The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

QUALITY ACCOUNT

2011/2012

Delivering Outstanding Patient Care

March 2012

Quality Accounts

What are the Quality Accounts and why are they important?

Quality accounts are an annual report to the public about the quality of services that heath care providers deliver and their plans for improvement.

The purpose of the quality account is to enable:

- Patients, their carers and families to make informed choices about the provider of their health care.
- Boards of NHS providers to report on their services and to set their priorities for the following year.

Healthcare providers measure the quality of the services they provide by looking at:

a. patient safety

b. the effectiveness of treatments that patients receive

c. patient feedback about the care provided

Our Quality Account contains information about the quality of our services, the improvements we have made during 2011/12 and sets out our key priorities for the forthcoming year. The report also includes feedback from our patients on how well they think we are doing.

Foreword from the Chief Executive

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has a clear ambition of '*Delivering Outstanding Patient Care'.* This ambition is supported by our five-year Quality Improvement Strategy which supports our commitment to the delivery of quality patient care year on year.

As a hospital we pride ourselves on the quality of the care we provide- our infection rates are extremely low for surgery and we have had no MRSA bacteraemias recorded for the past six years. We want our patients to experience the highest standards of care and this is evident in our extremely high positive patient feedback with 98% of patients who say they would recommend us to family and friends. In addition, our staff play an integral part in ensuring the quality of care provided remains of the highest standard possible.

This Quality Account provides evidence of our commitment to continuous Quality Improvement. It contains information about the quality of our services, the improvements we have made during 2011/12 and sets out our key priorities for the forthcoming year which are monitored through the Quality and Safety Committee a sub committee of the Board of Directors

We have redesigned the patient pathway through the further development of our pre-operative assessment services to include additional medical and nursing assessment processes supported by a pharmacist to identify potential medication issues prior to surgery. Enhanced the theatre pathway through the introduction of an electronic theatre scheduling system and supported earlier discharge through enhanced recovery and clear estimated discharge dates for all procedures

We continue to audit our care processes and have developed a comprehensive system of monitoring the care delivered to our patients through the implementation of the high impact interventions each supported by a senior clinical lead and tracked through the Quality and Safety Committee

We want patients to choose the Robert Jones and Agnes Hunt Orthopaedic Hospital for their care and treatment. During 2011/12 the Trust has continued to receive patient feedback through written comment cards and is committed to capturing real time Patient Experience data using iPad technology which has been piloted in 2011/12. We utilise all patient feedback in order to plan improvements for the future.

I am pleased to confirm that the Board of Directors has reviewed the 2011/12 Quality Accounts and confirm to the best of my knowledge that the information contained in the document is an accurate, true reflection of our performance

WENDY FARRINGTON CHADD

May 2012
Chief Executive
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Table of Contents

Our Priorities

Review of Last Year's Priorities

Last year we set ourselves the following three key priorities:

- Redesign of the patient pathway
- Implementation of High Impact Actions/Audits
- Implement use of Patient Experience Tracker System

Redesign of the Patient Pathway

Why this was a priority

This priority was identified in the Trust's Integrated Business Plan. The project is divided into three sections;

- Pre-operative & admissions
- Theatres
- Discharge

What we did in 2011/12

For each of the project sections, there was a clear vision, with identified goals and objectives that were linked to Key Performance Indicators (KPIs). Progress updates were provided on a regular basis to the Chief Executive who is the chair of the Patient Pathway Board and other members of the executive team.

How we did in 2011/12

The key priorities identified in each of the pathway redesign have been achieved:

Pre-operative assessment - This is now an anaesthetic led service and the process has successfully transferred to a triage system. Additional nurse practitioners have been employed to assist with the smooth transition and to minimise the patient waiting time. In addition and in keeping with best practice the Trust has employed a pharmacist to ensure that medicine reconciliation occurs prior to admission, there by minimising the poly pharmacy risks to the patient. The Trust has also established a nurse practitioner led pre contact service to ensure that patients remain fit and well for surgery following pre-operative assessment. The Admit on Day of Surgery (ADOS) service continues to run in the main outpatient department to ensure patient confidentiality, privacy and dignity is maintained.

Theatres - The Bluespier theatre management system has now been fully implemented across the Trust. All staff have received training and the booking process and list management has been improved through the full list utilisation and in forward planning of equipment preparation reducing the incident of cancellations. Also running concurrently is the productive theatre which is in the process of successful implementation. The initial phases have been fully implemented.

Discharge - The Trust set itself a challenging target in that all patients must be given an estimated date of discharge and have it entered onto the PAS system. The senior nurses (matrons) have been assisting and facilitating areas where there is slower discharge due to social care issues with success.

High Impact Actions/Audits

Why this was a priority

The High Impact Actions/Audits are integral to high quality care, which is frequently more productive, and enable staff to achieve this. There are eight separate high impact sub-sections:

- Your skin matters
- Staying Safe – preventing falls
- Keeping nourished
- Promoting normal birth (not applicable to this Trust)
- Important choices
- Fit and well to care
- Ready to go – no delays
- Protection from infection.

What we did in 2011/12

A lead was assigned to each high impact action. Updates relating to implementation were submitted to the Senior Nurse and Allied Healthcare Professionals (SNAHP) meeting on a regular basis and were tracked through the Quality and Safety Committee.

How we did in 2011/12

'Your skins matters' – A Back to Basics study day was planned and 'Skin' workbooks are currently being developed for all new starters.

'Staying Safe – Preventing falls' - A post fall protocol and procedure were introduced. Written guidance for patients on 'Prevention of Falls in Hospital' is currently being produced.

'Keeping Nourished' – An ongoing project has encouraged the use of a Red Tray to highlight a patient needing assistance with feeding'.

'Important choices – Where to die when the time comes' - The project is progressing and aim to improve the quality of care for all people receiving hospital care in their final year of life

'Fit and well to care' - Launch of a Health and Wellbeing strategy for the Trust along with Fast-track care pathways developed in partnership with Occupational Health Provider.

'Ready to go – no delays'– The corporate Discharge policy has been updated which has included a review of the specific patient pathways within the organisation. Collection of data for the EDD (estimated date of discharge) for all patients is being undertaken and monitored through the data collection process.
The EDD is being documented within the patient pathway, and patient care plans. As part of the pathway documentation the discharge documentation has been reviewed and updated. Patient status at a glance boards have been reviewed and new boards displaying the EDD have been purchased on the Midlands Centre for Spinal Injuries.

'Protection from infection' – Catheter Associated Urinary Tract infections have historically been audited on an annual basis. The Trust conducted a reaudit as part of the Health Protection Agencies European Prevalence Survey of Healthcare Associated Infections and Antimicrobial Use.

Implementation of Patient Experience Tracker System

Why this was a priority

As part of the Quality Improvement Strategy as agreed by the Commissioners for improving patient experience, the Trust has gathered real-time information relating to patient experience and care delivery. The senior nurse team and the Patient Panel have worked closely to determine this as a priority of quality. Use and effectiveness of the system will be monitored by the Patient Panel, with regular updates to the Trust Board.

What we did in 2011/12

The Trust has run a pilot of the Patient experience tracker and this will now be rolled out across the Trust with patient panel members assisting with this initiative.

How we did in 2011/12

During 2011 the Trust developed a real time Patient Experience data capture system using an iPad and the Trust wireless website technology. Questions have been selected around menu choices, feeling well cared for, noise disturbances at night, being involved and informed about care, time taken for call bells to be answered and frequency of seeing a doctor.

Our Priorities for 2012/13

Safety

NHS Safety Thermometer

The Safety Thermometer is a national initiative that provides a quick and simple method for surveying patient harms and analysing results so that Hospitals can measure and monitor local improvement and harm free care over time. Harm free care is defined as an absence of pressure ulcers, falls, catheter urinary tract infections and VTE (Venous thromboembolism) by December 2012.

The Trust is aiming for 95% of Patients to be Harm Free by December 2012 based upon the NHS Safety Thermometer data collection
Data is collected by ward staff and verified by Matrons on a specified day each month, gathering information on the total numbers of the following:

- Grade 2,3,4 Pressure Ulcers
- Falls
- Catheter associated urinary tract infections
- Venous thromboembolism (VTE)

All harms in each of these categories identified at anytime will have a full root cause analysis undertaken and will be reported through the Trust's committee structures

Effectiveness

To ensure a safe, quality patient pathway is maintained

To provide patient care through the delivery of an efficient and complete patient pathway of care that encourages a smooth transition throughout the whole episode of care including:

- A well defined outpatient clinic process
- An efficient Pre-operative assessment
- Clear defined length of staff in hospital supported by clear goals and post-operative support
- Smooth discharge process that includes patient and family involvement

Patient Experience

Maintain top quartile performance for 'Net Promoter' score.

A focus on safety, a commitment to quality and pursuit of excellence are vital in all aspects of what we do if we are to build on our recent successes. In order to succeed we aim to deliver a quality of care that we would wish for ourselves and those dearest to us

The Strategic Health Authority (SHA) has identified patient experience as one of their five ambitions and are concentrating on a 'net promoter score'. This is being defined as the 'friends and family' test and aims to focus the work being done to achieve one outcome; that patients and carers will recommend the service to their friends and family.

The 'Net Promoter Score' will ensure that real time systems are in place to monitor patients experience, improvements, and clear commitment from Ward to Board. This framework is significant for the trust because it provides a common evidence-based list of what matters to patients, and can be used to direct efforts to improve services.

This information regarding whether Patients would recommend the hospital to family and friends will be collected via the current comment card system which are provided to each patient on discharge. In addition, through the use of Ipad technology patients will be supported by volunteers in completing the survey electronically prior to discharge asking the specific family and friend's question

Data will be reported monthly to commissioners and the Board of Directors.

The priorities for 2012/13 have been considered as a result of National priorities, discussion with commissioners and consultation via patient's views and our Patient Panel in relation to the effectiveness of our pathway of care.

Progress on achieving these priorities will be reported to the Trust Board on a monthly basis as part of the integrated performance report.

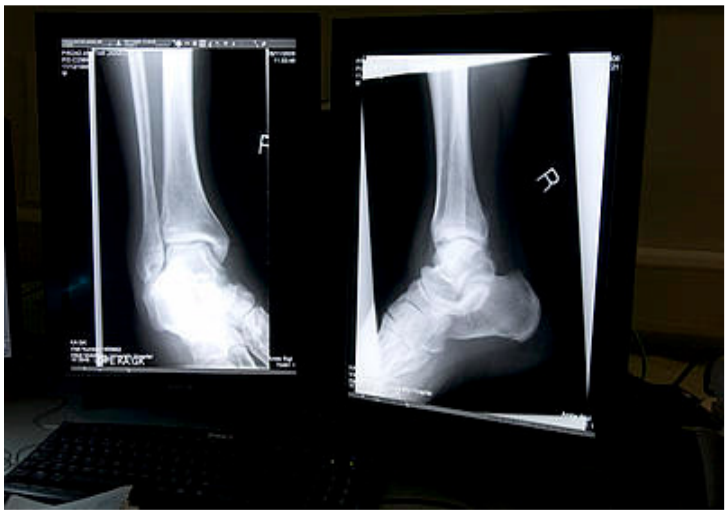
Statements of Assurance from the Board

These statements of assurance follow statutory requirements for the presentation of Quality Accounts, as set out in the Department of Health's regulations on Quality Accounts and the additional reporting requirements set by Monitor

Review of Services

During 2011/12, the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided 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 100 per cent of the total income generated from the provision of NHS services for 2011/12.

The Data reviewed covers the three dimensions of quality; patient safety, clinical effectiveness and patient experience



Clinical Audit

During 2011/12, 4 national clinical audits and 3 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 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which 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 was eligible and participated in during 2011/12 are;-

- NCEPOD - Peri-operative Care
- NCEPOD - Surgery in Children
- NCEPOD - Cardiac Arrest Procedures
- National Pain Audit - Chronic pain
- National Joint Registry - Hip, knee and ankle replacements
- National PROMs Programme - Elective surgery
- Bedside Transfusion (National Comparative Audit of Blood Transfusion)

The national clinical audits and national confidential enquiries that the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in and for which data collection was completed during 2011/12 are listed below alongside that number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit	Eligible to Participate	% cases submitted
National Enquiries		
Peri-operative Care (NCEPOD)	Yes	100%
Surgery in Children (NCEPOD)	Yes	100%
Cardiac Arrest Procedures(NCEPOD)	Yes	100%
Long Term Conditions		
Chronic pain (National Pain Audit)	Yes	100%
Elective Procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	80%
Elective surgery (National PROMs Programme)	Yes	100%

The reports of three national clinical audits published in 2011/12 that were relevant to this trust were reviewed and the Trust has put in place the following actions to improve the quality of healthcare provided:

National Joint Register - The trust has participated fully in the national joint registry with a high percentage of eligible patients (78%) submitted. There are no specific actions from the report but the trend data is in line with the trusts experience.

Peri-operative Care: Knowing the Risk (2011) NCEPOD - This NCEPOD report published in December 2011 highlights the process of care for patients who underwent inpatient surgery and their outcome at 30 days. The report and its recommendations have been reviewed by the Quality and Safety Committee.

Surgery in Children: Are We There Yet? (2011) - This NCEPOD report highlights the process of care of children who died within 30 days of emergency or elective surgery on the same admission. The report looks at areas where the care of patients might have been improved. Following the publishing of report work has been ongoing to complete a baseline review of the report by the Named Nurse for Safeguarding and other key paediatric medical staff.

