

The results for the Trust over the last five years are as follows based on the average percentage of FFT score (inpatients and outpatients).

	2018-19	2019-20	2020-21	2021-22	2022-23
National Average	96%	96%	94%	94%	94%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	76%	73%	65%	64%	73%*
The Robert Jones and Agnes Hunt	99%	99%	98%	98%	98%

*for 2022-23 national data includes up to Jan 23

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has a robust patient experience programme in place, that facilitates learning and implementing changes based on patient experience

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage:

- Continued patient engagement via the Patient Panel
- Renewal of its Patient Experience Strategy

Health Inequalities

RJAH reports Health Inequalities updates through its Quality and Safety committee. The Trust has been observing data through different lens in widening understanding of health inequalities. Reports have been created to look at:

- Priority 1: Restore NHS services inclusively.
- Priority 2: Mitigate against digital exclusion - assessing virtual outpatient activity for patients not attending.
- Priority 3: Ensure datasets are complete and timely - the Trust has improved ethnicity data collection.

The Trust also developed business cases during 2022-23 that directly or indirectly support with addressing health inequalities. For example, population assessments for 2019-20 (latest published data) from NDFA (National Diabetes Foot Audit) showed Shropshire and Telford to have the highest rate of minor amputations in the UK. The orthotics service put a case together to increase input within the Acute Diabetic Service to support this population.

A further example can be seen from the Trust submission and approval of the 'Theatre and Elective Beds Scheme' through NHS England's Targeted Investment Fund (TIF). The Scheme indirectly supports the PLUS 5 strategy, in particular severe mental illness, by improving access to surgery which will significantly improve patients' quality of life. In addition, the Scheme is addressing the needs of children and young people waiting for paediatric spinal surgery, by the increase in consultant capacity and by enabling succession planning for the workforce for the provision of complex paediatric and adult spinal surgery for our population.

To support continued improvements in outcomes for our patients the Trust during 2022-23 has piloted and launched a digital app (MyRecovery) to further support patients. The app is a suite of tools designed to support, empower, and inform a patient through their treatment. The aim is that the better informed and engaged patients they are less anxious, have a better experience and ultimately have improved outcomes. It further supports in monitoring of patient reported outcomes (PROMs) for our patients too.

Freedom to Speak Up Guardians

In 2022-23 FTSU has moved from the portfolio of the Chief People Officer, with the Chief Nurse and Patient Safety Officer as the Executive Lead for FTSU. The role of the FTSU Guardian is now incorporated into the Clinical Governance Team, ensuring effective triangulation of patient safety data and concerns raised. The FTSU Guardian is now supported by FTSU champions across the organisation.

The FTSU team have received concerns from a broad range of professional groups across the Trust. Admin and clerical, accounted for the largest portion of speaking up cases raised during 2022-23. In 2022-23, 33% of staff raised a concern anonymously which is an improvement compared to 2021-22, where 44% of the concerns raised, were done so anonymously.

The national staff survey indicated 70.9 % of staff do feel secure in raising a concern and 58.6% are confident that RJAH would address a concern.

FTSU Data 2022-23

Data For Quarter	April 2022- March 2023				
Organisation	Robert Jones & Agnes Hunt Orthopedic NHS Foundation Trust				
Size of organisation	Small Under 5,000				
Region	Midlands				
		April-June	July-Sept	Oct-Dec	Jan-March
Number of cases brought to FTSUGs per quarter		7	5	5	2
Numbers of cases brought by professional level					
Worker		1	5	5	2
Manager		2	0	0	0
Senior leader		0	0	0	0
Not disclosed		4	0	0	0
Numbers of cases brought by professional group					
Allied Health Professionals		0	0	1	1
Medical and Dental		2	0	0	0
Registered Nurses and Midwives		0	0	0	1
Administrative and clerical		1	3	1	0
Additional professional scientific and technical		0	1	1	0
Additional clinical services		0	0	1	0
Estates and ancillary		0	0	1	0
Healthcare scientists		0	0	0	0
Students		0	0	0	0
Not Known		4	1	0	0
Other		0	0	0	0
Of which there is an element of					
Number of cases raised anonymously		4	0	0	0
Number of cases with an element of patient safety/quality		3	1	1	0
Number of cases with an element of worker safety or wellbeing		0	1	1	0
Number of cases with an element of bullying or harassment		0	0	2	0
Number of cases with an element of other inappropriate attitudes or behaviours		1	1	1	0
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated					
Response to the feedback question,					
'Given your experience, would you speak up again?					
Total number of responses					
The number of these that responded 'Yes'		1	1	0	0
The number of these that responded 'No'		1	0	0	0
The number of these that responded 'Maybe'		0	0	0	0
The number of these that responded 'I don't know'		0	0	0	0

In 2022-23 the RJAH made a commitment to invest and promote in raising the profile of FTSU across the Trust. This has included:

- A self-assessment against NHS England standards for FTSU arrangements. The FTSU self-assessment tool was devised by NHS England and NHS Improvement as guide to help Trusts reflect on its current position and the improvement needed to meet expectations.
- The appointment of seven FTSU champions. Champions have been encouraged to raise the profile of FTSU to departments.
- Ensuring face to face presentations on FTSU at Trust indication and development days.

- The National Guardianship produced a generic NHS FTSU policy which has just been published. This policy has been adapted for use at RJAH.
- Refreshed posters and a new roller banner have been designed and will be posted around the hospital. Information page on the Trusts Intranet Percy.
- Investment in the role of the FTSU Guardian, increasing the provision in line with similar Organisations within the National Orthopaedic Alliance.
- FTSU training provided to the Trust Board.