The reports of 19 local clinical audits were reviewed by the provider in 2011/12 and the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Report Title	Action Plan / Recommendations
Scoliosis Imaging Protocol	1. Interactive dialogue with radiographers and Clinicians to draw up a new protocol.
Audit of Outcome of Medial Patellofemoral Ligament Reconstruction using the Leeds Keio Ligament	1. To discuss with relevant staff and devise a protocol to identify alternative treatments for patients unsuitable for the Leeds Keio ligament alone
Human Tissue Act	1. Estates to liaise with freezer alarm manufacturers to resolve problems 2. Person designate and Estates to identify cause of problem and solution 3. Designated room for research freezers to be identified
TJR/THR VTE	1. Reaudit after new/amended NICE guidelines are implemented
Bisphosphonates Audit	1. Review patients in clinic 2. Patients who report pain in their thighs are sent for X-Rays 3. Write to patients who reported a dental problem and advise them to see their dentist 4. Patients who report dental problems are referred for further investigation 5. Patients are appraised of risks prior to treatment 6. Review of patient information.
ORLAU Movement Analysis Service Referrer Review	1. Maintain or improve waiting times from referral to gait assessment – currently averaging 10 weeks 2. Maintain or improve reporting times – currently averaging 3 weeks 3. Send out written information to clinicians. Ensure website pages are informative. Publicise the service when opportunity arises 4. Annual session at Friday afternoon clinical conference 5. Invite clinicians to awareness day
An audit of Patient Reported Outcome of Tennis Elbow Surgery	1. Leaflets to be prepared 2. Discussion with the upper limb team

Report Title	Action Plan / Recommendations
Audit of the use of Radiographic Markers	1. Investigate the provision of metallic anatomical markers which can be used in X-Ray Room 1 2. Re-iterate the department policy regarding the use of electronic masking to all radiographic staff. Staff education 3. Re-iterate to all radiographic staff that use of anatomic markers within the primary beam is preferred and that use of annotated markers should only be employed as a "last resort"
Audit of the Physiotherapy Service for Duchenne Muscular Dystrophy	1. Purchase of two goniometers and ensure use. Re-train physiotherapists in the use of goniometers. Lead physiotherapist works in ORLAU and as such uses goniometry on a regular basis to assess joint range 2. Contact DMD families to assess need/interest in 4 monthly appointments via simple yes/no questionnaire 3. Visit local wheelchair services to clarify the need of DMD boys 4. In service training for the visiting physiotherapist will need to be undertaken at the Neuromuscular Centre, Winsford due to time constraints during clinic time at the RJAH Orthopaedic Hospital
CT guided Bone Biopsy: Results and their Interpretation	1. Inform all radiologists who perform bone biopsies 2. The CT biopsy report should include the details listed in the recommendations 3. The results of CT biopsy should be classified and analysed according to the new classification 4. For future audit
Child Protection Record Keeping Audit	1. Signature identifying document to be used for all children not on a pathway. Paediatric major surgical pathway to be completed, once adult pathway has been agreed. 2. Audit to be shared with MDT as a learning tool 3. Practice to be improved. 4. Update ward abbreviation list at least annually. 5. Audit to be shared with Therapy team as a learning tool. 6. Questions to be rewritten to allow for statistical comparison 7. Separate safeguarding page to be developed for inclusion in care pathways
Ponseti Clinic Outcomes	1. Focus on clinical technique including Tenotomy Rates, Cast complications, Number of casts
Audit of Pre-operative Chest X-ray (CXR) Reports	1. All pre-operative chest x-rays to be put through for reporting as no. 5 (or no. 4) for immediate/urgent report which when typed is also flagged up as requiring an urgent verification
GP Satisfaction Survey	1. Review requirement for additional consultants 2. Review with commissioners 3. Prepare and e-mail every 6 months 4. Messages to reassure 5. Review requirement for more clinics 6. Re-distribute direct dial numbers/website

Report Title	Action Plan / Recommendations
Management of Fallers Audit	1. 100% compliance/spot checks against compliance with management protocol for patients with high risk of falls 2. Referral and seen within 24 hours. Immediate attention provided by patient's own medical/surgical team members 3. Produce simple pamphlets/leaflets containing information of falls for patients 4. Close monitoring/spot checks against completion of FRASE Assessments
Rate of Positive CTPA's	To maintain the excellent rate of positive CT PA examinations.
Are the Orthopaedic Trainees aware of Healthcare Quality Improvement Partnership (HQIP)	1. Trainees read and follow the HQIP Information Leaflet to increase knowledge of HQIP 2. Trainees complete the online Clinical Audit Training
Acute Pain Audit (Early Mobilisation)	1. Review and assess patient's pain experience 2. Continue to review the assessment and management process 3. Review prescribed medication and audit anaesthetic compliance 4. Review and audit the early mobilisation of our patients and to ascertain the reasons associated with delay in mobilising 5. Audit patient satisfaction 6. Audit the management of the side effects associated with the analgesia on a daily basis
Reducing the Length of Stay for patients undergoing Arthroscopic Shoulder Surgery	1. To produce data for all surgeons in at re-audit in 18 months 2. Produce clear patient information regarding day surgery 3. Written information given in pre-op clinic and post discharge 4. Use newly published patient leaflet regarding post op multi modal analgesia 5. Ensure patients are aware of titrating the analgesia they have for more severe pain – on leaflet

Participation in Clinical Research

The number of patients receiving NHS services provided by the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2011/12 that were recruited in to National Institute for Health Research (NIHR) portfolio studies during that period was **477** against a target of **550** (**86.73**%).

Participants also contributed to local research studies (non-portfolio) approved by the Research Ethics Committee and the Trust. Participation in clinical research demonstrates the commitment of Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to improving that quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was involved in conducting **8** NIHR portfolio clinical research studies in musculoskeletal and cancer topic specialities during 2011/12.

There was a total of 22 medics and 12 members of the Nursing staff participating in research approved by a research ethics committee at the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust during 2011/12 (NIHR portfolio and non-portfolio studies). These staff participated in research covering Musculoskeletal, Cancer and Generic Relevance & Cross Cutting Themes.

As well, in the last three years, 5 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates the commitment of Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to testing and offering the latest medical treatments and techniques.

Commissioning for Quality & Innovation (CQUIN) Payment Framework

A proportion (1.5%) of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust contracted income from England in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and its Commissioners through the CQUIN (Commissioning for Quality and Innovation) payment. Further detail of the 2011/12 agreed goals and new goals agreed for 2012/13 are available online at:
http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275

The final value of the CQUIN schemes for 2011-12 was worth £620k, and the scheme overseen by the West Midlands Specialised Commissioner for our Spinal Injuries service was worth an additional £70k.

A summary of the 11-12 schemes is set out in the following tables.

1. Main CQUIN Scheme coordinated by Shropshire

(Value £620k)

Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)
VTE	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	15 %
Patient Experience	Improve responsiveness to personal needs of patients	10 %
Medicines Management	Improvements in Medicines Management linked to the DoH provider checklist for safer more cost effective prescribing (3 indicators)	15 %
Expected Date of Discharge	Improved recording of EDD in patient records and on the Hospital PAS, linked to patient engagement in agreeing EDD (2 indicators)	15 %
Out patient rescheduling and communication	An improvement in the administration of outpatient appointments, to reduce re scheduling and improve patient communication	15 %
Management of the Deteriorating Patient	Implementation of a modified trigger tool based on the national Alert Project	15 %
Productive theatre - pre op waiting and post op pain management	Reduction in waiting times in pre-operative anaesthetic area prior to operation and improving post operative acute pain management (2 indicators)	15 %

2 CQUIN Scheme coordinated by West Midlands Specialised Services

(Value £70k)

Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)
Reducing avoidable harm: VTE Prevention	VTE Prevention	10%
Patient experience	Improving outcomes from the adult in-patient survey	10%
Improving specialist rehabilitation services	Education on how Spinal Cord Injury complications can be avoided pre & post rehab	80%

The two national CQUIN Goals related to **Venous Thrombo Embolism (VTE) risk assessment** on admission for all inpatients, and the results of a subset of questions on **personal needs of patients**, extracted from the National Inpatient survey undertaken in late 2011.

The Trust was able to achieve the necessary target in the first by risk assessing over 97% of inpatients for VTE each month throughout the year, against a target of 90%.

Our previous high scores in the **National Inpatient Survey** meant that our agreed target with the PCT was to maintain or improve our score from the 2010 baseline of 82%, allowing for a margin of error in the sample of 5%. In the event our adjusted score in the relevant questions for 2011 was 80%, so we again exceeded the target.

Apart from the national CQUIN targets, the Trust also achieved the majority of the targets set with Shropshire Commissioners as part of the main scheme. The individual goals were:

Medicines Management – There were three separate elements to this – patient access to Certolizumab, giving written advice on post discharge NSAIDs (Non steroidal anti inflammatory drugs) and giving gastro protection to at risk patients taking NSAIDs. The first was achieved in full, the second was not achieved and the third partially achieved. (This means an underperformance of 7% on the CQUIN main scheme) This process is currently under review and will be included within the Medicines Management training for medical staff this year.

Expected Date of Discharge – Both elements of this goal have been achieved. Recording of EDD on PAS at admission was audited as 88% in January. Recording of the EDD in the paper notes with patient acknowledgement also averaged 88% in quarter 4.

Out patient rescheduling and communication – This goal has proved challenging – the Trust has successfully rolled out an appointment reminder process but the planned reduction in outpatient rescheduling requires further development, as the Trust was unable to achieve an improvement in quarter 4 against the quarter 1 baseline.

Management of the Deteriorating Patient – the implementation of the trigger tool for at risk inpatients (the ALERT project) has been achieved.

Productive theatre - pre op waiting and post op pain management – Two separate indicators were linked to improving the service in theatre by reducing delays in the theatre suite pre operatively and reducing self assessed pain scores post operatively. The PCT carried out a visit and inspection to confirm achievement of the former, and surveys of post operative patients have demonstrated success in the latter.

Overall then the Trust has delivered 85.5% of the main CQUIN scheme.

The scheme in place for the **West Midlands Specialised Commissioner** consisted of a single goal in addition to the successful VTE assessment and Inpatient survey result described above. This related to:

Improving specialist rehabilitation services – A number of different measures were in place for this CQUIN, to be achieved by milestone dates throughout the year. These included the organisation of a training day that was run at University Hospital Birmingham, and improved liaison between the Unit and hospital admitting patients with suspected spinal cord injuries to reduce the risk of pressure sores. The final Q4 result from the specialist commissioner will not be available until May, but to date the CQUIN has delivered 100% of the expected income.

CQUIN Scheme for 2012/13

The (agreed) goals and indicators are summarised in the table below. The main scheme will represent 2.5% of English contract income, an increase from 2011/12, and valued at approximately £980k. There is also a smaller scheme for the Specialised Commissioner. This is linked to the Spinal Injuries service and valued at approximately £200k. As a result of the increase in value, the scope and scale of the CQUIN schemes will become even more challenging in 2012/13.

Main Scheme coordinated by Shropshire PCT

Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)
VTE (National)	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	5%
Patient Experience (National)	Improve responsiveness to personal needs of patients	5%
NHS Safety Thermometer – (National)	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and Venous-thromboembolism (VTE)	5%
Improving Diagnosis of Dementia in Hospitals (National)	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting (3 indicators)	5%
VTE- Audit of at risk patients	Percentage of adult inpatients assessed to be at risk of VTE who receive appropriate prophylaxis in accordance with NICE guidance	10%
Productive theatre	Reduction in turn round time between cases in main theatres	15%
Making Every Contact Count	Number of NHS staff completing locally agreed training in delivering brief advice as required to implement the Making Every Contact Count ambition	15%
Net Promoter Question	Real time feedback to support the Patient Revolution work as embedded in the SHA Ambitions	15%
Mental Health/Wellbeing Awareness for Medical and Nursing Staff	Increase knowledge base and skills of medical and nursing staff in the spinal unit to recognise the need for specialist intervention for patients with suicidal thoughts/intents	10%
Medicine Management	Improving discharge information to GP's - renal function / allergies / TTO supplies (3 indicators)	15%

Scheme coordinated by West Midlands Specialised Commissioner

Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)
VTE (National)	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	5%
Patient Experience (National)	Improve responsiveness to personal needs of patients	5%
NHS Safety Thermometer – (National)	Improve collection of data in relation to pressure ulcers, falls, and urinary tract infection in those with a catheter.	5%
Improving Diagnosis of Dementia in Hospitals (National)	Improve awareness and diagnosis of dementia, using risk assessment, in a acute hospital setting (3 indicators)	5%
Implementation of clinical dashboards for specialised services	Ensuring that providers implement and routinely use the required clinical dashboards for specialised services	10%
Acute SCIC Outreach to newly injured patients	Taking the SCI service to newly injured patients / Support for ventilated patients / Waiting List reporting	70%

Statement from the CQC

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 enforcement action against the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust during 2011/12.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2011/12.

Data Quality

The Trust will be working to further improve data quality in 2012/13.

The Data Quality Team continues to monitor and investigate any data quality issues that are identified on our electronic patient administration system to assist in the delivery of high quality, reliable data.

In addition to this the Data Quality team will focus on the following:-

- Continue to raise awareness and profile of data quality
- Develop a robust Audit framework
- Work with key stakeholders in reviewing and ensuring that the information that supports the KPIs reported to the Board report is constantly being reviewed. The aim of this is to ensure that the data is of an agreed acceptable level regarding quality and robustness. This will be extended to cover any other areas of reporting not covered by those reported to the board.

The Trust submitted records during April 2011 – January 2012 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patients care
- 99.9% for outpatient care

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

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

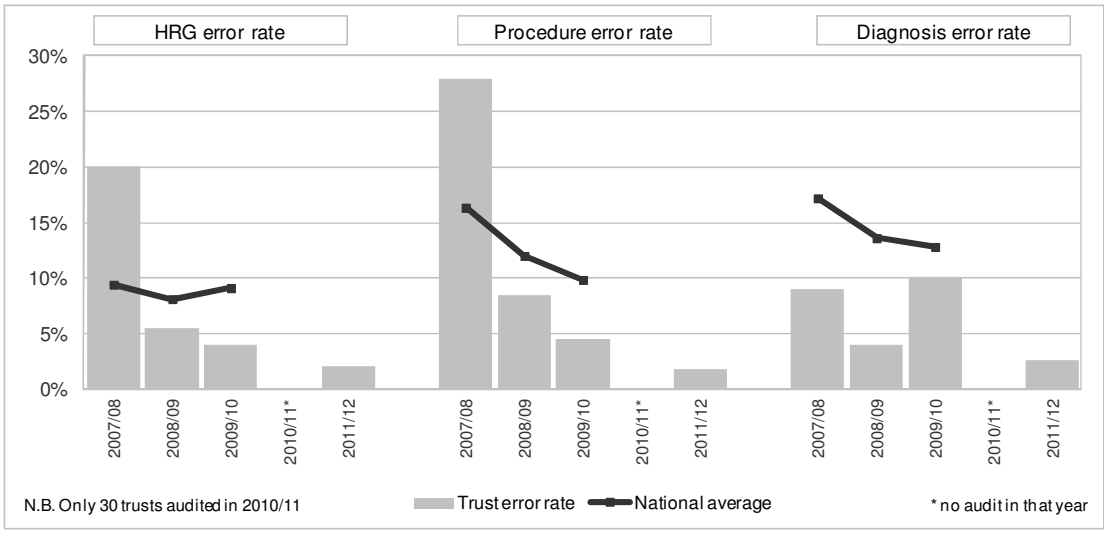
Information Governance Toolkit Attainment Levels

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust's Information Governance Assessment Report score overall for 2011/12 was 75% with an overall outcome of 'Satisfactory' (Level 2).

Clinical Coding Error Rate

The Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust was subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission. The excellent outcome of the audit is shown in the table below, while the graphs show the improvement over time and put the result in the national context.
NB these results should not be extrapolated further than the actual sample size.

Area audited	% Procedures coded incorrectly		% Diagnoses coded incorrectly		% of episodes changing HRG	% of spells changing HRG
	Primary	Secondary	Primary	Secondary		
Locally determined specialty – Trauma and Orthopaedics	5.0	0.8	2.0	2.8	3.0	3.0
Random selection from SUS	1.0	0.0	0.0	5.2	1.0	1.0
Overall	3.0	0.5	1.0	4.1	2.0	2.0



Review of Quality Performance

1. Indicators of Quality

The following outlines our performance against indicators set by the Department of Health, based on recommendations by the National Quality Board. They align closely with the NHS Outcomes Framework and are all based upon data that the Trust reports nationally.