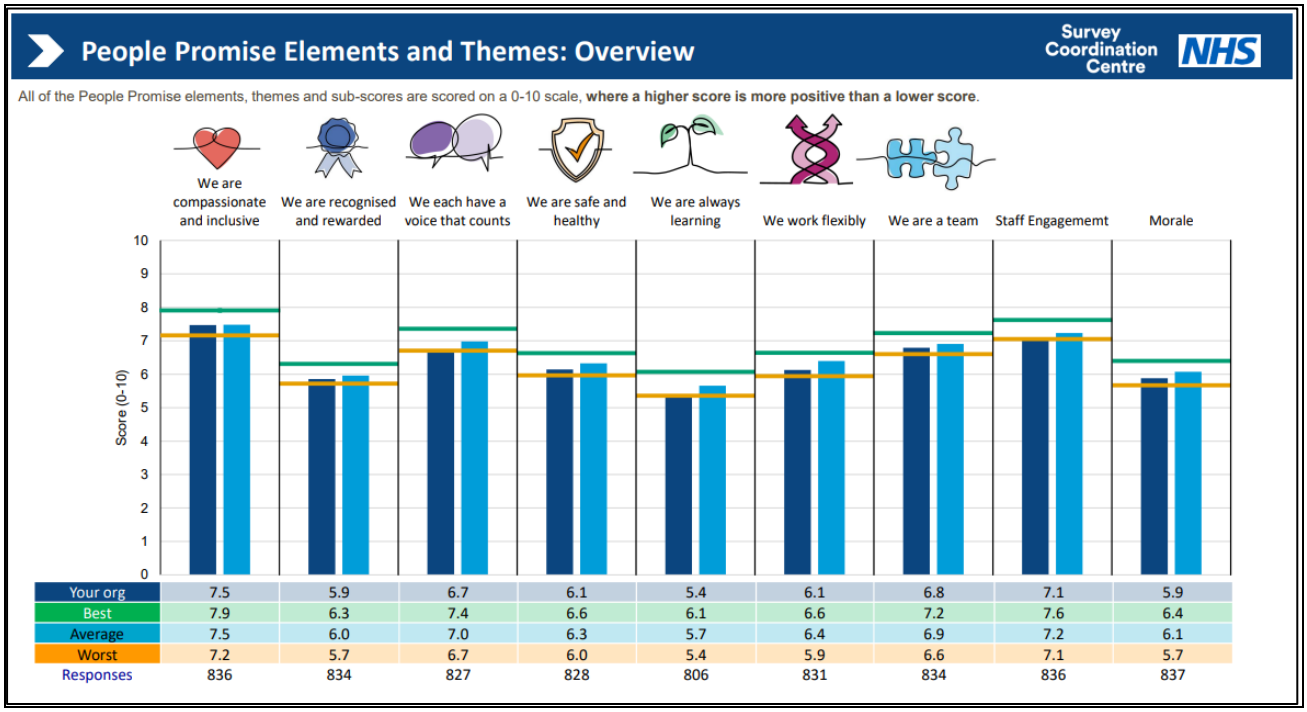
National Quality Indictors

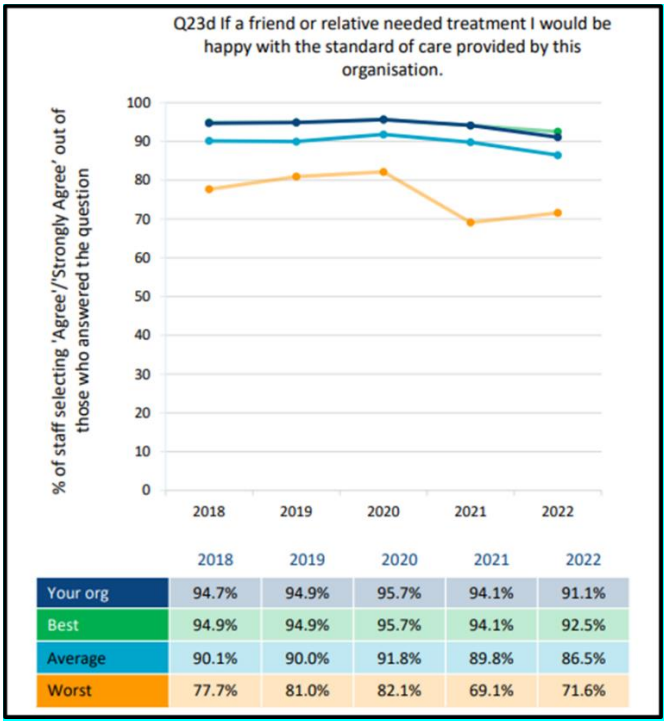
Staff Survey results

In the 2022 NHS Staff Survey, 91% of respondents said they would be happy with the standard of care provided if a friend or relative needed treatment and 80.4% of responses agreed the care of patients/service users was the organisation's top priority.

The response rate, and themed results are detailed below:

Response Rate	2018	2019	2020	2021	2022
	44.9%	62%	57%	52%	52%





	2018	2019	2020	2021	2022
Your org	94.7%	94.9%	95.7%	94.1%	91.1%
Best	94.9%	94.9%	95.7%	94.1%	92.5%
Average	90.1%	90.0%	91.8%	89.8%	86.5%
Worst	77.7%	81.0%	82.1%	69.1%	71.6%

Our overall staff engagement score was comparable with other acute specialist trusts.

Single Oversight Framework

The following section outlines the Trust's performance against the relevant indicators and performance thresholds set out in the NHS Improvement Single Oversight Framework where this data does not appear elsewhere in the report.

	Info taken from the published annual accounts						
Indicator for Disclosure	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate	**88.51%**	**89.49%**	**90.26%**	**88.85%**	**54.41%**	**55.96%**	**53.45%**

All cancers: 62day wait for first treatment from: • urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	**92.59%**	**75.76%**	**73.91%**	**86.84%**	**75.00%**	**65.63%**	**80.85%**
Maximum 6 week wait for diagnostic procedures	**99.84%**	**99.57%**	**98.97%**	**97.94%**	**59.00%**	**77.45%**	**64.68%**
Venous thromboembolism (VTE) risk assessment	**100%**	**99.9%**	**99.88%**	**99.89%**	**99.74%**	**99.77%**	**99.80%**

APPENDICES

Statement of Directors' responsibility in respect of the Quality Account

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

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

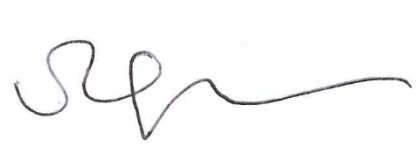
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2022-23 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2022 to March 2023
  - Papers relating to quality reported to the board over the period April 2022 to March 2023
  - Feedback from Shropshire Telford and Wrekin ICS dated 21 June 2023
  - Feedback from the Trust's Lead Governor dated 21 June 2023
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest national patient survey 2021 and national staff survey 2022
  - CQC inspection report dated February 2019
  - CQC pilot medicines optimisation report dated September 2022
  - NHSE IPC Improvement letters
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Harry Turner, Chairman



Stacey Keegan, Chief Executive Officer

RJAH Quality Account Statement from Shropshire Telford and Wrekin ICB 2022/23

Our Ref: VW/ICBQA

Re: Quality Account 1 April 2022 - 31 March 2023

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have had the opportunity to review the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Quality Account for 2022/23.

It is the ICBs view that the account accurately reflects the achievements made by RJAH in 2022/23 and the priority areas identified to the best of our knowledge. RJAH has worked collaboratively with partners in the integrated care system (ICS) as we grow our ICS to address the needs of the population and improve the quality of healthcare services within it.

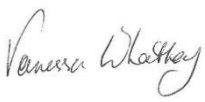
The ICB has been fully sighted on the challenges of restoring services after the COVID19 pandemic and establishing effective infection prevention and control processes including the progress the Trust has made in these areas including the development of a harm review process for those with long waits, and substantial improvements to the clinical environment and infection prevention and control processes in the delivery of the action plan to address the breach of license identified in February 2022. The speed of resolution of this issue was positive and the ICB is now working with NHSE and the Trust to sustain and further develop this area of practice. In addition, the ICB has worked with the Trust to ensure maximum learning from never events withing and beyond the trust.

It is pleasing to note the ongoing improvements particularly in relation to VTE assessment and the focus on patient safety led by those with patient safety specialist roles, working within the system the introduce the Patient Safety Incident Response Framework (PSIRF) in Autumn 2023. Also, the introduction of a quality improvement framework and range of clinical audit undertaken.

Patent experience has been enhanced with the introduction of the My Recovery app in the Trust, reduce delays in discharge and the developments in improving patient experience for those with learning disabilities and autism. While staff continue to highly recommend the Trust, we look forward to seeing the ongoing efforts to improve the experience of staff and future developments reflected in the staff survey.

In conclusion, the ICB views the 2022/3 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures. The ICB recognises the Trust's commitment to working as a partner in the system to ensure the ongoing delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin.

Yours sincerely



Vanessa Whatley, Director of Quality and Safety/Deputy Chief Nurse for NHS STW
21 June 2023

Lead Governor's Submission on the Quality Account Report for 2022-23 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The Quality Account Report 2022/23 demonstrates the continued significant achievements the Trust has made over the last year in despite of the challenges faced. This is particularly evident through the Inpatient Survey Results there is continued evidence of the Trust's work to strive for improvement.

The Governors involvement within the hospital has increased since the previous challenges relating to Covid-19. In previous years, the Governors were limited by social distancing requirements but where possible continued to be involved in meetings and visits virtually.
Within 2022/23, the Governors have been more involved in events, patient safety and patient experience initiatives and they welcome these opportunities to provide input on behalf of their members. In addition, seeing how the services run and hearing directly from patients about their experiences provides assurance to the Council of Governors that the patient needs are consistently being met.