Indicator 1 – Helping people to recover from episodes of ill health or following an injury

1. Patient Related Outcome Measures (PROMs)

PROMs measures used at Robert Jones and Agnes Hunt (RJAH) Orthopaedic Hospital are the Oxford joint specific score forms. They consist of a 48 point questionnaire – with 0 being the worst imaginable case and 48 = no problems with the joint. The score is taken just prior to the operation and nationally these are checked by the DoH independently at 6 months. We check directly with the patient at 12 months as part of our standard patient care package.

The RJAH Orthopaedic Hospital is the second largest provider of replacement hips and knees in England and has an excellent record of providing data to the Department of Health (DH) for the Patient Reported Outcome Measures (PROMs) program. The trust consistently returns the highest number of completed forms in the country and we have been mentioned several times as an example of good practice.

The DH publish monthly figures reporting on the 6 month outcomes of all hip and knee replacements in England and the trust average joint improvement scores are above the national average and rate highly amongst the select orthopaedic specialist hospitals. It is important to recognise that this is achieved despite the complexity and tertiary referrals the trust deals with.

The figures shown are the national comparison after 6 months, the actual joint improvement continues and the 12 month score increase is higher still.

Mean 6 months Oxford Hip Score Increase for Primary Hip replacement surgery

RJAH	National
22.35	19.72

Mean 6 months Oxford Hip Knee Score Increase for Primary Knee replacement surgery

RJAH	National
16.33	14.88

2. Emergency Readmissions to hospital within 28 days of discharge

Whilst some emergency re-admissions following discharge from hospital are an unavoidable consequence of the original treatment, others are could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self care.

Previous analyses have shown wide variation between similar NHS organisations in emergency readmission rates. By monitoring NHS success in avoiding (or reducing to a minimum) readmission following discharge from hospital, the NHS may be helped to prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from organisations with low readmission rates.

The indicators measure emergency admissions to hospitals in England occurring within 28 days of the last, previous discharge from hospital. Data is provided for around 700 health and local government organisations in England and there are five emergency readmissions indicators:

- fractured proximal femur
- hip replacement surgery
- hysterectomy
- stroke
- 'all readmissions'

In November 2011 the latest figures for the 2009/10 financial year were published by the NHS Information Centre. The results show that nationally:

- Emergency readmission rates were significantly higher for stroke and fractured proximal femur than for hysterectomy, primary hip replacement surgery and 'all readmissions' (16-74 age group).
- Primary hip replacement surgery had the lowest emergency readmission rates of the four procedures/diagnoses investigated.
- Emergency readmission rates were significantly higher for men than for women for fractured proximal femur, primary hip replacement surgery and 'all readmissions' (16-74 age group). There was no significant difference in the stroke readmission rates for men and women.

RJAH Orthopaedic Hospital Emergency Re-admission rates for 2009/10 financial year as published by the NHS Information Centre:

RJAH	National
5.05%	10.33%

Between April 2011 and February 2012 only 1.14% of patients were readmitted to RJAH within 28 days of discharge.

Indicator 2 – Ensuring that people have a positive experience of care

1. Responsiveness to inpatients' personal needs

Patient experience is a key measure of the quality of care. The table below shows the score achieved by the Trust in the CQC National Inpatient Survey 2011. The score is based on the average of answers to five questions:

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

	2003	2005	2006	2007	2008	2009	2010	2011
RJAH	78.5	81.8	76.6	79.3	78.5	78.7	82.5	**80.4**
SHA	68.6	69.2	67.2	67.4	68.2	67.5	68.5	68.2
National	67.4	68.2	67.0	66.0	67.1	66.7	67.3	67.4

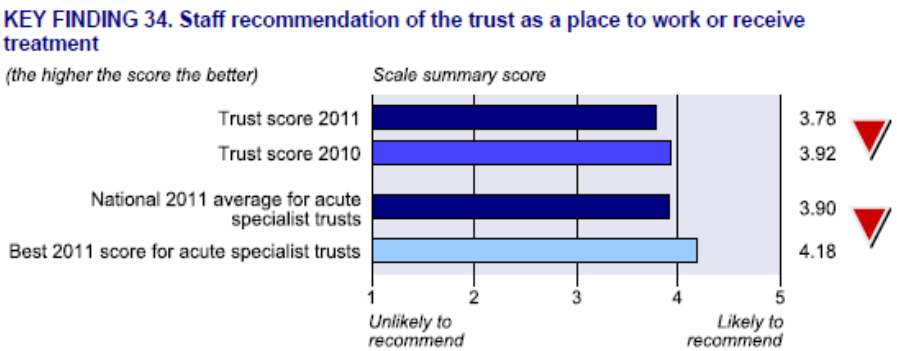
Trust score compared to other Trusts within same SHA
(CQUIN 2011 Scores based on Adult 2011 Inpatient Survey data)

2. The table below shows the score achieved by the Trust in the CQC National Inpatient Survey 2011. The score is based on question –
"Would you recommend this hospital to your family and friends?"

	This Trust		All Trusts	
All Patients	**n**	**%**	**n**	**%**
Yes, definitely	538	**92.4**	16137	**66.6**
Yes, probably	34	**5.8**	5963	**24.6**

3. Percentage of Staff who would recommend the provider to friends or family needing care
How members of staff rate the care that their employer organisation provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time.

This indicator is taken from a question with the annual NHS Staff survey.

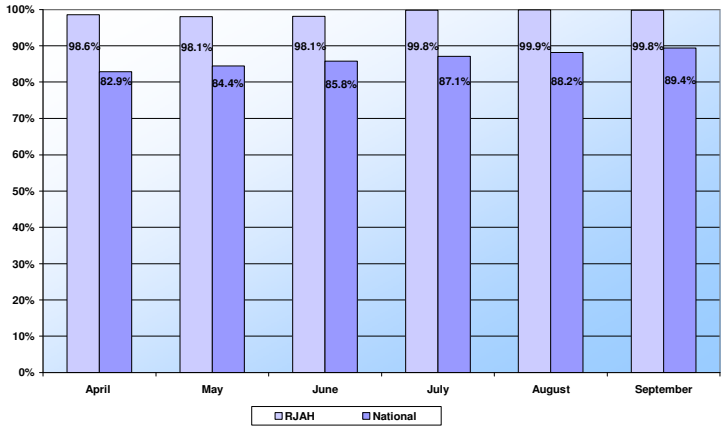


Indicator 3 – Treating and caring for people in a safe environment

1. Percentage of admitted patients risk assessed for Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE). A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg and if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a potentially fatal blockage (PE). In 2005 the House of Commons Health Committee reported that an estimated 25,000 people die from preventable hospital-acquired VTE in the UK every year. The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients and prescribing them appropriate prophylaxis (preventative measures).

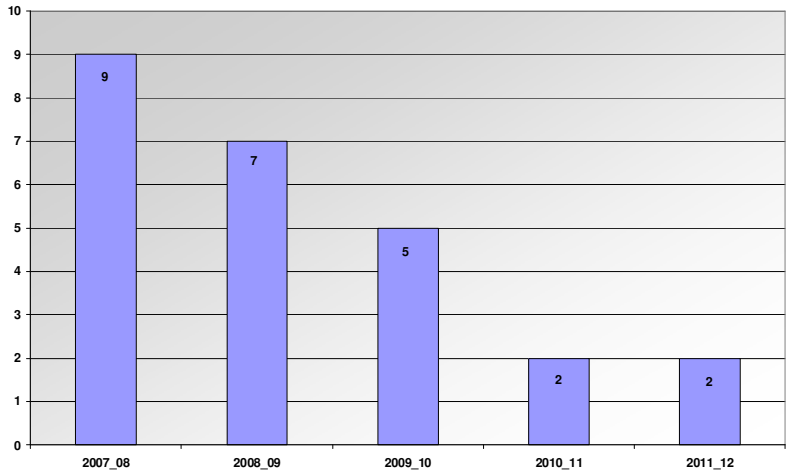
Percentage of admitted patients risk-assessed for VTE



2. Rate of C. Difficile

Clostridium Difficile is a common cause of hospital acquired diarrhoea. It is bacteria that are harmlessly present in the bowel of 3% of healthy adults, and up to 30% of elderly patients. When certain antibiotics disturb the balance of bacteria in the gut, Clostridium Difficile can multiply rapidly and produce toxins which cause diarrhoea and illness.

Number of C. Difficile cases (2007 – 2012)



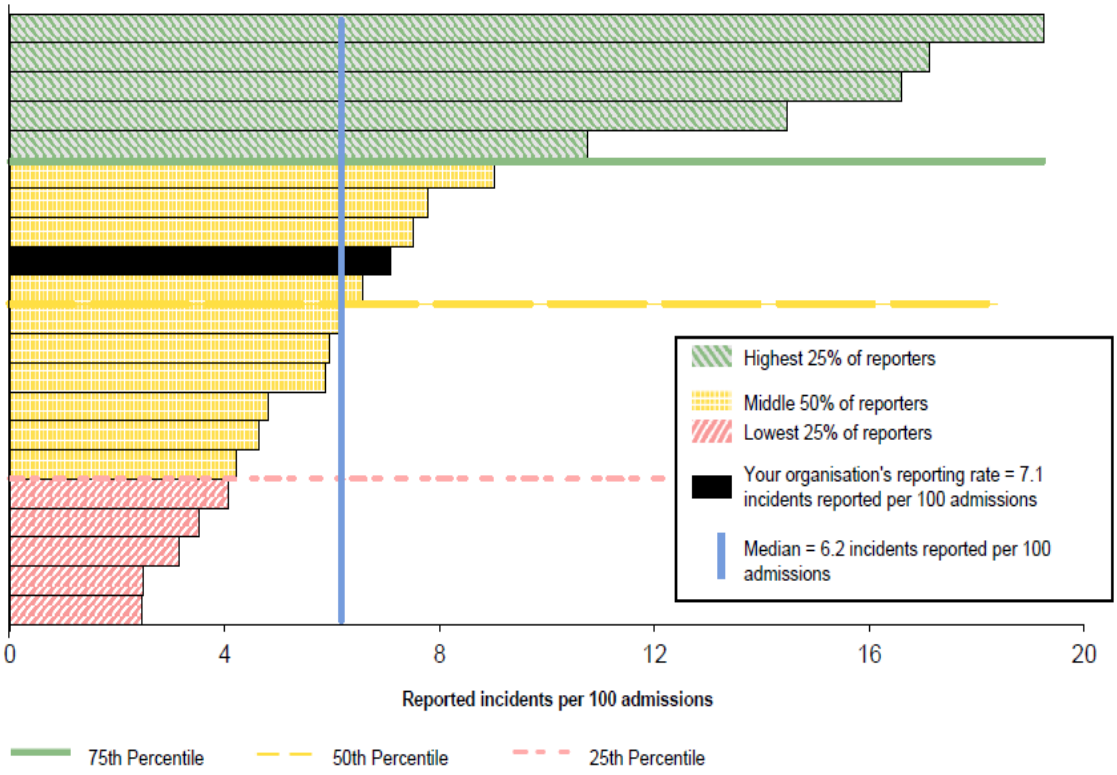
This data is governed by standard national definitions.

3. Rate of patient safety incidents and percentages resulting in severe harm or death

An open reporting and learning culture is importance to enable the NHS to identify trends in incidents and implement preventative action.

Some patient safety incidents are reportable to the National Patient Safety Agency. The comparative reporting rate summary shown below provides an overview of incidents reported by RJAH to the National Reporting and Learning System (NRLS) between 1 April 2011 and 30 September 2011. *(508 incidents were reported during this period.)*

Figure 1: Comparative reporting rate, per 100 admissions, for 21 acute specialist organisations.



Source: Organisation Patient Safety Incident Report (NPSA)

The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the numbers of incidents resulting in severe harm or death should reduce.

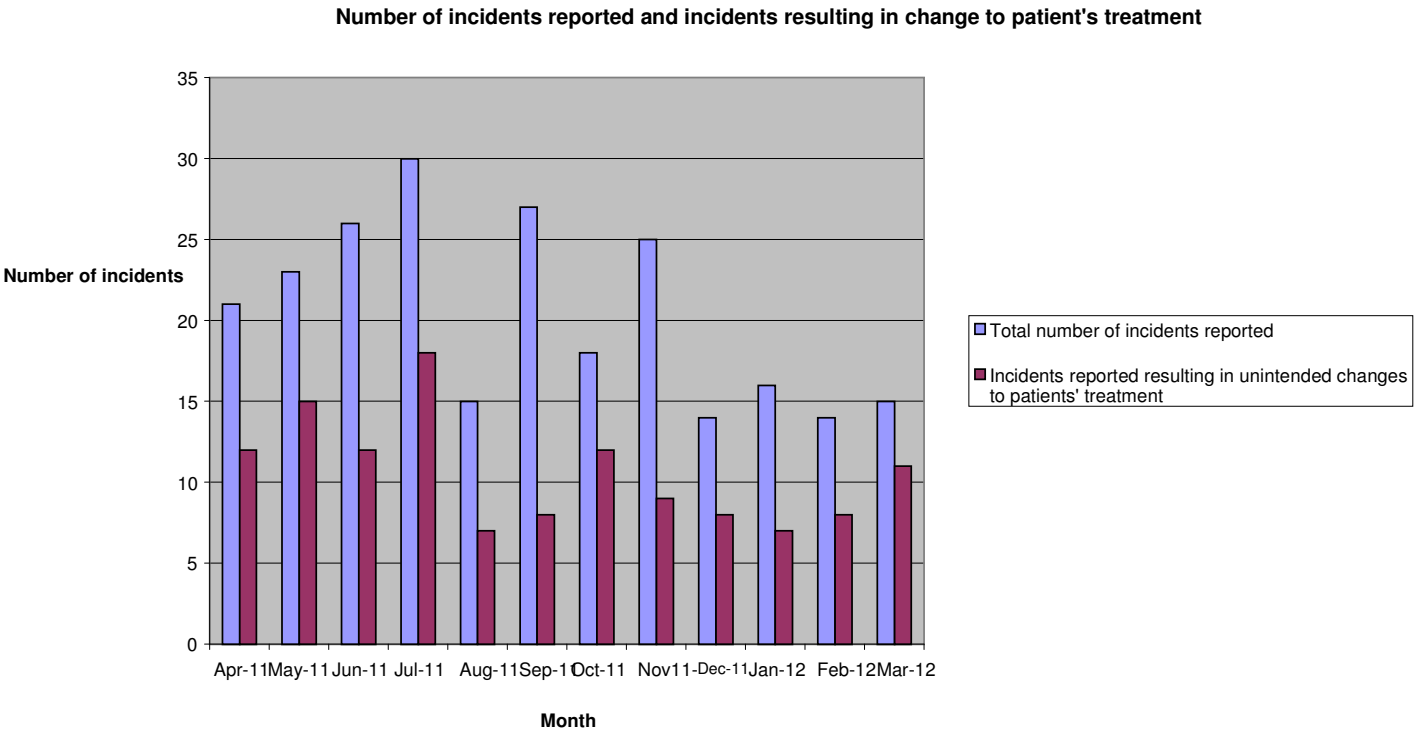
2. Patient Safety

Medication report for 2011-2012

The trust encourages reporting of medicines related incidents as this ensures that areas of weakness can be identified and remedial action implemented. As a result of incidents reported the trust has implemented new procedures and has been able to provide targeted medicines management training. All nursing and medical staff are required to complete annual medicines management training. This is delivered in face to face sessions and via online training packages. Each incident is investigated by the trust's Medicines Management Co-ordinator and feedback given to individuals involved in order to foster lifelong learning. In 2011-12 an adult drug assessment workbook and IV medicines competency workbook has been trialled. Completion of theses will be mandatory for all new staff from April 2012 as will attendance at an IV training day.

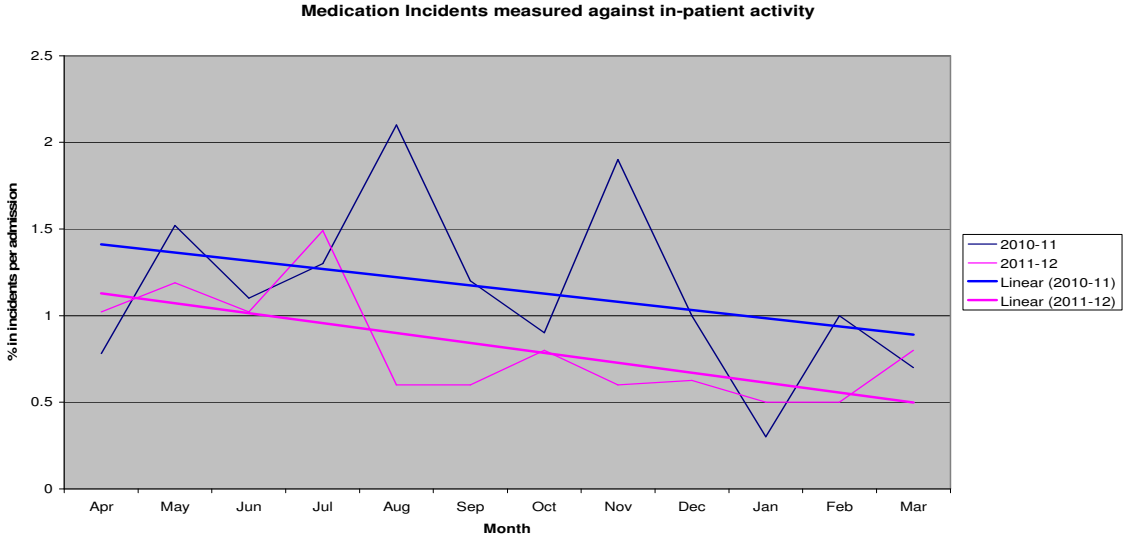
During 2011-12, 244 incidents involving medicines were reported. Of these 127 resulted in an unintended change to the patient's treatment as shown in graph 1.

Graph 1



Graph 2 represents medication incidents measured against in-patient activity showing a continued downward trend, though as with the previous year, the month on month figures do vary.

Graph 2



Medication incidents are categorised as shown in Table 1 into Prescribing, Administration, Dispensing and Other incidents.

Table 1 Stage in medication process

Stage in medication process	**Apr 2009 - Mar 2010**		**Apr 2010 - Mar 2011**		**Apr 2011 – Mar 2012**	
Prescribing	44	24%	62	36%	27	21%
Administration	95	52%	95	55%	69	54%
Dispensing	22	12%	15	9%	20	16%
Other	21	12%	0	0%	11	9%
Total	**182**	**100%**	**172**	**100%**	**127**	**100%**

75% (96) of incidents are either administration or prescribing incidents which is a reduction compared with last year. Prescribing incidents have decreased since last year, however dispensing incidents have increased.
The increase in dispensing incidents has occurred for several reasons including increased workload and introduction of new services within the trust. No patient harm occurred as a result of dispensing incidents. The trust is continuing to monitor all incidents and where needed working practices are changed to prevent recurrence. Staff involved with incidents are given support to learn form the incident and improve future practice.

As a result of incidents reported and a review of the patient pathway a pharmacist is now directly involved in the preoperative assessment clinic. Surgical inpatients are reviewed by a pharmacist in clinic prior to admission to assess any changes which need to be made to a patient's medication before surgery.
This ensures that any medicine related issues can be dealt with before admission and provides patients with the opportunity to ask questions about their medicines.

Resuscitation training

The Trust provides training internally on Basic Life Support (BLS), Immediate Life Support (ILS), Paediatric Immediate Life Support (PILS) and Advanced Life Support (ALS). ALS, ILS and PILS continue to be offered to outside agencies as a source of income generation.

In 2011/12, the following training was provided internally:

Basic Life Support:
225 members of staff (Target 292)

Advanced Life Support:
14 members of staff (Target 23)

Intermediate Life Support
255 members of staff (Target 353)

Paediatric Life Support
152 members of staff (Target 41)

We will be monitoring attendance against a quarterly target, to ensure a significant improvement in resuscitation training in 2012/13.

Human Tissue Act

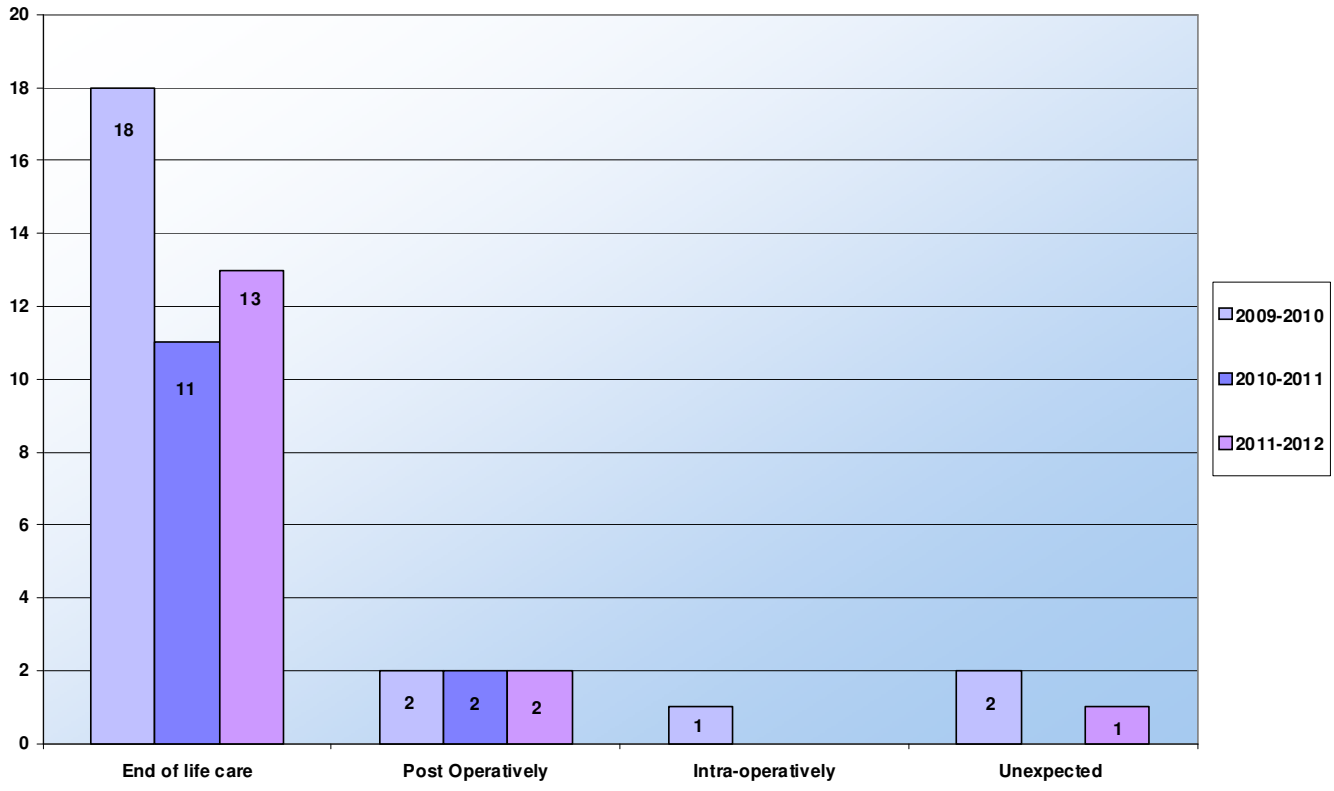
In March 2011 the Trust had undergone an audit and inspection to assess compliance against the requirements of the Human Tissue Act. The final report was published by the Human Tissue Authority in June 2011. An action plan was developed to address one significant shortfall that had been identified and a small number of minor areas for improvement or clarification. These were addressed within three months and the Human Tissue Authority has confirmed its assurance of our response. The next inspection will be due in March 2013 as part of the rolling biennial programme of inspections.

Mortality

The standardised mortality rates for hospitals, produced nationally by Dr Foster are not applicable to small specialist Trusts like the RJAH Orthopaedic Hospital, because the numbers of deaths are too small for change to be statistically significant.

However, there has been ongoing monitoring of all deaths which occur within the Trust for some years now and the graph below outlines the number of deaths that have occurred over the past three financial years, commencing in April 2009 and ending in March 2012. The hospital has one medical ward which cares for Elderly patients following transfer from Shrewsbury Hospital and clearly contributes to the higher profile in end of life care.

Mortality rates April 2009 – March 2012

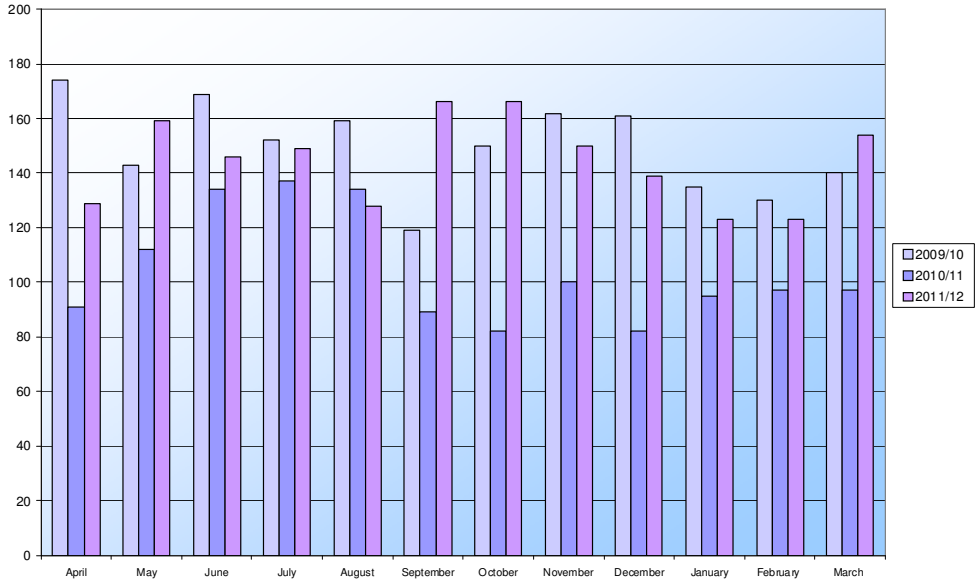


All deaths are case-reviewed as part of the Morbidity & Mortality section at the twice-yearly Multi-Disciplinary Clinical Audit Meetings, and are thoroughly examined as part of the discussion forming the Deterioration Recognition Group. All post-operative, unexpected and intra-operative deaths are recorded as Serious Incidents and are investigated in accordance with the Trust Serious Incident Policy which are reviewed and agreed by the Quality and Safety Committee.

Incidents

The Trust continues to use the Datix Risk Management system for incident reporting purposes, allowing aggregation of data on a regular basis and robust monitoring of incident investigations including any root cause analysis undertaken and changes in practice implemented.

All incidents reported April 2009 March 2012

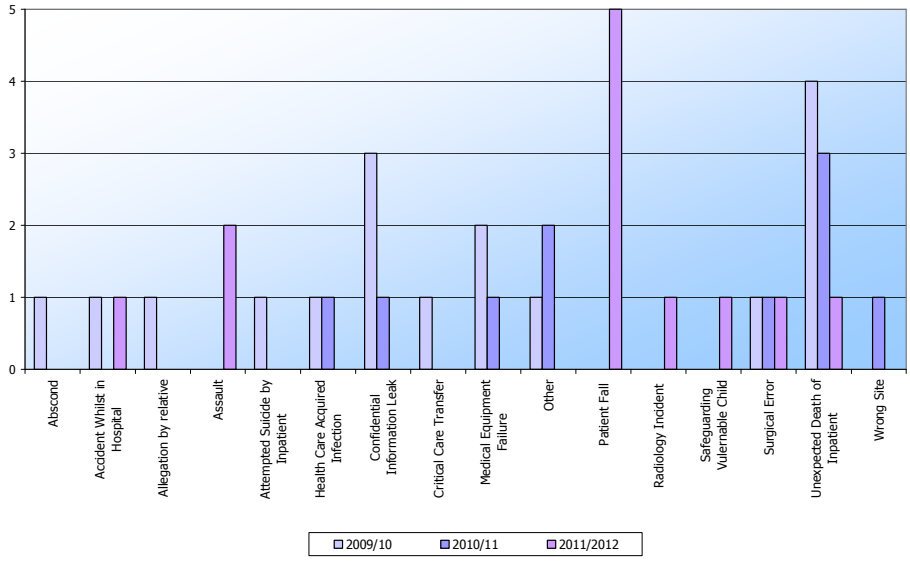


Investigations are undertaken as appropriate for every incident that occurs within the Trust and reports are provided to Divisional Meetings, and a number of Trust Committees. The Trust Board are notified of any trends and themes and are provided with Data on Serious Incidents. The Trust meets with the Coordinating Commissioners on a monthly basis where all incidents are shared with them.

Serious Incidents

The Trust reported twelve serious incidents to the lead commissioner and strategic health authority in 2011/12 via the National Patient Safety Agency (NPSA)'s reporting system. A full investigation was carried out for each incident and action plans put in place.

Breakdown of Serious Incidents from April 2009 to March 2012



Hospital-acquired infections

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a well known health care associated infection. It is estimated that 3% of people carry MRSA harmlessly on their skin, but for hospital patients the risk of infection may be increased due to wounds, or invasive treatments which make them more vulnerable. Serious MRSA infection may result in MRSA blood stream infections (bacteraemia). The Trust's MRSA blood stream infection target for 2011/12 continued to be 0. Since 2006 the Trust had no MRSA bacteraemia infections.

Surgical Site Infections

Studies have shown that surgical site infections account for up to 20% of all hospital acquired infections and that in the region of 5% of all patients who undergo a surgical procedure develop a surgical site infection (NICE, 2008).

A significant amount of surgical site infections present after the patient has been discharged from hospital. Therefore there is also a significant burden placed on community care providers such as general practitioners and district nurses in dealing with this preventable complication. Many surgical site infections are preventable and measures can be taken before, during and after surgery to reduce the risk of infection (NICE, 2008).

The Trust collected the following Surgical Site Infection data between January and December 2011:

Procedure	Number of procedures	Number of infections	Percentage	Comparable average *
Total Hip Replacement. All four quarters	1425	11	0.8%	1.0%
Total Knee Replacement All four quarters	1365	7	0.5%	0.9%
Spinal Surgery (data collected between July and September 2011)	155	1	0.6%	1.3%

National Average of hospitals who did not complete post discharge questionnaires.

Wound Clinic

A wound clinic was commenced in August 2011; the clinic is for all patients who have post surgical wound problems. The aim of the clinic is to enable post discharge surveillance and to prevent patients being prescribed inappropriate antibiotics and readmissions. It is held three times a week and has proved to be a very valuable service for the patients.

Health & Safety

There have been zero Fire incidents against a target of zero.

There have been a total of five RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable accidents.

Health and Safety Plan 2012

A review and audit of the Trust Health and Safety Management System, to include:
A review of all H&S policies and procedures to take place
A review of existing Risk Assessment processes and local Risk Awareness training to take place for Managers and staff
DATIX training and incident reporting training to be carried out for Managers and staff.
Risk Register co-ordination within the Trust.

Benchmarking of the Trust exposure to risk and integrate evidenced best practice

Safeguarding

The Trust has recently appointed a New Director of Nursing who will be the Executive lead for safeguarding children and young people. She will continue to lead on the Trust Safeguarding Committee to ensure that the Trust meets its full range of obligations with regard to Children, young people and vulnerable adults. A Named professional or Executive lead also attends the County wide Named nurse, Health governance safeguarding children committee and until recently also represented on the Shropshire safeguarding children board meetings. Attendance to this meeting is currently under review by the Shropshire Safeguarding children Board (SSCB) and it is envisaged the Health Governance group will be a sub group to the board and will no longer require board representation from this Trust.

The Trust had a Quality visit in October 2011 following a number of complex safeguarding cases. This visit was undertaken by The West Mercia NHS cluster and they have identified a number of actions that need to be addressed by the Trust. An action plan has been commenced and needs to be worked through with the new Executive lead for safeguarding children.

Safeguarding Children training, levels one and two, continue to be provided by the named nurse and three other Trust trainers. The majority of staff have now been trained to level one and level two training is mainly provided as an e learning package for all clinical staff. All paediatric staff undertake level 3 developing practice modules externally and these are booked on a rolling programme. Our Named nurse and doctor are both trained to level 4 and the Trust Board received training in October 2011.

This year has seen an increase in child protection referrals from the Trust and one has been reported as a serious incident. As a result of this increase in workload, supervision for the named nurse was increased and cascaded to other staff involved in these cases.

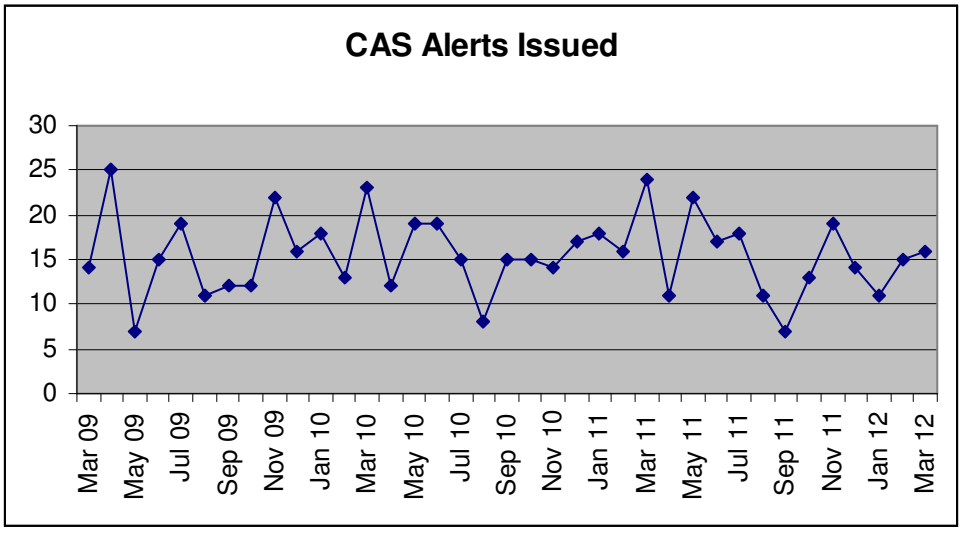
Safeguarding Adult Training has been delivered on induction and is part of the annual statutory E-Learning programme. This training is mandatory for all Trust employees. Training has also been provided on the Mental Capacity Act and the legislation regarding Deprivation of Liberty.

A full review of all safeguarding processes across the Trust will be undertaken in 2012/13.

Central Alerting System alerts

The Central Alerting System (CAS) is the web-based portal for distribution of safety alerts from the Department of Health (DoH) to NHS Trusts. All Medical Device Alerts (MDA), Estates and Facilities Alerts (EFA) and National Patient Safety Agency (NPSA) alerts are received by the Trust though the system.

The number of alerts issued have stayed consistent over the last 3 years, averaging over 15 a month.



The Trust has so far received 174 CAS alerts in 2011/12 down from the 192 that were received in total over 2010/11. Fig 1. tabulates the alert status at 31st March 2012. The Risk Officer is responsible for the distribution and administration of the CAS system. All of the CAS alerts received this year were actioned within the specified timeframe.

Fig.1

2011/12 CAS Alert Status				
Originated By	**Action Completed**	**Action Not Required**	**Assessing Relevance**	**Response Not Required**
CMO Messaging				21
DH Estates and Facilities	1	7	2	
MHRA Dear Doctor Letter				1
MHRA Drug Alerts				37
MHRA Medical Device Alerts	9	89	3	
National Patient Safety Agency	2	1		
Others				1

3. Patient feedback about the care provided

This section reviews and summaries Trust activity related to all areas of patient experience from April 2011 to March 2012 including:

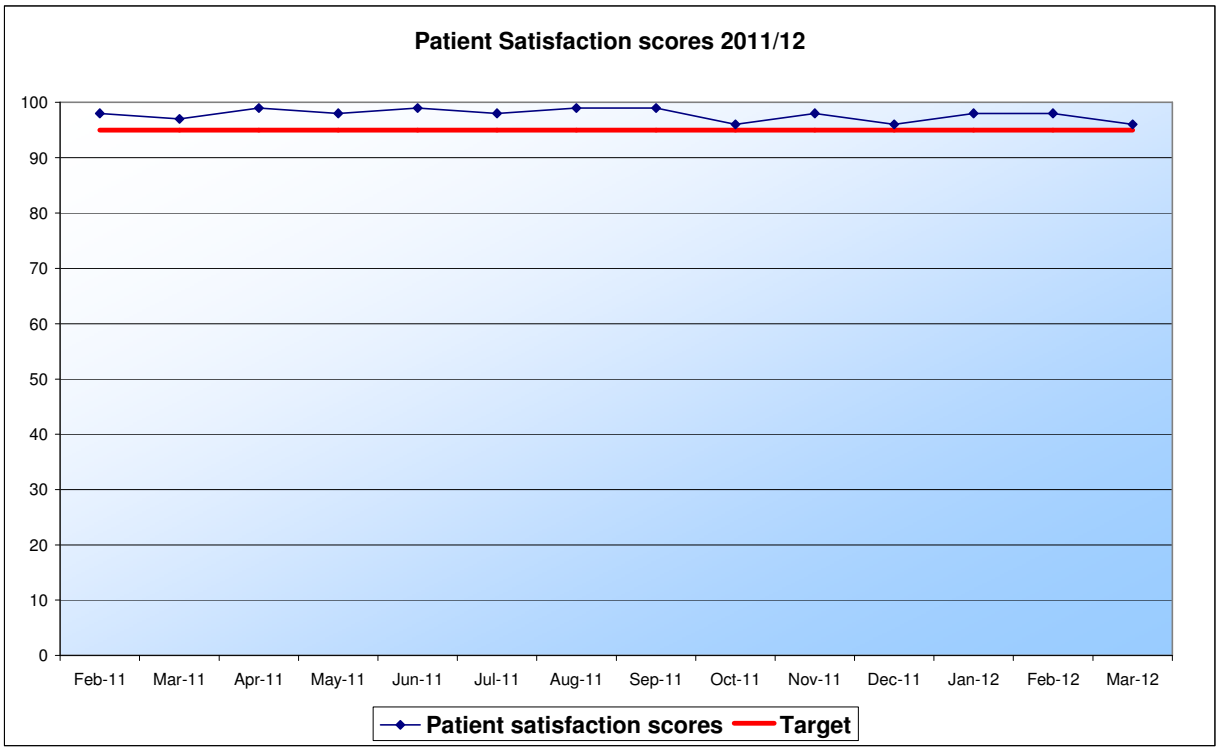
a. Complaints and Local Resolutions, PALS activity, Patient comments

b. Patient Panel activity

c. Patient feedback via other sources such NHS choices, patient stories

Patient Feedback

On average since April 2011, 98% of patients have successfully scored the Trust excellent or good, across all wards when asked to rate their overall experience on the Trust comment card.



"Very impressed"
– Alice Ward

Couldn't have expected more help and support staff very friendly and supportive and very helpful thank you"
– Menzies Unit

Comment cards

A sample of compliments collected from Comment Cards

"Thank you all so much for your excellent care and kindness for looking after me above and beyond the call of duty" **– Ludlow Ward**

"This hospital is the best hospital and cleanest that I have been in"
– Sheldon ward

"Excellent treatment, care and kindness from everyone on the ward"
– Powys Ward

"I have attended this hospital for 23 years and the service, quality of food and staff just gets better and better. Excellent"
– Gladstone Ward

"Staff very friendly, welcoming, helpful and an excellent ambassador to the hospital" **– X-ray**

"I cannot praise the staff enough and the surgical team, everyone involved in the ward. The bedside manner of all made me feel special Nursing and surgery at its finest"
– Ercall Ward

"A very thorough, well managed place providing reassurance and confidence. Thank you."
– Pre-op Unit

"I feel that I am very lucky to be referred to RJAH. The expertise and standards of nursing care are second to none, no wonder they are recognised as a centre of excellence"-
Clwyd Ward

"All the staff are fantastic especially after my operation very kind and caring nothing is too much trouble for them" **– Kenyon Ward**

"Excellent hospital, staff were brilliant could not fault anything" **– Outpatients**

"Couldn't fault the department was made to feel very comfortable and secure when I was very anxious"
– High Dependency Unit

"All the staff on the programme have gone out of their way to ensure that I have been well looked after" **– Physiotherapy**

The patient satisfaction score is calculated from the percentage of excellent and good ratings scored on the Trust comment card in response to a question about overall care.

- The total number of cards returned for April – March 2012 was 2316. This is 94 less than the same period last year.

- Patients scored an overall monthly average of 98% of excellent or good when asked to rate their overall care.

- From the written comments 1026 (75%) were complimentary and 345 (25%) were negative or suggestions for improvement.

- There were 15 service improvements made on wards following a manager's investigation into a negative comment.

The main areas for suggested development/improvement were:-

- Aids and appliances, equipment, premises (including access) and poor ward environment (including bathrooms, lockers, temperature, day room facilities, natural light on some bays in Clwyd ward, noise at night, visiting times, TV facilities, wifi, radio, space between beds), sign posting, car parking and access.

- Waiting times in Pre-op or outpatients

- Quality of food includes choice, quality, temperature and loss of menu cards and did not get what ordered

- Some aspects of treatment (mainly perceived lack of nursing staff)

- Poor communication/information to patient includes written and oral

- Waiting times for operation on day of surgery

- Staff attitude, nursing medical and admin

Summary of Activity by month

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Complaints 2010/11	3	6	11	8	8	3	5	5	6	3	6	12	**76**
Complaints 2011/12	3	9	6	7	6	12	10	2	8	5	10	10	**88**
Local resolution 2010/11	4	6	5	4	8	4	5	4	3	4	4	6	**57**
Local resolution 2011/12	4	3	4	2	4	4	0	0	2	2	3	1	**29**
Pals concerns 2010/11	11	30	31	23	20	15	17	21	18	17	18	17	**238**
Pals concerns 2011/12	21	28	30	18	21	30	35	32	12	36	44	25	**331**

PALS contacts

- For April 2011 to March 2012 there were 931 PALS contacts, 108 more than the previous year, a 13% increase.
- Of these 931 PALS contacts 331 were PALS concerns, (36%) and 600 were information requests, (64%). An average of 28 PALS concerns per month were received.
- The information requests include general enquiries made by patients on the Trust website. Examples of why patients contact PALS for help or advice include; how to make a referral to the hospital, waiting times, changes to appointment dates, asking for staff contact details, enquiries for stem cell treatment, private patients, work experience placements, queries a patient has about their medical treatment, compliments, transport queries, travel expenses reimbursement, patient information, how to complain, benefit advice, patient support, interpreting services, FOI requests, how to access their medical records, accommodation requests and selective dorsal rhizotomy treatment.

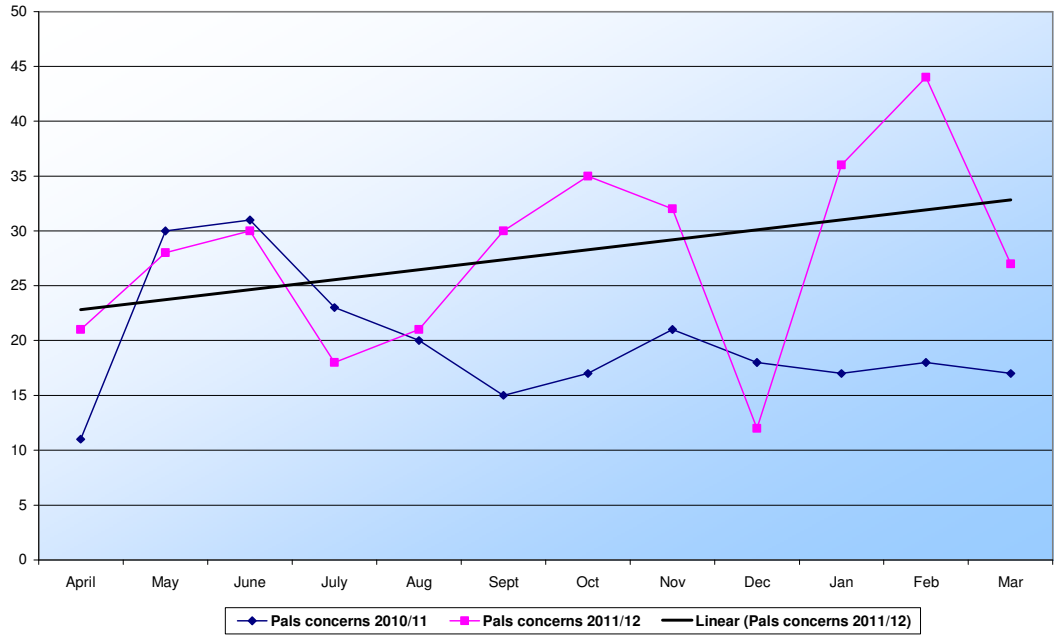
April 2011 – March 2012			
	2011/12	2010/11	Difference
Total PALS contacts	931	823	108
Information requests	600	585	15
PALS concerns	331	238	93

- The PALS concerns have increased from the previous year by 93 (39%). Patients are contacting PALS with more complex enquiries where a patient would like to raise a concern but not make a formal complaint. PALS staff investigate patient's concern and reply to the patient. Examples of this include explaining why an operation was cancelled, waiting for treatment dates, waits on the ward for medication or call bell, staff attitude, lack of Physiotherapy care, not enough information on discharge.

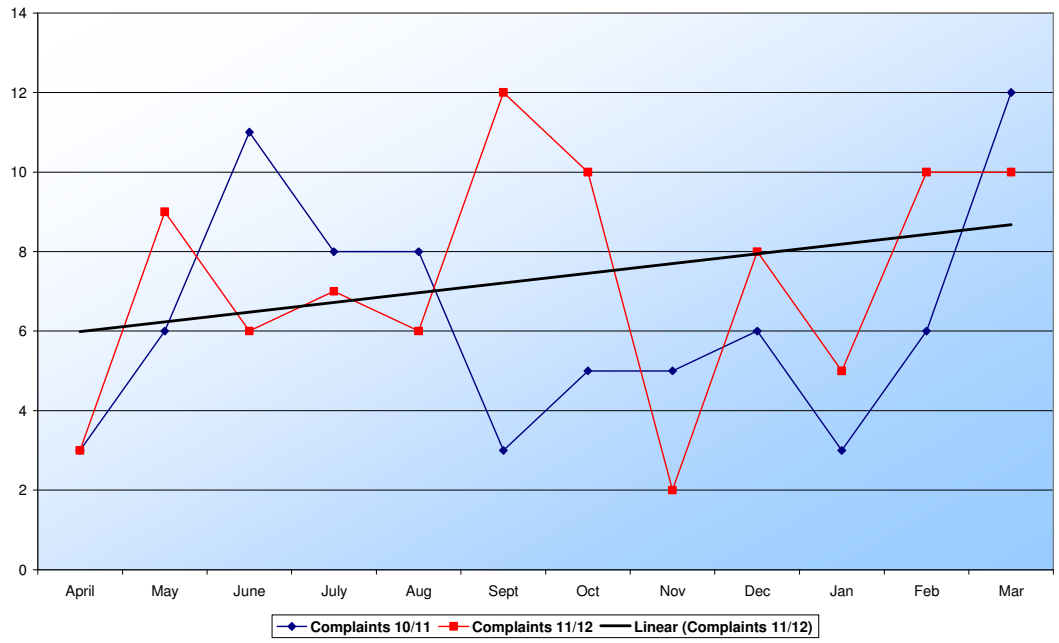
The top 5 reasons for patients contacting PALS (after information requests) are:

- Outpatients Appointments - delay/cancellation, (mainly for spinal disorder, upper limb and Arthroplasty) - 121
- Inpatients Appointments - delay/cancellation - 64
- Some aspects of treatment - 42
- Communication / information to patients - 34
- Attitude of staff - 15

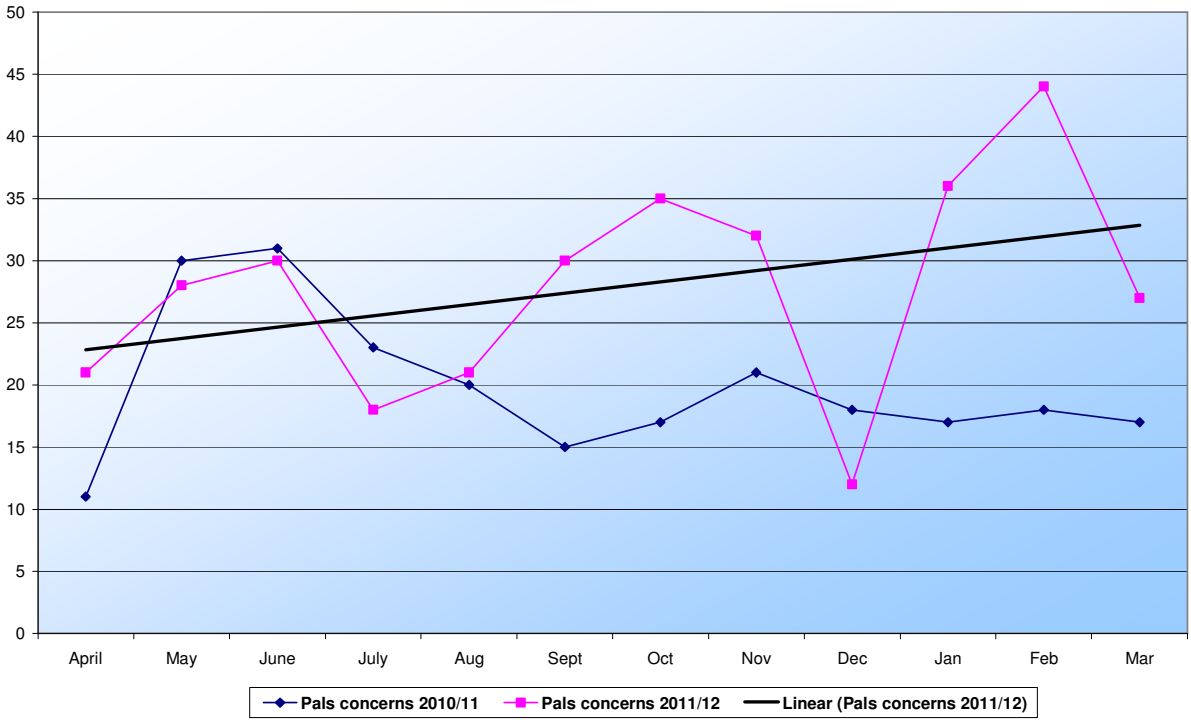
Trend of Complaints, local resolutions and PALS compared with 2010/11 and 2011/12



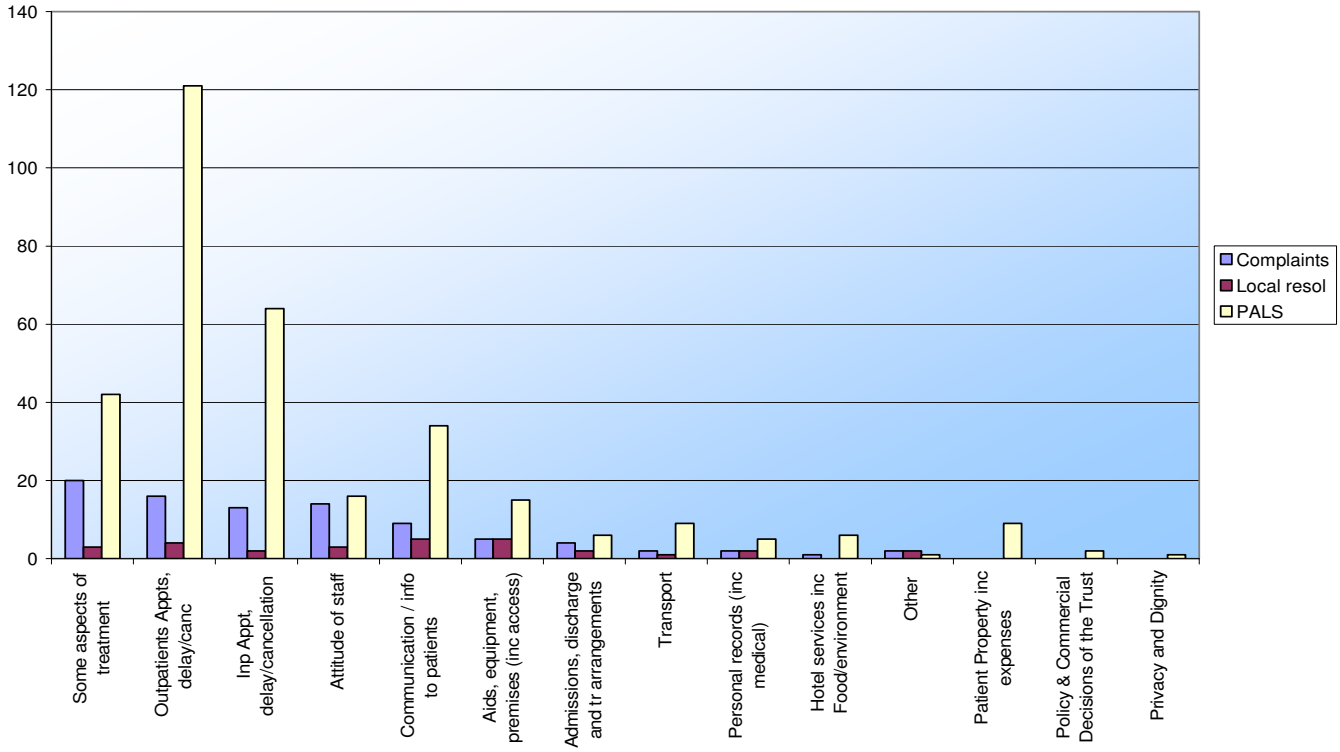
Trend line for Complaints and comparison of activity for 2010/11 to 2011/12



Trend line for PALS concerns and comparison of activity for 2010/11 to 2011/12



Main reasons for patients making a Complaints, PALS concern and Local resolution from April 2011 to March 2012



What you said and What we did - Making Experiences Count

Services have seen Improvements as a result of patients making a complaint, PALs concern or completing a comment card. Since April 2011 there have been 36 improvements in service following a complaint (7), PALS contact (14) or comment card (15). A selection is listed below, the full list can be seen in Appendix 1

"I would like to be able to access BBC iplayer & ITV player whilst I am an inpatient"

BBC iplayer and ITV player are available for patients to use on wards as part of the Trust wifi system – Completed August 2011

"Please improve signage to Minor Injuries Unit (MIU)"

New signage to MIU displayed - Completed by Estates August 2011

"I want to know how long I am going to have to wait."

New signs in Pre-op put up to advise patients to contact the nurse who is coordinating the clinic for information relating to waiting times – Completed by the Pre–op Manager

What time can my friends and family visit?

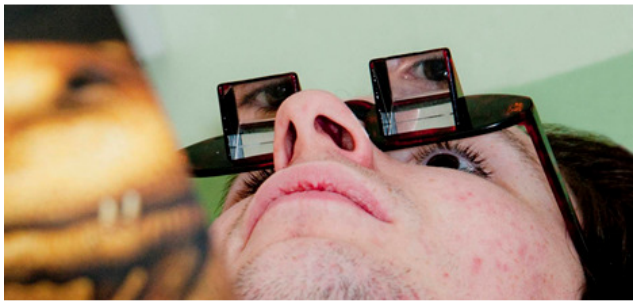
Powys ward manager reviewed visiting times after patient's comments – completed by Powys Ward Manager

Patient Safety Walkabouts

The Trust has a programme of 'Patient Safety Walkabouts' when Executives and Non-Executive board members visit clinical areas to hear first hand from patients and staff about how safety standards might be improved. These visits are structured and planned so that an action plan can be agreed to tackle any issues highlighted.

"How can I read and eat whilst lying flat?"

20 prism glasses have been purchased by the Hospital League of Friends for Spinal Injuries patients.



The following changes were made as a result of patient safety walkabouts:

- Environmental changes were made to several clinical areas. For example –
- Patient toilets and bathroom areas were upgraded to eliminate mixed sex accommodation
- Ward dayrooms were also renovated
- Privacy screens were purchased to ensure patient dignity on the wards were maintained
- New soft close bins were purchased following a comment made by a patient that the bins were noisy at night.

- Expected Date of Discharge (EDD) is visible in each patient bed space

Patient Panel activities

The Trust has had an active patient panel for a number of years which is chaired by the Director of Nursing and Governance. 22 of the regular patient members are previous and current patients, or members of the public and local stakeholder groups such as the Welsh Community Health Council, Shropshire LINks, FT Governor, League of Friends, Oswestry Rheumatology Association and Red Cross Association. The Patient Panel meets every other month to discuss current issues and has met 5 times during since April 2011. 7 new patient members were recruited in July 2011 and the Terms of Reference of the group reviewed and updated.

There has been an active patient Experience programme work plan in the last 12 months that members can choose to be involved. Members have been consulted regarding Patient Information Packs for the redesigned Pre-Op process and main entrance plans. A patient panel member was influential in setting up a hip and knee patient support group that was officially launched in October 2011.
The patient panel have made enquiries to the local District and Shropshire Councils about improving the bus stop directly outside the hospital after it had been identified that wheelchair users are unable to access the bus shelter.
The patient panel have also contacted the Muller dairy company with suggestions for improving the opening of the yoghurt pot lids which has been reported as a problem for patients with certain orthopaedic conditions.

Other activities patient panel members have had an input into during 2011/12

- Patient Pre-op redesign project and new main entrance update

- Patient experience projects plan for 2011/12
- Design of iPad Patient experience data capture project.
- Patient Kiosks
- PEAT inspections
- High Impact actions projects
- Patient Experience Newsletter
- Reviewing of Patient information leaflets including; for Patients with learning disabilities and hip and knee patient information leaflet.
- Setting up of a Hip and knee Support group
- Presenting personal Patient Experience Story at the Quality and Safety Committee and the Senior Nurses Forum meeting.
- Patient Stories, patient panel members conduct patient stories on wards and departments.
- Observations of care
- Nutrition Audits
- Attending various meetings as the patient representative, such as the Nutrition Steering group, Clinical Effectiveness, Main Entrance project, Medical audit committee, learning disabilities working group
- Input into Trust Medical Research Activities
- Attended a Dignity and Essential care conference on 30/6/11 and feedback to panel

Patient stories programme

Patient Panel Members and PALS staff carry out a rolling programme of patient stories interviews each month. 18 Patients have been asked their views on their experience of using hospital services at the RJAH Orthopaedic Hospital. All wards have been surveyed including Menzies Day Case Unit, Pre-op Assessment Unit and Outpatients Department.

As well as identifying areas for improvement and suggestions, patient stories also highlighted what the Trust does well.

Ward/Departmental managers are involved by reviewing the stories and providing a response to the suggestions made and carry out any actions where appropriate. A copy of the final report is sent to ward managers, the patient panel and patients involved in the patient stories.

All patients are very complimentary about their treatment at the Trust and sometimes had to be encouraged to make suggestions for improvement.

Patients Comments made on NHS Choices Website and Patient Opinion

Patients Comments made on the NHS Choices website were overall complimentary.

Some compliments made since April 2011:-

- *"RJAH is like a family-run B&B that does excellent surgery! The staff's dedication to some of the lowest infection rates in the country, and the RJAH has that rarest of things; friendly porters. Thanks RJAH, you made me smile pretty much constantly."*

- *"My mother was admitted for spinal surgery and was placed on the Clwyd ward. Being based in Manchester I was too far to visit and so phoned the ward while she was in surgery to check on her*

progress. The staff were so helpful and very warm and friendly over the phone. I was really impressed by the level of service and the respect shown for worried relatives. Knowing your mum is being looked after by such people took an enormous weight off my mind."

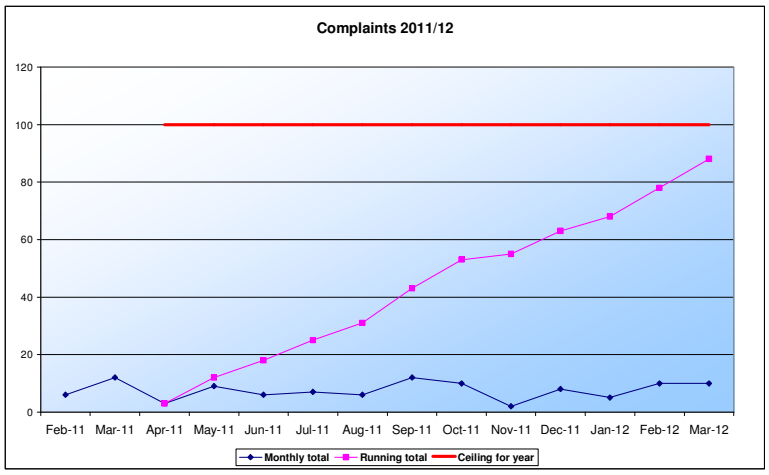
- *"Excellent treatment for an ankle Arthrodesis."*
- *"I've been treated at this hospital all my life. As a child, the staff on Alice Ward were exceptionally friendly, I had to have surgery, I was incredibly anxious and they did plenty to ease this. As an adult, I have to say that I am very impressed with the standard of care received. My consultant and I are able to make joint decisions about what we think is best. This means I'm not anxious. Where possible, he offers me a convenient date for myself for my treatment (botox injections)"*
- *"The porters are very friendly. One in particular made me laugh on the way down to theatre. This was lovely, and eased my fears. Also, I do think I have the best physiotherapist ever really. She attends my consultant meetings so that she can be involved in the care as much as possible."*
- *"Nurses were very friendly and welcoming."*
- *"Nursing and phlebotomy staff in outpatients clinics are nice and remember me and are very friendly. Would recommend them definitely. Consultant asked me the right questions."*
- *"Consultant discussed and explained all aspects of proposed procedures from initial consultation through to day of operation. Post operative care on the wards could not have been bettered. Physio and O.T. extremely professional. I doubt if a better catering service could be found in the N.H.S. Wherever I lived in the U.K. I would opt to travel to Gobowen for treatment."*
- *"I experienced the first class team and facilities in the Menzies Short Stay Surgery Unit at Oswestry's Orthopaedic hospital. From leaving the waiting area to the point of being told I could go home, I felt that I was in very safe hands in a premier operating and recovery unit. Everything was pristine and ship-shape whilst being friendly yet professional."*
- *"Great experience. Staff and organisation were wonderful, efficient, sympathetic understanding....especially the HCA who took first details. I came away knowing a lot about my operation and with staff knowing a lot about me."*
- *"Physiotherapy session was delivered on time and with the same approach. My final session was spent carefully checking out progress and most importantly whether I felt ok to be discharged. This hospital is unusual in my experience in that every member of staff always seems to want to help and in a most caring manner"*

Suggested areas for improvement were to do with:-

- Nursing staff attitude during a night shift
- Clinic waiting times in outpatients
- Suggestion for hooks for dressing gowns in all toilets.
- No named consultants listed for Rheumatology services when using choose and book
- Clinical outcome after seeing a spinal disorders consultant
- Long waiting times for surgery and time for splint adjustment appointments at Orthotics.

Complaints

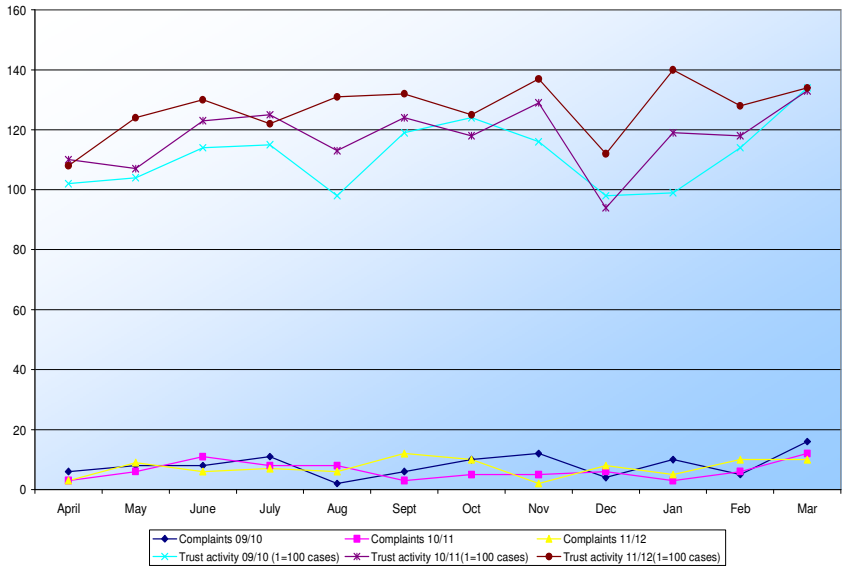
Total complaints are only a very small percentage, 0.05% of the Trust total activity, including inpatients and outpatients. PALS contacts are 0.20%. The average number of complaints is 7 per month. In the period April 2011 – March 2012 the Trust received 88 formal complaints, which represents a 16% (12) increase from the previous year.
These were split fairly evenly between 53% (47) complaints about the quality of care received and 47% (41) complaints about operational issues.



The most common subjects for patients making a complaint are:-

- Aspects of their clinical treatment (20)
- Outpatients Appointments, delay/cancellation (16)
- Attitude of staff (14)
- Patients unhappy with their inpatients treatment dates or cancellation (13)
- Communication / information to patients, (9)

The graph below shows the number of complaints compared against Trust activity from April 2009 to March 2012:



National Outpatient Survey

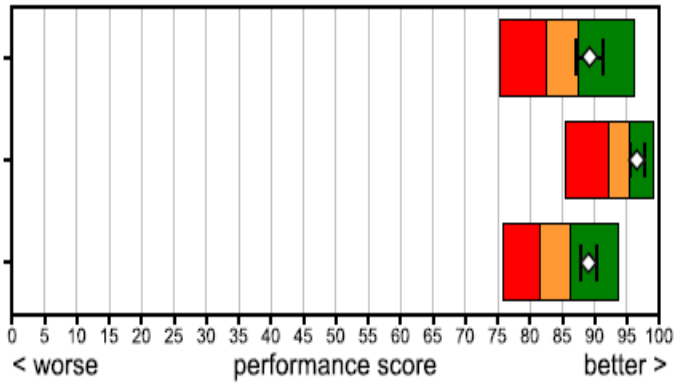
In 2011/12, the Trust participated in the National Outpatient Survey. A questionnaire was sent to patients who had recently attended an outpatient appointment. 509 responses were received giving a response rate of 60%.

Overall impression

Was the main reason you went to the Outpatients Department dealt with to your satisfaction?

Were you treated with respect and dignity at the Outpatients Department?

Overall, how would you rate the care you received at the Outpatients Department?



Best performing 20% of trusts

Intermediate 60% of trusts

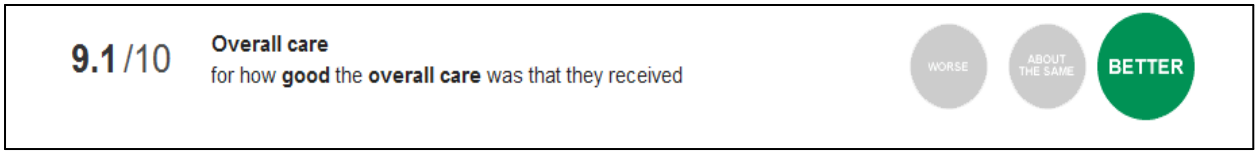
Worst performing 20% of trusts

◇ This trust (vertical lines show amount of uncertainty as a result of random fluctuation)

This trust's results are not shown if there were fewer than 30 respondents.

National Inpatient Survey

The Trust had one of the highest scores for overall care received by patients in the 2011 National Inpatient Survey published by the Care Quality Commission. Patients gave an extremely high rating of 9.1 out of 10 for overall care received, as well as top scores about various aspects on their experience throughout the hospital. Highlighting that the Trust had performed 'Better' in this area than other Hospital Trusts surveyed.



Of the 61 questions, The RJAH Orthopaedic Hospital NHS Foundation Trust scored top or almost top in over half of the questions and the specialist hospital was in the group of best performing hospitals on 90% of questions. The Trust's top scores included ward and bathroom cleanliness, hospital food and choice of food, hand washing by doctors, confidence in doctors, consistency of information and involving patients in decisions, nurses clearly explaining answers to queries and explanations about specific operations.

Patient Environment Action Teams (PEAT)

PEAT is an annual assessment of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity. The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England. Using the definitions below, the Trust self scored its assessment:

Score	Description
5	Excellent Standards - Consistently exceeds expectations; the highest possible standards have been achieved and are being maintained. There is little if any room for improvement;
4	Good Standards - Always meets and regularly exceeds expectations. There is a clear commitment to achieving and maintaining the highest standards and there is only limited room for improvement;
3	Acceptable Standards - Always meets but rarely exceeds expectations. Room for improvement is clearly evident.
2	Poor Standards - Regularly fails to meet expectations. Significant room for improvement and remedial action needed.
1	Unacceptable Standards - Fails to meet expectations in most if not all areas and remedial action required as a matter of urgency.

The scores demonstrate how well the Trust believes it is performing in key assessment areas. Scores in each audited area were determined by a team, whose profile was inline with documented guidelines, including representatives from the Trust Board, catering, housekeeping, estates, infection control, nursing and a member of the patient panel. In addition to the aforementioned team the Trust instigated independent validation through the inclusion of the Facilities Manager for Cleanliness at Shrewsbury & Telford Hospital. By converting the results into percentages the table below demonstrates the progress from 2011 to 2012:

Scoring Area	2011 Score	2012 Score	Trend
National Cleanliness Score	97.0%	97.4%	↑
Cleanliness	99.0%	99.3%	↑
Condition / Appearance	96.2%	98.8%	↑
Cleanliness Toilets and Bathrooms	98.5%	99.2%	↑
Condition / Appearance Toilets and Bathrooms	97.9%	98.2%	↑
Additional Services – NEW	-	100.0%	
Access Wayfinding and Information	89.7%	93.1%	↑
Social Spaces and Facilities – NEW	-	90.0%	
Privacy and Dignity	96.5%	97.3%	↑
Food and Hydration Services	100.0%	97.8%	↓

Scoring in 2012

To determine the overall score for the Trust the above scores have been weighted and grouped to provide three headline scores, all categories up to and including Access and External Areas coming under the heading of Environment Score, with Food and Hydration Services and Privacy and Dignity having their own category. This year's provisional results were published in May 2012 and are as follows:

Site Name	Environment Score	Food Score	Privacy & Dignity Score
ROBERT JONES & AGNES HUNT ORTHOPAEDIC HOSPITAL	5 Excellent	5 Excellent	5 Excellent

This represents the second successive year, with independent validation, the Trust has achieved Excellent in all categories.

Poor Scoring Elements:-

The following elements received scores of 3 (acceptable) or less:

Access and External Areas:

Car Parking - Building exterior and grounds	3
Signage - Building exterior and grounds Main receptions	3 3

Areas where the service could be improved / scores dropped:-

Car parking:
As with last years submission, there is room for improvement with there currently being too great a distance between the car park and other areas of the hospital and due to the increased throughput, an influx of visitors can lead to a shortage of spaces. Contributing factors to the score surround the nature of the patients who attend out patients, and the particular distance from the main car park.

The main entrance development programme will reduce the journey length of the patient pathway, and should therefore boost the car parking score in the future.

Signage:
Whilst completing the audit both Teams came into contact with patients and relatives who were having difficulty finding their way around the site. It was noted particularly that way-finding from the car park and to the main outpatients reception was causing confusion. The redesign of the patient flow and the work on the new main entrance will address this issue.

Food and Hydration Services:
The panel felt the sealed drinks containers could pose a problem to open for some patients. This resulted in a very minimal drop in score from the last audit (2.2%) However as the Trust is always looking to improve a patient's experience of the Trust a review of drink containers is planned for the forthcoming year.

Areas where the service has demonstrated an improvement over the last 12 months
Specific Cleanliness – Radiators and Ventilation Grills:
Following a reduced score in this category last year, a programme was put in place to maintain a high standard across the site. Greater frequency of cleaning and monitoring lead this element of the PEAT score to improve to an average of "Excellent"

Additional Services – Waste Management:
Although a new category, Additional Services includes aspects that were previously recorded in other categories. The Waste Management score has shown an improvement from "Good" to "Excellent" following the introduction of signage throughout the Trust, thus guiding users to correctly dispose of waste at point of disposal.

Hospital Entrance Project

This project was approved by the Trust Board who recognised the need to improve the patient pathway. This was achieved by the creation of a new patient and visitor car park and a Main Entrance. The new Entrance will provide a reception and information point to assist patients to the relevant area, as well as additional public toilets, a wheelchair collection point, shops and retail area. The new main entrance will provide easy access to the outpatient and diagnostics facilities and will reduce the traffic flow up and down the main corridor, thereby increasing the privacy and dignity of inpatients being wheeled to theatres. This scheme will also reduce the huge congestion on the main hospital corridor. The new main entrance will be officially opened on 22nd May 2012.

Shaped by the views of patients, staff and volunteers, the new entrance integrates the outpatient clinic and diagnostics areas, making it easy for patients and visitors to access the hospital and to find their way around. The new nearby car parking facilities and drop off point outside the hospital entrance will provide much needed access improvements. The hospital's volunteers, particularly the League of Friends, have swelled in numbers to operate the plush new café, with an outdoor eating area

Within the new entrance, patients will be able to 'self check-in' at kiosks using the bar coded letters that they have been sent. Help Ambassadors will be on hand to guide patients and the main reception desk is now easily accessed from the new entrance.

Significantly within the 2011 staff survey, 91% of staff agreed that if a friend or relative needed treatment, they would be happy with the standard of care provided in the Trust. This was significantly higher than both the NHS national responses, including the specialist acute trust average at 88%.

The majority of staff said they feel satisfied with the quality of care they provide to patients (87%), with nine out of ten staff feeling their role makes a difference to patients.

Overall, the results of the 2011 survey showed:

- 3 key findings improved since 2010
- 10 key findings were above average (compared to 17 in 2010 and 6 in 2009)
- 18 key findings were at or around the average (compared to 14 in 2010 and 18 in 2009)
- 10 key findings were below average (compared to 7 in 2010 and 25 in 2009)
- 2 Key findings had got worse since 2010
- The Trust response rate for 2011 was 44% (306 staff) which was lower than the 47% response rate in 2010.

The Trust's top four ranked scores were:

- Percentage of staff saying hand washing materials are always available
- Percentage of staff appraised in the last 12 months
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion

Staff experienced improved in the following findings:

- Percentage of staff appraised in the last 12 months
- Percentage of staff appraised with personal development plans in the last 12 months
- Effective Team Working

The Trust's Action Plan will be updated to include any areas not already covered.

4. Workforce Factors

Staff survey

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Statements of Engagement

Statement from the Shropshire LINk

"The Shropshire LINk works to be the voice of people in Shropshire to improve health and social care. We are very pleased with the quality outcomes set out in these accounts.

RJAH has a tremendous reputation locally and regionally as a centre of expertise, and people rarely complain about their experience as patients. The work carried out by the Trust last year to improve quality and outcomes can only enhance this reputation.

Shropshire LINk is pleased to be working with the Trust to support quality improvement and some areas of patient experience, and we look forward to our strong relationship continuing for the benefit of patients."

Statement from Shropshire Overview and Scrutiny committee

"The Panel was impressed with the content of the Quality Account document, the presentation by the Director of Nursing, and the responses given to questions raised. The Panel felt that the document was extremely easy to understand, and were interested to see the Trust had included negative as well as positive issues, and showed how the negative issues had been addressed.

Members were satisfied with the progress made with last year's priorities, and the way in which they had been implemented. They were also satisfied over the priorities identified for the coming year. The Panel have indicated that there would be a benefit to receiving a quarterly update on the priorities to enable HOSC to monitor progress.

The introduction of 'Bluespier' is of great benefit to clinical staff and patients, and the improvements within pre-operative services and discharge were deemed essential. The Panel were happy with the way in which the Trust had indentified, and addressed problems, but stressed the need to highlight outpatient appointment improvements. Members considered it was particularly positive to see the establishment of a wound clinic, and patients have information on how to access this service on discharge.

National survey and inpatient survey – The Trust scored very highly through these surveys, however areas for improvements suggested on page 45 of the Quality Account need to be addressed in the next 12 months, with clearer information to patients on procedures and discharge.

Pressure ulcer, falls, catheter urinary tract infections, and Venous Thromboembolism are a national priority and the percentage being reported by the Trust are extremely low, which is an excellent achievement. Keeping patients nourished is a simple but essential part of patient care, and the Panel was particularly impressed with the implementation of the red tray/jug system, it was simple but extremely effective. The implementation of the 'Patient Experience Tracker System' is very innovative. It appears that any problems identified within the Hospital have been addressed immediately, and patient care and wellbeing is extremely high because of these actions.

Members recognised that the Trust is undergoing national audits and performing well against the set criteria. CQUINs are also being achieved, and are assisting in your continued excellence. The review of Quality Performance indicates that the Trust is a high performer against other similar Trusts.

It is pleasing to see the rate of Cdiff is reducing drastically and MRSA continues to see zero cases.

The introduction of telephone reminders a week before treatment is an excellent way of reducing patient no shows, and the Panel would like to suggest piloting an email notification system instead of the conventional

appointment letter for those patients being able to book follow up appointments at the conclusion of initial consultations.

It should be noted that the Trust is also performing well with the delay in Outpatients and Waiting Lists, and the length of wait for treatment has been examined fully and addressed. Also information given to inpatients has improved, and increasing information would improve a patient's confidence in their treatment pathway.

The Panel are pleased they were able to comment on the Quality Account and look forward to monitoring the Trust's progress through a quarterly report, and working with the Trust in the future".

Statement from Shropshire County Primary Care Trust

West Mercia Cluster monitors the quality and performance of the services delivered by the Trust reviewing all data through the monthly Clinical Quality Review meetings which are attended by members of the CCGs, Senior Managers and members of the Quality Team.

We believe that the Quality Account is reflective of the achievements within the year and demonstrate the Trust's commitment to strive for excellence across all clinical services.

We continue to recognise the improvements to quality and innovation within the Trust as a result of the contractually agreed 'Commissioning for Quality and Innovation (CQUIN) Scheme for 2011/12'. The agreed CQUIN scheme for 2012/13 reflects the continued ethos of partnership working to improve patient safety, clinical effectiveness and patient experience as a key priority of the organisation and commissioners. Whilst we are assured that the Quality Account clearly identifies key priorities for 2012/13, we do note that these also reflect certain elements contained within the CQUIN Scheme. The document also makes reference to the NHS Midlands and East SHA Ambitions 2012/13 including the elimination of avoidable grade 2, 3, 4 pressure ulcers and increasing the quality of patient experience and customer care.

We continue to welcome the opportunity to have involvement at an earlier stage in the development of the Quality Account for 2012/13 in line with the planned changes outlines jointly by the Department of Health and Monitor Independent Regulator of NHS Foundation Trusts.

Accuracy of information

West Mercia Cluster in conjunction with local NHS Commissioners has taken the opportunity to check the accuracy of information provided with in the Quality Account in relation to the services commissioned from the Trust and believes it is a true reflection.

Statement of Directors' responsibilities in respect of the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor 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 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 2011-12
- 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 2011 to June 2012
    - Papers relating to Quality reported to the Board over the period of April 2011 to June 2012
    - Feedback from the commissioners dated May 2012
    - Feedback from the governors dated May 2012
    - Feedback from LINks dated May 2012
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2011.
    - The 2011 national patient survey dated February 2012
    - The 2011 national staff survey dated March 2012
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 19th April 2012

- 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 is been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality report (available at www.monitor-nhsft.gov.uk/annualreportingmanual))

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

NB: sign and date in any colour ink except black

.....Date.....29 May 2012
Chairman

.....Date.....29 May 2012
Chief Executive

Appendix 1 Changes in Service from April 2011 to March 2012:

Change in practice	Source	Implemented
Pre-op Disabled toilet - there was only one rail to support patients.	Comment May 2011	Completed, Estates have put up another handrail in patient disabled toilet in July 2011.
Patients from spinal unit smoking outside Kenyon Ward by open windows.	Comment May 2011	Kenyon Manager asked Estates to put up no smoking signs outside Kenyon ward and SIU dining room- completed
Clwyd Day room needs updating to make more inviting. Staff are looking at improving the dayroom on ward and have asked patients to provide ideas	Comment June 2010 Comment September 2010 April 2011 comment	Main improvements to Day room completed with funding by the League of Friends. Awaiting some new chairs and tables on Clwyd
Powys ward manager reviewed visiting times after patients comments	PALS contact April 2011	Completed by Powys ward manager April 2011
Choose & Book system updated to ensure that hand & wrist surgeons do not appear under the shoulder clinics	Complaint May 2011	Completed
Current fault with Radiology Information System (RIS) which is a national system means staff need to be vigilant and carry out extra checks to ensure that no reports are missed. Fault has been reported to RIS.	Complaint June 2011	Interim solution. No resolution has been forthcoming from the national system software RIS. Until national system updated, X-ray have implemented an internal check system whereby radiologists are e-mailed their oldest cases waiting for report each week
Staff to ensure that letters about last minute appointment changes are sent out first class	Complaint June 2011	Completed

Change in practice	Source	Implemented
Ward clerk ensuring correct Menu cards being given out to patients on high protein diets on Gladstone ward over the weekend. Patient on special diets are being monitored.	PALS contact June 2011	Completed by Dietician June 2011
Estates to remind car park attendants to put up signs on ticket machines if out of order to stop confusion for patients paying for parking.	Comment June 2011	Completed by Estates Manager August 2011
Improved signage to MIU	Comment July 2011	Completed by Estates August 2011
Patient reported smell in room 2 in Pre-op clinic.	Comment July 2011	Completed Estates had drain in pre-op checked and cleared in July 2011
Please put a hook in the shower room – "there's nowhere to put clothes whilst in the shower"	Comment June 2011	Ward manager has put requisition to put hooks in all bathrooms on Ercall ward on 14th July as an urgent action. - completed
A new leaflet on "A Guide for patients undergoing rehabilitation "is being produced on the MCSI wards.	PALS contact September 2011	Gladstone ward manager ongoing
League of Friends to provide funding for storage of patient toiletries/belongings in bathrooms if items are sourced.	Comment August 2011	League of Friends and Ward managers ongoing
Radiology Consultant to positively identified all patients before any clinical information is discussed with them	Complaint August 2011	Completed
Introducing new system where patient can indicate whether they wish to be visited or not by one of the clergy.	Complaint August 2011	Ongoing

Change in practice	Source	Implemented
Estates made adjustments to the Telephony voice recognition service.	Complaint September 2011	Completed
Trust have identified the occasions when updating a patient's record on PAS does not automatically update CRIS as it should. Fault reported to Computer supplier	Complaint September 2011	Completed
First class stamps are to be used on Pre-op clinic letters to inform patients of test results when patients have a short timescale for admission	PALS contact August 2011	Pre-op Manager – completed August 2011
BBC iplayer and ITV iplayer are available for patients to use on wards as part of the Trust wifi system	Pals contact August 2011	IT Dept completed August 2011
DNA letter contents to be reviewed and Access manager to decide who receives letter	Pals contact Nov 2011	Patient Access Manager completed
Kenyon ward manager requested shelf in toilets	Comment August	Completed Kenyon ward manager
Access Manager ask Pain management consultants not to advise patients for 4 month interval for injections until capacity improves	Pals contact Oct	Completed Patient Access Manager
Patient Access Manager to review processes for staff handover when staff go on leave to ensure all urgent work in handed over	PALS contact	Completed Patient Access Manager

Change in practice	Source	Implemented
Access manager updating maps for pain clinic to go out with clinic letters.	Comment Nov 2011	Completed Patient Access Manager
Access manager to look at staffing arrangements for a receptionist at the Pain clinic	Comment Nov 2011	Ongoing, Patient Access Manager
Menzies manager asked cleaning staff to checked patients toilets on a more regular basis.	PALs contact Nov 2011	Completed Menzies ward manager
The automatic telephone message system remind plus has been updated to include telephone number of Trust	PALs contacts January 2012	Completed by Service Improvement coordinator
The address of GP Practice updated on EPR/PAS by IT as the national GP file on PAS was out of date	PALS contact January 2012	Completed by IT
A nurse given extra training on Kenyon ward about her bedside manner	PALS contact December 2011	Completed by Kenyon ward manager
OPD Reception area to be reviewed to ensure effective customer care approach provided	Comment January 2012	Completed by Patient Access Manager
New signs in Pre-op put up to advise patients to contact the nurse who is coordinating the clinic for information relating to waiting times.	Comment January 2012	Completed by Pre-op Manager
In X-ray Estates Requisition submitted to amend wooden finish on low wall so that there is no overhang after a patient banged his head.	Comment December 2011	Completed by X-ray Manager

Change in practice	Source	Implemented
DVD discs in Pre-op being changed more frequently and played for appropriate patients. Also looking at getting TV aerial	Comment December 2011	Completed by Pre-op Manager
The Physiotherapy department have updated a patient exercise advice sheet 4 weeks post op to patients after a hip operation	PALS contact January 2012	Orthopaedic Therapy team lead
Remind plus appointment reminder system changed so that no delay was left before the voice mail message started.	PALs contact February 2012	Completed by Service Improvement coordinator
Pre-op Manager and patient rep are redesigning the Pre-op appointment letter to reflect the length of time spent in department.	Comment March 2012	Ongoing - Pre-op manager

Appendix 2 - National clinical audits and national confidential enquiries

Audit	Eligible to Participate	% cases submitted
National Enquiries		
Peri-operative Care (NCEPOD)	Yes	100%
Surgery in Children (NCEPOD)	Yes	100%
Cardiac Arrest Procedures(NCEPOD)	Yes	100%
Peri and Neonatal		
Perinatal Mortality (MBRRACE)	No	N/A
Neonatal intensive and special care (NNAP)	No	N/A
Children		
Paediatric pneumonia (British Thoracic Society)	No	N/A
Paediatric asthma (British Thoracic Society)	No	N/A
Pain Management (College of Emergency Medicine)	No	N/A
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	No	N/A
Paediatric intensive care (PICANet)	No	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	N/A
Diabetes (RCPH National Paediatric Diabetes Audit)	No	N/A
Acute Care		
Emergency use of oxygen (British Thoracic Society)	No	N/A
Adult community acquired pneumonia (British Thoracic Society)	No	N/A
Non invasive ventilation (NIV) - adults (British Thoracic Society)	No	N/A
Pleural procedures (British Thoracic Society)	No	N/A
Cardiac arrest (National Cardiac Arrest Audit)	No	N/A
Severe Sepsis and Septic Shock (College of Emergency Medicine)	No	N/A
Adult critical care (ICNARC CMPD)	No	N/A
Potential donor audit (NHS Blood & Transplant)	No	N/A
Long Term Conditions		
Diabetes (National Adult Diabetes Audit)	No	N/A
Heavy menstrual bleeding (RCOG National Audit of HMB)	No	N/A
Chronic pain (National Pain Audit)	Yes	100%

Audit	Eligible to Participate	% cases submitted
Ulcerative colitis & Crohn's disease (National IBD Audit)	No	N/A
Parkinson's disease (National Parkinson's Audit)	No	N/A
Adult asthma (British Thoracic Society)	No	N/A
Bronchiectasis (British Thoracic Society)	No	N/A
Elective Procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	80%
Elective surgery (National PROMs Programme)	Yes	100%
Intra - thoracic transplantation (NHSBT UK Transplant Registry)	No	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	No	N/A
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	No	N/A
Carotid interventions (Carotid Intervention Audit)	No	N/A
CABG and valvular surgery (Adult cardiac surgery audit)	No	N/A
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	No	N/A
Heart failure (Heart Failure Audit)	No	N/A
Acute stroke (SINAP)	No	N/A
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	No	N/A
Renal disease		
Renal replacement therapy (Renal Registry)	No	N/A
Renal transplantation (NHSBT UK Transplant Registry)	No	N/A
Cancer		
Lung cancer (National Lung Cancer Audit)	No	N/A
Bowel cancer (National Bowel Cancer Audit Programme)	No	N/A
Head & neck cancer (DAHNO)	No	N/A
Oesophago-gastric Cancer (National O-G Cancer Audit)	No	N/A
Trauma		
Hip fracture (National Hip Fracture Database)	No	N/A
Severe trauma (Trauma Audit & Research Network)	No	N/A
Psychological Conditions		
Prescribing in mental health services (POMH)	No	N/A

Audit	Eligible to Participate	% cases submitted
Schizophrenia (National Audit of Schizophrenia)	No	N/A
Blood Transfusion		
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes	90%
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	No	N/A
Health Promotion		
Risk Factors (National Health Promotion in Hospitals Audit)	No	N/A
End of Life		
Care of Dying in Hospital (NCDAH)	No	N/A