It is reassuring that the hospital continues to be a place staff would recommend to their friends and family as a place of treatment and further as a place to work. This really is testimony to the quality of the care that the Trust continues to provide.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2022/23.

Victoria Sugden, Lead Governor
21 June 2023

Acronyms

ACL	Anterior Cruciate Ligament
ASIA	American spinal injury association
BBE	Bare below the elbow
BMI	Body Mass Index
BOFAS	British Orthopaedic Foot & Ankle Society
BSCOS	British Society for Children's Orthopaedic Surgery
BSR	British Spinal Registry
CAP	Community required Pneumonia
CD	Controlled Drug
CDI	Clostridioides Difficile Infections
CEO	Chief Executive Officer
CLD	Criteria Led Discharge
CMC	Carpometacarpal
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSP	Chartered Society of Physiotherapist
CURB-65	Severity Score for Pneumonia
DIPC	Director of Infection Prevention and Control
DMARDS	Disease-modifying anti-rheumatic drugs
DMD	Duchenne Muscular Dystrophy
DSPT	Data Security and Protection Toolkit
DVT	Deep vein thrombosis
EDD	Estimated Date of Discharge
EPR	Electronic Patient Record
EQ5D	Equality Health Index Score
FFFAP	Falls, Fragility Fracture Audit Programme
FFT	Family and Friends Test
FTSU	Freedom to Speak Up
HCAI	Healthcare Acquired Infection
HCPC	Health and Care Professionals Council
HDU	High Dependency Unit
HSE	Health and Safety Executive
HSIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance
IHI	Institute of Health Improvement
IHOT	Intensive Health Outreach Teams
IM	Intramuscular
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
IQVIA	Patient Experience monitoring system
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
ISNCSCI	International Standards for Neurological Classification of Spinal Cord Injury

KLOEs	Key Line of Enquiry's
KPI	Key Performance Indicator
LD	Learning Disabilities
LOS	Length of Stay
MADE	Multi Agency Discharge Event
MAHR	Non-Arthroplasty Hip Registry
MDT	Multidisciplinary Team
MPFT	Midland Partnership Foundation Trust
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MSCI	Midlands Spinal Cord Injury
NDFA	National Diabetes Foot Audit
NEIAA	National Early Inflammatory Arthritis Audit
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
NJR	National Joint Register
NMR	Non-medical Referrer
OHS	Oxford Hip Score
OKS	Oxford Knee Score
OT	Occupational Therapist
PALS	Patient Advice and Liaison Service
PE	pulmonary embolism
PEoLC	Palliative and End of Life Care
PLACE	Patient Led Assessment of the Care Environment
PQIP	Peri-operative Quality Improvement Programme
PR	Peri Rectum Examination
PROMs	Patient Reported Outcomes Measures
PSAG	Patient Status at a glance
PSI	Patient Safety Incident
PSIRF	Patient Safety Incident Response Framework
QI	Quality Improvement
RCA	Route Cause Analysis
RCOT	Royal College of Occupational Therapists
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RJAH	Robert Jones and Agnus Hunt
RSH	Royal Shrewsbury Hospital
RTT	Referral to Treatment Time
SCI	Spinal cord injury
SCIM	Spinal cord independence measure
SEIPS	System Engineering Imitative for Patient Safety
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious hazards of transfusion
SI	Serious Incident
SIRO	Senior Information Risk Owner
SOF	Single Oversight Framework

SOOS	Shropshire Orthopaedic Outreach Service
SSCP	Shropshire Safeguarding Community Partnership
SSI	Surgical Site Infections
SWAN	Signs Words Actions Needs
TER	Total Elbow Replacement
THR	Total Hip Replacement
TIF	Targeted Investment Fund
TKR	Total Knee Replacement
TQ Pressure	Tourniquet Pressure
TSR	Total Shoulder Replacement
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent