Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Quality Account 1 April 2020 – 31 March 2021

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INTRODUCTION

The safety and quality of the care that we deliver at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is our utmost priority. We therefore value the opportunity to review the quality of our services each year and outline the progress we have made against our set quality priorities. This is as well as acknowledging the challenges that we have faced in some areas in delivering care to the standard that we aspire.

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

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

In addition, NHS Foundation Trusts are required to follow the guidance set out by NHS Improvement with regard to the quality account and there are a number of national targets set each year by the Department of Health against which we monitor the quality of the services we provide.

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

Foreword from the Chief Nurse and Chief Medical Officer

The Trust's aspiration is to provide world class care and quality and patient experience sits firmly at the core of this.

During 2020-21 we have experienced a year like no other in the NHS, and we responded by changing our core work to support the response to the pandemic within our System, whilst maintaining our critical services.

Despite these changes we continued with our aim to deliver outstanding patient care to every patient, every day. Our staff adapted and continued to deliver the level of care we are so proud of.

We pride ourselves in the high quality of the services we deliver and during 2020-21 this has been reflected in the feedback received from our patients.

As we move into 2021-22 our focus will be to build on the significant improvements seen in previous years and to ensure that providing quality care remains at the heart of everything we do, every day.

Stacey Lea Keegan

Chief Nurse

Dr Ruth Longfellow

Chief Medical Officer

PART 1

Statement on Quality from the Chief Executive

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

These Quality Accounts set out our key achievements in 2020-21, as well as sharing our priorities for 2021-22. The Covid-19 pandemic has obviously had a significant impact on the NHS and the need to focus on maintaining high quality standards has never been more important. Further, it is important to emphasise that the quality priorities for 2020-21 were set prior to the Covid-19 pandemic and have been worked on throughout the year in order to maintain quality services throughout the pandemic. We hope this will provide patients, their families and carers with confidence in the quality of their services.

During 2018-19, we were inspected by the Care Quality Commission, who rated the Trust as 'Good' overall and 'Outstanding' for care. We were also rated as 'Good' for safety. The Trust had expected an inspection in 2019-20 and would have welcomed the opportunity to showcase its services again, however, this was postponed due to Covid-19. The Trust has continued to work towards achieving outstanding against the CQCs standards and despite the fantastic work set out in this report which indicates we are heading in the right direction, we know there is still more to do if we are to deliver on our world class vision.

The Trust has maintained low infection rates, with no MRSA bacteraemia since 2006 and low surgical site infection rates. We ensure ongoing monitoring and surveillance of all infections, as well as regular monitoring of ward and department level practices.

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

The National NHS Staff Survey which is undertaken by more than 300 NHS organisations again provided very positive feedback with 57% of staff completing the survey and a record 96% of respondents saying they would be happy with the standard of care provided if a friend or relative needed treatment. It is the fourth year in a row that the Trust secured the highest marks in response to this question. We also scored highly as a place to work, with 79% of staff saying they would recommend RJAH as an employer.

Once again, we were also delighted with the excellent feedback we received from our patients over the past year. Overall patient experience at RJAH was rated as the best in the country compared to other NHS Trusts, according to the annual Adult Inpatient Survey carried out by the CQC. As part of the survey results, RJAH was also named as one of just nine organisations placed in the top band of Trusts delivering results that are considered "much better than expected", delivering patient experience that is substantially better than

elsewhere. The same survey also saw the food we prepare and serve at RJAH rated as the best in the country for the 14th time in 15 years, as well as the wards being highlighted as the cleanest in the country – for the second year running.

The Trust remains committed to promoting equality and inclusion for both it's staff and patients and in June 2020 the NHS Rainbow Badge was launched. The badge provides staff with a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBTQ+, and acts as visual symbol identifying the person wearing it as someone who is there to listen.

Quality is at the heart of every decision we take and, with the significant contribution of staff from across the hospital, we will strive to keep improving in 2021-22 to deliver ever higher levels of patient experience and care despite the continuing challenges of Covid-19.

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

Mark Brandreth
Chief Executive

PART 2

Priorities for improvement

Our Quality Priorities for 2021/22

Deciding on our quality priorities for the coming year

This part of the report describes the areas for improvement that the Trust identified for the year 2021-22. The quality priorities have been derived from a range of information sources consulting with key staff and including our Council of Governors. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire.

In choosing our priorities, we considered the quality issues raised about the Trust through the various feedback mechanisms available to our staff and patients and our commissioners. We also took account of the national landscape at the time and shaped our priorities to align with emerging national quality priorities.

Each of the quality priorities outlined below will be monitored throughout the year via existing governance structures which will be described in more detail below. In addition we will facilitate stakeholder engagement workshops where we will chart our progress and discuss any challenges to implementing the quality improvement priorities as agreed.

Patient Safety

1. Enhanced patient safety in Theatres & Diagnostics.

Objective: Reduce number of patient safety incidents in Theatres and Diagnostics

Rationale: It is recognised that these areas are where interventional procedures are undertaken and therefore there is the highest risk of patient safety incidents and the highest focus needed on patient safety processes such as the WHO process[1].

Measures:

- Improvements in the audited compliance against the 5 steps to safer surgery (using an observational model)
- Multi-disciplinary Safety Champion role embedded within the departments
- Increased levels of associated training compliance
- Reduction in theatre and diagnostic incidents related to non-adherence with WHO process.

Board Sponsors: Ruth Longfellow and Stacey-Lea Keegan

[1] World Health Organisation safer surgery process which sets a number of safety checks that must be undertaken before, during and after interventional procedures

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

2. Improve detection and escalation of the deteriorating patient.

Objective: Reduce number of un-expected admissions to HDU

Rationale: This is linked to the Trust's quality priorities in previous years on the improving the management of deteriorating patients and will take this work to the next level of outcome and assurance.

Measures:

- Improvements in NEWS audits to demonstrate 90% compliance in line with deteriorating patient policy
- Reduced number of un-expected admissions to HDU monitored via Datix
- Critical Care Outreach service available 24/7.

Board Sponsor: Ruth Longfellow

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

Clinical Effectiveness

3. Provide an effective, safe and healthy working environment to promote staff wellbeing

Objective: Improvements in staff survey in two primary themes resulting from the Staff Survey 20/21; Communications with Senior Management and Workplace health and wellbeing.

Rationale: These two areas have been identified through the staff survey results as an area where more focussed work is needed. Further it is recognised that over the last year the Trust's staff have been working in unprecedented and challenging circumstances and the need for additional support has more important than ever.

Measures:

- Improved responses to staff survey
- Increased response rates and engagement with internal quarterly pulse checks
- Reduction in incidents reporting incivility.

Board Sponsor: Sarah Sheppard

Oversight Committee: People Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

4. Increasing awareness of non-medical research in practice

Objective: Improvements in Research awareness survey

Rationale: The Trust aims to provide care that is 'world class' and can only do this by ensuring it continues to improve its existing services and develops new and innovative services. Research is a key factor in this and increased awareness will therefore support this ambition.

Measures:

- Research champions in ward and departments
- Improvements in Research awareness survey.

Board Sponsor: Ruth Longfellow and Stacey-Lea Keegan

Oversight Committee: Quality and Safety Committee and People Committee, this will ensure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

Patient Experience

5. Reduction in delayed discharges and improved patient communication

Objective: This objective is made up of two parts, establish a zero tolerance of delayed discharges by completing a review of the discharge and resettlement leadership and further review and improve patient communications to ensure that all patients can access the information they need when they need it.

Rationale: Covid-19 has impacted on all clinical pathways and that includes the discharge pathways, it is important that patients are receiving their care in the most appropriate place with beds available to those who need it.

Discharges from hospital are complex and can be a source of anxiety for patients if they are not being discharged to their homes and therefore improved communication around the discharge process will hopefully alleviate concerns and improve their overall experience.

Measures:

1. Achieve the Trust KPI of less than 2.5% of all patients delayed
2. Patient feedback regarding communication and inclusion in the discharge process
3. Monitoring of complaints / incidents relating to discharges

Board Sponsor: Stacey-Lee Keegan.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis and monitored by the Patient Experience committee.

6. Improved communication to patients accessing outpatient services

Objective: To ensure that patients have access to information regarding their treatment pathway in an appropriate format and at the appropriate time.

Rationale: During Covid-19 services have either been temporarily paused for periods or scaled back to ensure that infection prevention and control measures are taken. This has unfortunately resulted in patients waiting longer than usual for their appointments and increased communication regarding this will help to ensure patients remain appropriately informed whilst they are waiting.

Measures:

- Reduction in number of negative comments relating to outpatient waits
- Development of a KPI for ongoing monitoring)

Board Sponsor: Stacey-Lee Keegan.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis and monitored by the Patient Experience committee.

Statements of Assurance from the Board

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

Review of Services

During 2020-21, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided three NHS services, in musculo-skeletal surgery, medicine and rehabilitation.

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

The income generated by the relevant health services reviewed in 2020-21 represents 100% of the total income generated from the provision of NHS services by The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for 2020-21

Participation in Clinical Audit

During 2020/21, 13 National clinical audits and 0 national confidential enquiries covered NHS services that the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in during 2020/21 were as follows:

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

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2020/21 are as follows:

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

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2020/21 are listed below however at the time of writing the data had not been collated with regard to the submissions made for each audit or enquiry. This will be published when available as an addendum.

Audit	% cases submitted
National Joint Registry	
Elective Surgery (National PROMS Programme)	
Mandatory Surveillance of HCAI	
National Early Inflammatory Arthritis Audit (NEIAA)	
Case Mix Programme	100%
National Comparative Audit of Blood Transfusion programme	
Perioperative Quality Improvement Programme (PQIP)	Paused due to Covid-19
Surgical Site Infection Surveillance	
British Spine Registry	

The reports of 19 local clinical audits were reviewed by the provider in 2020/21 and The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in below to improve the quality of healthcare provided.

	Audit Number	Title of Audit	Action Points
1	20/21_025	Paediatric Transfer Audit	1. Provide a way of risk assessing unwell paediatric patients before they arrive at COPD. Amend letter to request parents before arriving for their appointment to inform COPD if their child is unwell. 2. Provide a way of risk assessing unwell paediatric patients before they arrive on the ward for rehabilitation. Introduce a pre-physio assessment. 3. Major surgery listed between Monday-Wednesday whenever possible. 4. Ensure that the Sop covers the most common co-morbidities of paediatric patients
2	20/21_015	Audit of compliance with IR(ME)R Procedures – Non medical imaging using medical equipment	1. Improved documentation of compliance with IR(ME)R procedure 3 – Produce and share written SOP 2. Improve staff knowledge of process by sharing new SOP with Staff via email and audit results via monthly newsletter
3	20/21_035	IR(ME)R Procedures – benefits and risks information Audit	1. IRMER pause and check posters available for referrers. Share with outpatient managers and encourage them to display in consultation rooms. 2. Imaging patient information leaflets to include statement of risk. Review of all information leaflets.
4	20/21-033	IR(ME)R Procedures Audit: recording clinical evaluation for Medical Exposures	1. Increase compliance with IR(ME)R Procedure 10 – share the results with the relevant stakeholders 2. Increase knowledge of responsibilities of referrers under IR(ME)R promote the referrer 'pause and check' poster within the Trust
5	20/21_026	IR(ME) R Audit – making enquires of individuals of childbearing potential	1. Increased compliance with IR(ME)R procedure 4 for the individual radiographer identified – Inform radiographer of their performance 2. Inform line manager of Radiographer performance 3. Review of individuals compliance with procedure 4
6	20/21_019	BOFAS Study: Outcomes of Foot and Ankle Surgery during COVID-19	1. Not Applicable

7	20/21_013	Audit of the use of pain response forms for interventional procedures in Radiology	1. Education regarding diagnostic and therapeutic injections and timely collection of pain response 2. Making the Radiologists aware of the proper filling in of the procedure details in these forms and timely generation of reports
8	20/21_012	Audit of the consent forms for interventional procedures in Radiology Department	1. All consent forms to be scanned onto CRIS 2. Consent forms to be fully completed 3. Send out information leaflet via email to patients who book via telephone / at short notice to ensure they have appropriate awareness of procedure prior to giving consent
9	20/21_009	Audit of compliance IR(ME)R procedures – correct identification of patients	1. Remind radiographers to record who justified the exposure on the CRIS record 2. Create flow chart of the referral process in all modalities 3. Speak to PACs team to ensure all referrers are entered on the CRIS Record 4. Follow up the referral of patients from an unauthorised non-medical referrer, confirm with the individual's line manager that the need to refer is necessary to the post and if so undertake a formal application process with them.
10	19/20_046	Audit of compliance with IR(ME)R procedures – correct identification of patients	1. Remind radiographers to ensure the ID check is recorded for all examinations, when more than one examination is being performed
11	19/20_034	An audit measuring compliance of VTE prescribing and documentation NG89	1. Have VTE information leaflets readily available for patients and their families/carers 2. Prioritise patient counselling 3. Education for healthcare practitioners on the importance of VTE assessment 4. Encourage regular measurement of patient weight and height 5. Education on prescribing for renally impaired patients 6. RJAH VTE policy to all new doctors on induction 7. Re-audit regularly (every year) and inform staff of the results 8. Expand audit to surgical wards
12	19/20_039	Audit of the use of a safety checklist for interventional procedures in Radiology	1. Remind radiographers to initial the form when they have introduced themselves and to use "Hello my name is" note in Quality Newsletter 2. Completion of checklist for urgent in patient referrals 3. Ensure that the RDAs they feel confident and comfortable with performing the 'stop clock'

			4. Design of checklist review of checklist and its design
13	19/20_032	Reaudit of Delirium among in-patients CG103	1. Confusion screen at admission for patients – Inform all staff of the requirement
14	19/20_023	Reaudit of VTE Prophylaxis compliance in patients undergoing shoulder replacement	1. None as compliance was fully met
15	19/20_020	NG 59 – Low back pain and sciatica: Ax and management in the Physiotherapy Department	1. More thorough documentation of what explanations are given to patients. Introduce a question in the paperwork to prompt clinicians to discuss this with patients 2. More thorough documentation of advice and information that patients are being given. 3. More thorough documentation including use of patient specific goals. 4. Patients requiring psychological therapies should be referred to Pain Management Solutions (PMS) either through SOOS or GP
16	19/20_001	Reaudit of Foot and Ankle Day case forefoot surgery	1. Amend booking strategy for these patients in line with following: • Book day cases for the morning • Avoid booking day cases in the evening • Bilateral cases and complex will be booked as inpatient stays
17	18/19_044	Reaudit of 2018 reaudit of CTPA Studies	1. To reaudit annually but compliance was high therefore no actions
18	19/20_027	An audit to look at how patients with CTEV are managed in Ponseti clinic at RJAH	1. Share results at Paediatric Grand Round Jan-19

9 Service Evaluation projects reports were reviewed by the provider in 2020/21 as follows:

	Project Number	**Project Title**	**Action Plans**
1	16/17_004	Enhanced recovery after major spinal surgery	1. None as it was shown from this evaluation that significant improvements were seen across all main outcome measures
2	20/21_006	Minimising the need for HDU support in Adolescent Idiopathic Scoliosis Surgery	1. Continue current scoliosis management care for AIS patients

3	20/21_045	Length Discrepancy Outcomes in THR Surgery	1. Not applicable
4	20/21_030	Audit of Scoliosis X-Ray Evaluation	1. Change the primary beam field for in-brace x-rays. Radiographers to reduce field to eliminate the reproductive organs
5	19/20_045	Evaluation of order enquiries received in Orthotics from external companies	1. Include details on footwear orders – checklist created for orthotists to use when completing orders 2. More specific detailing required for stock/modular footwear – Full specification sheet generated to include more in depth requirements 3. Ensure orthotics have access to all catalogue codes in clinic rooms – Orthotics assistants equip and check all clinic rooms to have latest company catalogues and online versions input onto shared drive 4. All stock items to be catalogued on Oracle 5. Database software to be considered for updating department
6	19/20_043	Reaudit of patients satisfaction of telephone follow up following Upper Limb Surgery	1. To explore the suitability of telephone facilitated follow ups for patients other than those listed within this service evaluation.
7	19/20_029	Primary THR and TKR Discharge Audit	1. Tighten processes and systems for monitoring length of stay by creating RAG system 2. Initiate two team huddles to improve multidisciplinary communication between physios and MDT to discuss delayed discharged categories to be utilised for more specific reasons for patients going over their EDD 3. Monitoring of staffing levels via E-Rostering and rota to ensure there are enough staff to patient ratio to effectively monitor LoS
8	19/20_002	Evaluation and Outcomes following MPFL + TTD for recurrent patellar instability	1. None - In carefully selected patients with patellofemoral instability and patella alta, MPFL reconstruction and TTD is a safe and effective treatment
9	18/19_015	Service Evaluation into the limited benefit of DWI and DCE MRI in MSK Tumour Recurrence	1. None

Participation in Clinical Research

Research at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continues to flourish. The total number of studies active at the Trust during 2020-21 was 64, of which 45 were adopted onto the National Institute for Health research (NIHR) portfolio. These studies fall into 4 of the 6 Clinical Research Network speciality areas (Cancer, Children's, Musculoskeletal, and Surgery). They include commercial, academic and RJAH-sponsored studies.

The number of participants that were enrolled in research eligible for inclusion in the NIHR portfolio was 293. This figure represents a 60% reduction on the previous year's recruitment total due to a national pause in recruitment to non-urgent public health studies during the COVID-19 pandemic. Despite our orthopaedic speciality, we were able to contribute to 5 COVID-19 research studies, including 2 with Urgent Public Health status.

Our five-year research strategy and delivery plan was approved and published in January 2021.

CQUIN framework

During 2020/21 none of of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust income was conditional on achieving quality improvement and innovation goals agreed between the Trust and its Commissioners through the CQUIN (Commissioning for Quality and Innovation) payment. This was because the schemes were paused nationally due to the pressures of Covid-19

CQC registration

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2020/21.

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

Ratings for The Robert Jones and Agnes Hunt Hospital

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

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

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

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 202021.

Secondary Uses Service Submission

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2020/21 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
- 100.00% for outpatient care

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

- 99.3% for admitted patients care
- 99.9%for outpatient care

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

- Raise the awareness and profile of data quality, developing within the Trust a positive culture, through encouraging best practise and promoting new processes, and

ensuring that all staff recognises that they have a responsibility for ensuring a high standard of Data Quality.

- Maintain a robust Audit framework that provides assurance for key performance indicators as reported in the Trust's Integrated Performance Report (IPR).
- To monitor and review a set of data quality KPI's focussing on any areas of concern.
- Improve the Data Quality in relation to 18 week referral to treatment time (RTT) through audit, validation and education of both clinical and non-clinical teams, providing support and advice when needed.
- To ensure compliance with all data quality standards as specified within the Data Security and Protection Toolkit.

Information Governance

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

The Trust has an established information governance management framework and continues to develop information governance processes and procedures in line with the information governance toolkit. The Trust`s Information Governance status is the subject of ongoing review by the Information Governance Committee which is responsible for reviewing policy and monitoring compliance with Department of Health Guidelines. This process is overseen by the Audit Committee which also has a role in ensuring that all serious data governance risks or incidents are brought to the attention of the appropriate Board Committee. The Trust has in place the Chief Nurse as the Caldicott Guardian, and the Director of Digital as the Senior Information Risk Owner (SIRO). Further, the Trust Secretary is the Data Protection Officer.

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

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2020/21 has not yet been determined as the final submission date is 30 June 2021.

For 2019/20 the Trust's score was STANDARDS MET.

During 2020/21 the Trust identified and reported no serious IG breaches.

Clinical coding error rate

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was not subject to the Audit Commission's Payment by Results clinical coding audit during 2020-21. However, an internal audit was conducted with the results as outlined below:

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
97.50%	97.55%	99.46%	99.62%

Seven Day Working

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

NHS Outcomes Framework: Review of performance against mandated indicators

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

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

Mortality

During 2017/18 the Trust put in place a Learning from Deaths Policy in line with national requirements. This policy ensures that the Trust reviews all deaths in line with the NHSE/NHSI framework. We record all of our expected and unexpected deaths and all have a mortality review completed. These results are reviewed through the Trust mortality group. We have a lead consultant who chairs this committee and reports to the Patient Safety Committee chaired by our Chief Nurse.

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

During 2020-21 fifteen patients of Robert Jones and Agnes Hunt Orthopaedic Hospital died. This comprised the following number of deaths which occurred in each quarter of that reporting period: seven in the first quarter; three in the second quarter; one in the third quarter and four in the fourth quarter.

By 31 March 2021, twelve case record reviews and three coroner's investigations have been carried out (coroner outstanding in two cases) in relation to the fifteen deaths.

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

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

patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter.

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

COVID Deaths

The Trust had seven deaths where COVID appeared on the death certificate. None of these were definitely attributable as RJAH acquired. One case became positive 9 days after admission, however this was in April 2020 before national regular testing schedules were in place, and acutely falling lymphocyte count indicated that they would likely have been an asymptomatic positive from day three.

Notwithstanding the information above, through the case record reviews and investigations the Trust identified an opportunity to improve liaison between the wards and critical care around the planning of limits for treatment this has prompted discussion between the MCSI lead and HDU lead for providing opinion on treatment limits planned.

There is work ongoing with our local acute trust for us to become a satellite of their Medical Examiner service, which will further improve the process of bereavement, and the liason with families.

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

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

0 representing 0% of the patient deaths during 2020-21 are judged to be more likely than not to have been due to problems in the patient care.

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

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has continued with the implementation of the ongoing Learning from Deaths Policy introduced during 2017-18.

Helping people recover from episodes of ill health or following injury

Readmission Rates

During 2020/21 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0% and for 16+ years old it was 1.57%.

	Readmission rate for 0-15 year olds	Readmission rate for 16+ years old
2015-16	0.17	0.76
2016-17	0.78	0.63
2018-19	0.19	1.0
2019-20	0	0.93
2020-21	0	1.57

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

- No comparative data is now available
- Data is submitted and checked on a monthly basis as part of regular performance reporting.
- The data has been subject to external audit

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

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

Patient Reported Outcome Measures (PROMS) measures health gain in patients undergoing hip replacement and, knee replacement, varicose veins and groin hernia surgery in England, based on responses to a questionnaire before and after surgery.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients. The responses are combined to provide a single score.

PROMS collect information on the effectiveness of care delivered to NHS patients, as perceived by the patients themselves, making it a particularly important indicator which adds to the wealth of information available on the care delivered to NHS funded patients to complement existing information on the quality of services.

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

by NHS England, Primary Hip replacements, Revision Hip replacements, Primary Knee replacements and Revision Knee replacements.

The table below summarises the Trust's performance as reported in the year 2020/21 for hip and knee replacements as the only PROMS procedures offered by the Trust and provides a comparator to the national average and the highest and lowest scores nationally. Data is also provided for previous years with the publication dates as follows:

- 2015-16 Final Release - August 2017
- 2016-17 Final Release - August 2018
- 2017-18 Final Release – February 2019
- 2018-19 Final Release - February 2020
- 2019-20 Final Release – February 2021

The Trust's data published in February 2021 shows that the Trust achieves good outcomes for its patients, particularly given the complex nature of the procedures it carries out.

Primary Hip Replacement

	EQ5D Index					Oxford Score				
	2015/16	2016/17	2017/18	2018/19	2019/20	2015/16	2016/17	2017/18	2018/19	2019/20
National Average	0.438	0.445	0.468	0.465	0.459	21.607	21.800	22.680	22.680	22.687
Highest Score	0.510	0.537	0.566	0.557	0.539	24.755	25.123	26.299	25.376	25.547
Lowest Score	0.321	0.310	0.376	0.348	0.352	16.884	16.428	18.871	18.752	17.059
Robert Jones and Agnes Hunt	0.414	0.453	0.489	0.496	0.468	20.847	22.211	23.574	24.429	24.135

Revision Hip Replacement

	EQ5D Index					Oxford Score				
	2015/16	2016/17	2017/18	2018/19	2019/20	2015/16	2016/17	2017/18	2018/19	2019/20
National Average	0.283	0.29	0.289	0.287	0.307	13.206	13.512	13.901	13.864	14.065
Highest Score	0.374	0.362	0.322	0.396	0.380	16.209	16.504	17.664	18.961	16.130
Lowest Score	0.224	0.239	0.142	0.206	0.238	9.358	10.253	10.735	7.853	10.648
Robert Jones and Agnes Hunt	0.236	0.334	0.298	0.248	0.297	11.163	13.719	15.912	10.387	14.177

Primary Knee Replacement

	EQ5D Index					Oxford Score				
	2015/16	2016/17	2017/18	2018/19	2019/20	2015/16	2016/17	2017/18	2018/19	2019/20
National Average	0.320	0.325	0.338	0.338	0.335	16.365	16.546	17.259	17.330	17.486
Highest Score	0.398	0.404	0.417	0.405	0.419	19.970	19.884	20.635	20.011	20.688
Lowest Score	0.198	0.242	0.234	0.266	0.215	11.955	12.335	13.156	13.774	12.622
Robert Jones and Agnes Hunt	0.316	0.318	0.354	0.361	0.364	17.027	17.843	18.541	17.740	19.188

Revision Knee Replacement

	EQ5D Index					Oxford Score				
	2015/16	2016/17	2017/18	2018/19	2019/20	2015/16	2016/17	2017/18	2018/19	2019/20
National Average	0.258	0.273	0.292	0.288	0.295	11.980	12.346	13.124	13.598	13.840
Highest Score	0.335	0.296	0.328	0.297	0.394	14.157	13.781	15.444	15.784	16.384
Lowest Score	0.190	0.156	0.196	0.196	0.168	8.328	8.602	9.374	9.014	8.650
Robert Jones and Agnes Hunt	0.190	0.251	0.328	0.279	0.326	8.505	10.946	14.392	15.113	12.439

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

- The Trust is a specialist orthopaedic hospital that continually monitors patient outcomes and best practice to ensure the outstanding patient care and achievements

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

- Continuing to review both national and local data to identify any areas where improvements can be made.
- Internally collecting and monitoring of PROMs in other specialities not currently covered by the national programme.

Staff Survey

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

It should be noted that trusts have been asked to temporarily suspend the Staff FFT during the coronavirus pandemic, however the Staff Survey continued to include the following

question "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". Results to this question are set out below and it is notable that the Trust achieved the best in the country at 95.5%.

	2016	2017	2018	2019	2020
Best	95.1%	93.1%	94.8%	94.9%	95.5%
Your org	92.3%	93.1%	94.7%	94.9%	95.5%
Average	90.5%	89.9%	90.1%	90.0%	91.7%
Worst	76.5%	79.9%	77.7%	81.0%	82.0%

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

- The Trust continues to participate and improve the Staff survey results

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

- An ongoing annual objective for 2021-22 aimed at enabling staff to flourish at work
- Implementation of the people plan

Ensuring that people have a positive experience of care

Responsiveness to Inpatient's Personal Needs

Patient experience measured by scoring the results of a selection of questions from the National Inpatient Survey focussing on the responsiveness to personal needs.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
National Average	68.7	68.9	69.6	68.1	68.6	67.2	67.1	To be released August 2021
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	81.6	79.8	82.0	82.5	81.7	83.8	83.1	
Highest	84.2	86.1	86.2	85.2	85.0	85	84.2	
Lowest	54.4	59.1	58.9	60.0	60.5	58.9	59.5	

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

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

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

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

Patient Friends and Family Test

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

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
National Average	96%	96%	96%	96%	96%	Data not available
Highest Score	100%	100%	100%	100%	100% (to Feb 20)	
Lowest Score	75%	75%	76%	76%	73% (to Feb 20)	
Robert Jones and Agnes Hunt	99%	100%	99%	99%	99% (to Feb 20)	

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

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

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

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

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

VTE Assessment

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

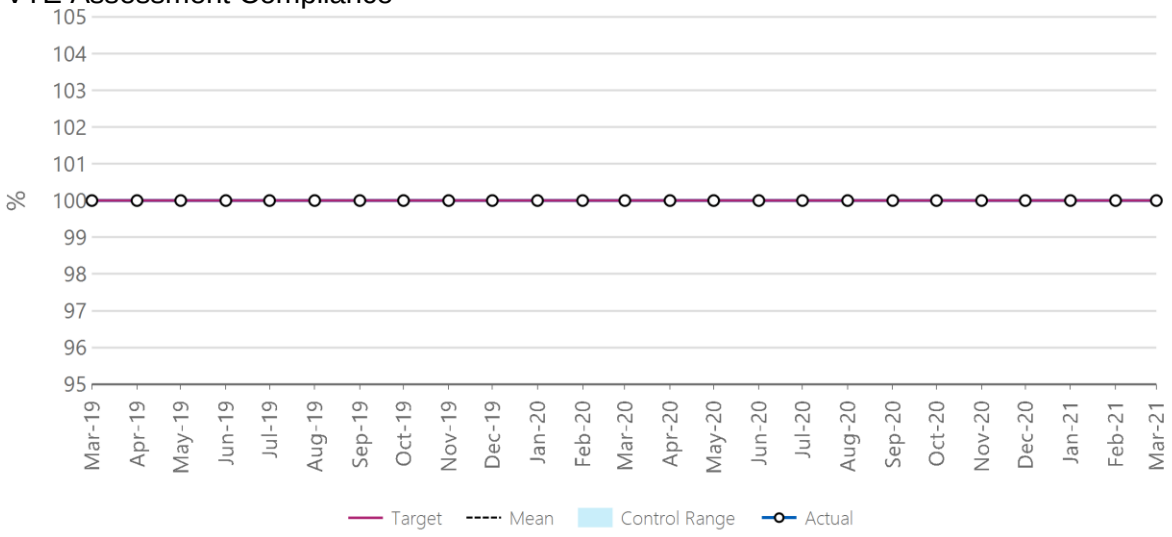
The Trust has in place a robust system of audit to measure compliance with the VTE assessment process. Further, any incidence of DVT or PE is subject to a full root cause analysis review to ensure that learning is taken. The Quality and Safety Committee receives regular reports on the Trust's work on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

The chart below outlines the percentage compliance for VTE assessments for the year (up to Mar 2020) and the preceding three years:

	2016-17	2017-18	2018-19	2019-20	2020-21
National Average	95.75%	95.3%	95.6%	95.5%	
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	100%	99.9%	99.9%	99.9%	99.7%
HIGHEST PERFORMER	100%	100%	100%	100%	
LOWEST PERFORMER	71.42%	64.3%	63.2%	67.5%	

Performance for 2019/21 and 2020-21 by month was as follows:

VTE Assessment Compliance



RJAH has maintained the required percentage of VTE assessments completed. The Trust monitors this through the monthly performance reports. During 2018-19 the Trust implemented recommendations from the internal auditors regarding the capture of the data in order to improve the VTE data quality and this has continued through 2019-20 and 2020-21.

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

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

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

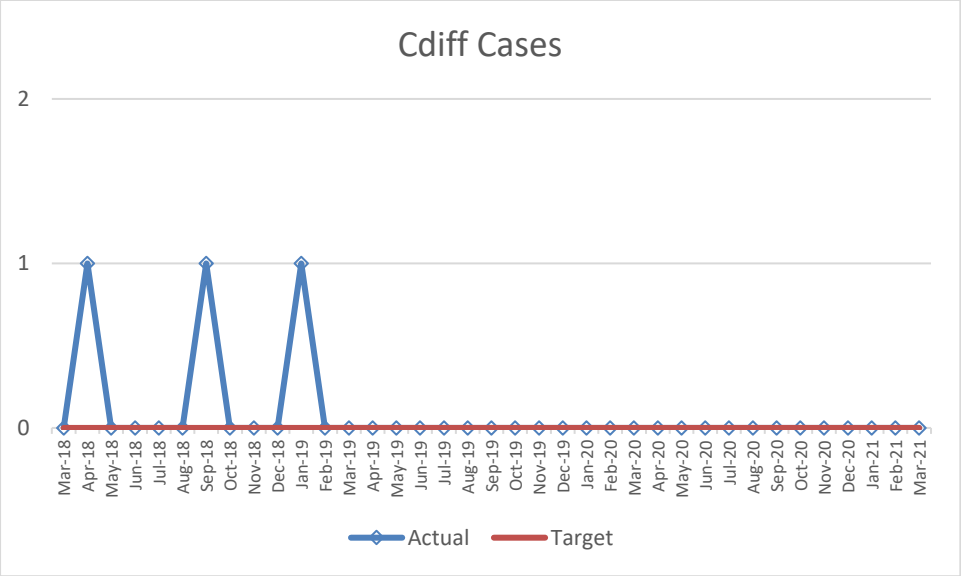
- Ongoing documentation audits to ensure the completion of the necessary risk assessments are further implemented

C.difficile Infections

The Trust measures infection control performance as a rate of Trust apportioned cases per 100,000 bed days of cases amongst patients aged 2+**.**

The Trust has had no attributable cases of C Difficile for the year 2020/21. This was against a target of 0.

Number of C.Difficile Infections



	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	1.9	3.8	2.0	0.0	2.2	6.2	0	0
HIGHEST PERFORMER	37.1	62.2	24.3	82.7	91.0	39.8	37.1	*
LOWEST PERFORMER	0.0	0.0	0.0	0.0	0.0	0.0	0.0	*

* Benchmark data not yet available

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

- Data is reported and monitored on a monthly basis.

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

- Continuing to carry out regular audits and monitoring instances of non-compliance with the Trust infection control and prevention practices

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

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

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

Patient Safety Incidents Reported per 1000 Bed Days

Period of Coverage	Rate of incidents	Number of incidents
Apr 20 – Sep 20		
Oct 19 – Mar 20	37.5	884
Apr 18 – Sep 19	39.50	911
Oct 18 - Mar 19	42.00	987
Apr 18 – Sep 18	39.00	898
Oct 17 – Mar 18	37.40	900
Apr 17 – Sep 17	38.30	820
Oct 16 – Mar 17	36.90	797
Apr 16 – Sep 16	31.90	704
Oct 15 - Mar 16	36.80	871
Apr 15 - Sep 15	29.60	752
Oct 14 - Mar 15	29.00	761
Apr 14 - Sep 14	26.3	684
Oct 13 - Mar 14	9.70	689
Apr 13 - Sep 13	7.20	510

Patient Safety - Severe Harm / Death

Period of Coverage	Rate of incidents	Number of incidents
Oct 19 - Mar 20	0.00	0
Apr 19 - Sep 19	0.04	1
Oct 18 - Mar 19	0.04	1
Apr 18 - Sep 18	0.04	1
Oct 17 - Mar 18	0.00	0
Apr 17 - Sep 17	0.09	2
Oct 16 - Mar 17	0.14	3
Apr 16 - Sep 16	0.00	0
Oct 15 - Mar 16	0.04	1
Apr 15 - Sep 15	0.08	5
Oct 14 - Mar 15	0	0
Apr 14 - Sep 14	0.12	3
Oct 13 - Mar 14	0.07	5

Serious Incidents

In 2020/21 the Trust reported six serious incidents as defined by the NHS England Serious Incident Framework. All of these incidents have had Root Cause Analysis completed and reports prepared for presentation and agreement at Quality and Safety Committee. In

addition, all our serious incidents have been reviewed by the Clinical Commissioning Group to ensure they are in line with the NHSE Framework.

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

- Pressure Ulcers
- 2 Anaesthesia Issues
- 2 Infection Control Issues Relating to Covid-19
- Referral Delay

In comparison, during 2019/20 the Trust reported four serious incidents.

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

In 2020-21 there were 0 never events reported. This compares to 2019-20 when there was 1 never event.

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

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

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

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

PART 3

Review of Quality

Summary of Performance Status for Quality Priorities Set for 2020/21

In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders, the Trust identified the following key priorities for 2020/21:

- Safety: Reduction of medication errors resulting in patient harm
- Safety: Reducing Inpatient Falls
- Safety: Reduce hospital acquired category 2 (and above) pressure ulcers
- Safety: Enhanced patient safety in Theatres & diagnostics
- Safety: Improve detection and escalation of the deteriorating patient in line with national guidance
- Effectiveness: Pathway redesign for primary hips and knees

Progress made for quality priorities 2020/21

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

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

Priority	Metric	Lead	Overview	Recommendations and Actions to take forward	Achieved (Fully, Partial, Not)
1. Reduction of medication errors resulting in patient harm	Reduce by 30% in year 1 with aim of reducing to zero (with harm) within 3 years	Maryse Mackenzie – Medicines Safety Officer (MSO) supported by Sara Ellis-Anderson Executive sponsor: Chief Nurse Clinical Champion: Mr Lewthwaite	A total of 15 low harm incidents recorded in 19/20 and 12 low harm incidents recorded in 20/21. A total of 2 moderate harm incidents recorded in 19/20 compared to 1 moderate harm in 20/21. This Quality Priority was achieved through the Medicines Safety Officer (MSO) having greater understanding of the definitions of harm from the National Learning and Reporting System and quality checking the medication incidents reported. This learning has been shared via monthly medication reports trust wide and a policy has been written and implemented to support managers with responding to medication incidents. Deep dives were conducted to ensure themes were being captured. Allergens were a theme identified and further work to strengthen this is being taken forward.	Continue Trust Wide monthly reports Continue regular deep dive analysis of medication incidents Devise alert icon for use on electronic and paper pathways for allergens	Fully achieved **Monitoring Committee** Medicines Safety Committee

Priority	Metric	Lead	Overview	Recommendations and Actions to take forward	Achieved (Fully, Partial, Not)
2. Reducing Inpatient Falls	Reduce 2.5 falls per 1000 bed days as per Trust target	Nicki Bellinger Executive Sponsor: Chief Nurse Clinical Champions: Andrew Roberts; Linda Head; Helen Yarnold; Nicki Williams	The Falls collaborative was paused during Covid-19. However a Falls lead for the Trust was appointed to continue this work and key objectives. A different cohort of patients was admitted during Q1/Q2 in 2020/21 during Covid, this had an impact on our anticipatory falls reduction. Deep dive analysis summary was presented from Sept 2020 to February 2021 to the Patient Harms Group. A total of 55 total falls in the period 1 Sep 2020 to 28 Feb 2021 there were 5 patients that fell or had a near miss more than once accounting for 12 of the total falls.	Continue Falls Collaborative work through falls prevention task and finish groups Quarterly Falls deep dive to assess themes and trends Analysis of patients that fall multiple times Development of dedicated Trust Falls webpage to share learning. Regular audit of falls documentation.	Partially achieved **Monitoring Committee** Patient Safety Committee

Priority	Metric	Lead	Overview	Recommendations and Actions to take forward	Achieved (Fully, Partial, Not)
3. Reduce ***hospital acquired*** category 2 (and above) pressure ulcers	Reduce incidence by 30% in year 1 (not currently measured in pressure sores per 1000 bed days), therefore aim for a 50% reduction.	Matron supported by Sara Ellis-Anderson Executive sponsor: Chief Nurse Clinical champions: Ward Managers; Tissue Viability link nurses; Pharmacist; MCSI Nurse Consultant	In 2019/2020 a total of 36 moisture lesions and 15 RJAH acquired category 2 HAPU were recorded. For 2020/21 there were a total of 29 moisture lesions; 20 Category 2 HAPU and 1 Category 3 HAPU. Increased HAPU were deemed to be as a result of the patient demographic seen in Q1/Q2 when trauma care was being delivered at RJAH and increased education and awareness amongst staff. An external audit provided a moderate level of assurance for pressure ulcer prevention care and recommendations included strengthening training and regular documentation audits. In addition, an internal audit was conducted with recommendations accepted and being progressed.	Regular documentation audit Education – roll out of system wide e-learning when available To capture themes and trends consideration to be given for ward/department managers to complete short concise RCA for RJAH category 2 acquired pressure ulcers. These recommendations will be taken forward by the Tissue Viability Specialist Nurse.	Partially achieved **Monitoring Committee** Patient Safety Committee

Priority	Metric	Lead	Overview	Recommendations and Actions to take forward	Achieved (Fully, Partial, Not)
4. Enhanced patient safety in Theatres & diagnostics	Audited compliance (using an observational model, rather than audit of documentation) shows improvement of baseline of at least 80%)	Ian MacLennan Executive sponsor: Chief Nurse Clinical champions: Theatre leadership MDT		This is to be carried forward for 2021/22 Quality Priority in the Patient Safety Domain The objectives were not achieved due to Covid-19, redeployment of key staff and lower Theatre activity in 20/21	Not achieved **Monitoring Committee** Patient Safety Committee
5. Improve detection and escalation of the deteriorating patient in line with national guidance	60% of all unplanned critical care unit admissions from wards of patients aged 18+, have received timely escalation and clinical response to NEWS2 score	Craig Lammas supported by Ian MacLennan Executive sponsor: Steve White	.	This is to be carried forward for 2021/22 Quality Priority in the Patient Safety Domain The objectives were not achieved due to Covid-19, redeployment of key staff and the delay in implementing Sepsis 6 and escalation bundles on vital pack upgrade	Not Achieved **Monitoring Committee** Patient Safety Committee

Priority	Metric	Lead	Overview	Recommendations and Actions to take forward	Achieved (Fully, Partial, Not)
6. Pathway redesign for primary hips and knees	75% of patients entered into the rapid recovery programme are discharged within the planned timeframe	Mr Graham Clinical champion: Mr Thomas	There has been significant progress made with this pathway. The priority is now at the pilot phase prior to full implementation.	Continue to monitor impact of pathway redesign through monthly LOS metrics	Partially Achieved **Monitoring Committee** Clinical Effectiveness Committee

Local Quality Indicators *

In addition to the Quality Priorities for 2020-21 the Trust has selected a number of local quality indicators. These remain the same as those reported in 2019-20 save for the falls priority has been removed as this was covered in one of the quality priorities for 2020-21.

Safety

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

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

A Patient Safety Committee has been established and is led by the Chief Nurse and Patient Safety Officer; this is multi-disciplinary and monitors patient safety improvement action plans, risks and associated policies. The Patient Safety Committee receives upward reports from the Patient Harms Group which conducts deep dive analysis on patient safety incidents to determine themes, trends and areas for improvement.

Medication Incidents

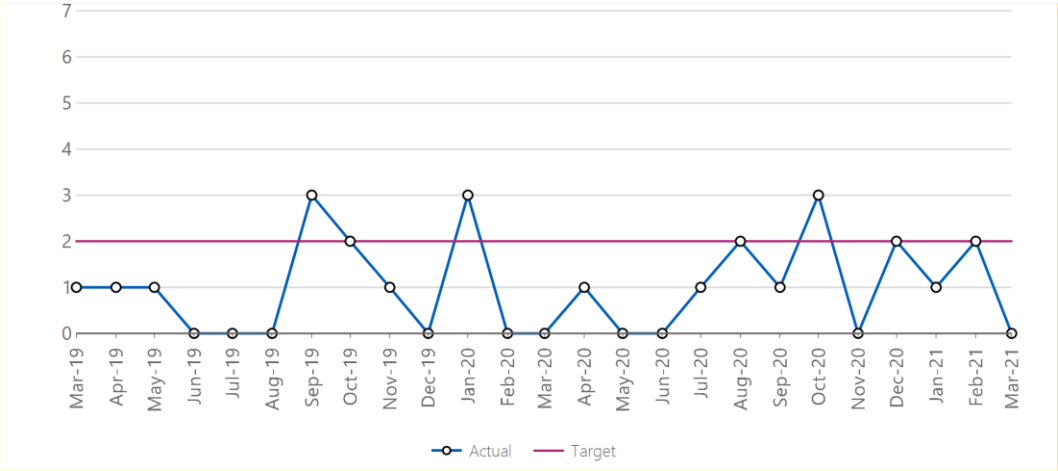
Medication Incidents
Medication errors are any patient's safety incidents (PSIs) where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy.
The Trust have continued to monitor the amount of harm experienced from patient medication incidents together with monitoring the total number of incidents amongst all clinical areas of the organisation.

We have a medication safety group in place chaired by our Chief Pharmacist. Both the Chief Pharmacist the Medicines Safety Officer and the clinical teams work together to ensure that medication incidents are reported and learning occurs.

Ward walkabouts have been limited in 20/21 due to Covid but regular monthly reports have been shared with staff demonstrating the increased reporting of medication incidents whilst the harms have remained low. Key lessons learnt are also shared within this report.

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

Medication errors with harm – performance over 24 months



Learning Lessons from incidents

- The Trust holds incident debrief meetings with relevant teams and support from the Governance Team. These are conducted in a blame-free way with the focus being on the learning.
- Over the last year there has been an increased focus on improving the quality of the incident investigations through a multidisciplinary approach.
- A new Harms Group has been established to focus on the detail of incidents with deep dives conducted into any identified themes or trends.
- The Trust has amended its serious incident investigation template to ensure a systems based focus and increased consideration of human factors.
- The Trust continues to involve patients in serious incident investigations with a nominated Patient/Family Liaison person for each investigation. The investigation reports are shared with patients and where applicable their families and opportunities are provided for the investigation to be discussed with clinical and governance staff.
- Finally, during 2019-20 the Trust reconfigured it's Clinical Governance department to align with each of it's new Units and the Governance Leads are supporting the Units with the reporting of and learning from incidents and this has been further strengthened during 2020-21 with the introduction of Unit Governance Meetings and the Unit Delivery Boards have incidents as a standing agenda item for discussion and sharing.

Sign up to Safety

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has committed its support to 'Sign up to Safety', an NHS England National Patient Safety Campaign.

Sign up to Safety was announced in March 2014 by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has signed up to the campaign and our commitment to the five pledges remains:

1. **Putting safety first.**

Committing to reduce avoidable harm in the NHS.

- Continue to monitor harm through the monthly patient and medicines safety thermometer tool, using the data to identify areas for improvement and putting in place actions to address those areas.
- Comply with safer staffing requirements, displaying daily information on ward staffing boards
- Utilise the national initiative from NHS England around the identification of Acute Kidney Injury (AKI) to improve the identification of this for someone using our services
- Introduction of a clinical prioritisation process to ensure that patients are able to access services in order of clinical priority in line with national guidance
- Introduction of a harms review process which proactively triages patients at the highest risk of harm whilst they are waiting for treatment further in the event of harms being identified the process ensures appropriate learning.

2. **Continually learn.**

Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.

- Continue to actively participate and share learning with the West Midland Safety Collaborative to promote improvements across the NHS
- The introduction of Unit Governance Meetings to consider and share learning and feedback from incidents
  Monitor and audit actions arising from Serious Incidents (SIs) and other serious adverse events to ensure that actions have been effective.
- Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe services are.
- Increased multi-disciplinary approach to serious incident investigations to ensure a broader perspective of mitigating actions

3. **Being honest.**

Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- Continue to ensure that Duty of Candour is applied across the Trust
- Link in with the Local Health Economy (LHE) to strengthen and develop our learning
- Provide regular updates to the Patient Panel on the progress against our Sign up to Safety action plan
- The appointment of a patient / family liaison person in the event of a serious incident, this role provides a link and ensures there is patient and/or family input into any investigation as well as a sharing of any outcome.

4. **Collaborate.**

Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

- Introduce change collaboratives for key areas relating to patient harm
- Celebrate what we do well
- Working on the quality strategy as a system to ensure cross organisational collaboration

5. **Being supportive.**

Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate the progress.

- Deep dives undertaken through the Trust's Harms Group
- Where harm has occurred, this will be shared to ensure maximum learning
- Encourage all staff to Sign up to Safety and complete personal pledges
- The introduction of rolling half days for the education and support of staff

Schwartz Rounds- Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research into the effectiveness of Schwartz Rounds shows the positive impact that they have on individuals, teams, patient outcomes, and organisational culture

Human Factors- We recognise that at the heart of our approach to quality and safety improvement, there needs to be awareness of the interactions between people, and between people and non-human elements involved in complex systems. Human Factors is not a stand-alone solution, but rather a broad approach that ensures that people have a better understanding of how people are affected by the teams they work with, the systems they operate, and the environment they work within. It ensures that people know how the combination of the factors affects patient safety and wellbeing so that consistently safe and reliable care can be provided to our patients.

Effectiveness

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

In 2020-21 NICE published 150 Guidances to which there were:

- 5 clinical guidelines
- 48 National Guidelines
- 18 Interventional procedures
- 66 Technology appraisals
- 9 Medical Technologies guidance's
- 5 Diagnostic Guidance's
- 2 Highly Specialised Technology Guidance's

NICE also produced 64 advice/recommendations to which there were:

- 11 Evidence Summaries
- 40 MedTech innovation briefings
- 13 Quality Standards

A baseline assessment was carried out for guidance's relevant to the Trust and where appropriate audits were undertaken to measure compliance are put in place. Audits that are being carried out or have been carried out in 2020/21 in relation to NICE guidance include:

- National Rheumatology Audit CG 79 and QS 33
- Catheter associated UTI's on MCSI over a 3-month period (QS Urinary tract infections in adults)
- Audit of Acute Upper GI Bleed among in-patients (CG 141 Acute Upper GI Bleeding in over 16's: management)
- Low back pain and sciatica: Ax and management in the Physiotherapy Department (NG 59 Low back pain and sciatica in over 16's: assessment and management)
- Reaudit of Delirium among in-patients (CG 103 Delirium: prevention, diagnosis, and management)
- An audit measuring compliance of VTE prescribing and documentation (NG 89 Venous thromboembolism in over 16's: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism)

Health and Safety

Health and Safety incidents are monitored on an ongoing basis throughout the year. All incidents are investigated and remedial actions taken to prevent or reduce the likelihood of reoccurrence. Those incidents reported that involve specified injuries, dangerous occurrences or result in a member of staff taking more than seven days off work as a result of a work-related accident are also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

During 2020-21 there were 8 incidents reported to the HSE under the requirements of the RIDDOR regulations compared with 5 in 2019-20 and 3 in 2018-19. Six of the incidents resulted in staff sickness absence of more than seven days; two reports were as a result of COVID-19 outbreaks on wards.

Improvements were made to health and safety oversight, with the establishment of a Health and Safety Working Group and a review of the membership of the Health and Safety

Committee. Terms of Reference of the Fire, Security and Electrical Systems Group were also reviewed.

The Chief Nurse retained Board-level responsibility for health and safety, with the Health and Safety Committee being chaired by the Director of Estates and Facilities. The Trust employed a 0.4 WTE Health and Safety Advisor to assist with compliance with the requirements of section 7(1) of the Management of Health and Safety Regulations 1999.

The Health and Safety Committee met bi-monthly and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations 1977. The Health and Safety Working Group was chaired by the Health and Safety Advisor with a remit to manage operational level safety issues and to improve the safety culture of the Trust.

Chair's reports from the Health and Safety Working Group and Fire, Security and Electrical Systems Group were presented to the Health and Safety Committee, with an overarching Chair's reported presented to the Risk Management Committee.

Experience

Highlights of the Patient Experience Strategy

The Trust has maintained excellent patient care delivery despite the challenges of the ongoing Covid 19 pandemic to improve the patient experience. The main aims of the Strategy are:

- Listening to what our patients, relatives, carers and the public say about our services what their priorities of care are and how to align them together.

Provide patients, relatives and service users with information which enables them to make informed decisions about their care in a manner which is accessible for them to understand.

- We will engage with our patients to facilitate support they need to manage their own health conditions and get the best out of maximising their wellbeing through a collaborative partnership.
- We will listen to the needs and priorities of our patients to ensure that we make sure our patients have a voice and we act upon these. In doing so our patients will feel safe and cared for. The Trust will participate in the Always Events® initiative.

The Trust is implementing the Ready, Steady, Go project to assist clinicians work with young adults to prepare them to transition to adult care and take responsibility for their own long term condition or health care needs.

Building on the previous strategy is a commitment to continue to work in partnership with our patients, staff and stakeholders. Restarting the patent participation group panel via virtual platforms to maintain safety of the members to provide their valuable contribution is vital to the experience strategy.

The Trust is seeking new members to join the patient panel to provide a more diverse group which brings new perspective to patient experiences whilst recognising the valuable contribution of existing members.

The IQVIA was paused during Covid however this has now been restarted and is a tool to monitor patient feedback in relation to their inpatient stay or clinic appointment in a timely. Satisfaction results with patient care remain positive.

Inpatient questions and results

Ward/Clinic	Surveys	Overall experience of the service?	Were staff caring and compassionate?	Did you like the food provided?	Ward was clean?	Staff welcoming and friendly?	Acceptable night noise levels?	Good hand hygiene?	Privacy/dignity protected?	Admission date changed?	Support from staff after discharge?	Involved in decisions in your care?	Total
Baschurch	618	98	99	94	99	99	98	99	99	91	95	95	**97**
Clwyd	101	99	99	89	100	99	83	99	99	84	92	96	**94**
Gladstone	100	91	93	82	96	96	78	98	96	91	85	79	**89**
Kenyon	42	97	98	87	98	98	77	100	99	89	85	88	**92**
Ludlow	47	99	99	92	100	100	91	99	100	91	98	97	**97**
Oswald	94	97	97	90	99	98	95	99	98	91	92	93	**95**
Powys	68	99	99	85	98	99	83	99	100	87	95	93	**94**
Recovery	1	100	100	100	100	100	100	100	100	66	100	50	**92**
Wrekin	47	98	96	85	99	96	89	97	100	96	90	93	**94**
Overall	**1118**	**97**	**98**	**91**	**99**	**99**	**89**	**99**	**99**	**90**	**93**	**93**	**95**

Outpatient Questions and Results

Ward/Clinic	Surveys	Overall experience of the service?	Ward was clean?	informed on waiting times?	Staff welcoming and friendly?	Privacy/dignity protected?	HCP explain procedure?	Staff caring and compassionate ?	HCP introduce themselves?	HCP listen to you?	Total
Main Outpatients	6042	96	99	83	98	99	98	98	97	99	**96**
MCSI Outpatients	129	97	99	94	99	99	99	99	98	99	**98**
Montgomery	182	99	99	89	99	99	99	99	100	100	**98**
MRI	1	50	100	75	50	75	75	75	100	100	**78**
Pre-Op	1027	95	99	79	98	99	98	98	99	100	**96**
SOOS - non-RJAH	4	94	100	94	94	100	100	94	100	100	**97**
SOOS - RJAH	301	96	97	73	96	99	98	97	98	99	**95**
Overall	**7687**	**96**	**99**	**83**	**98**	**99**	**98**	**98**	**97**	**99**	**96**

Key:	
<= 100	
< 75	
< 50	

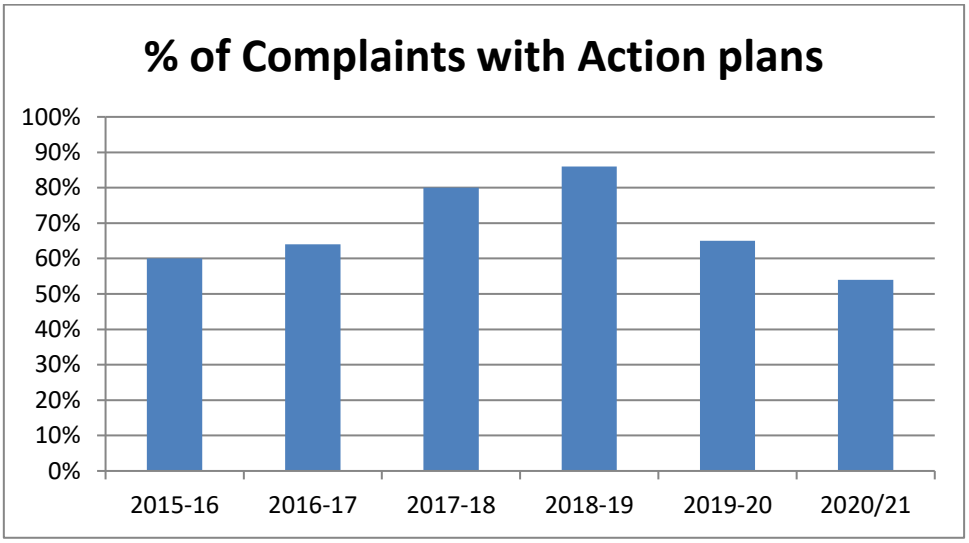
The Trust is resolved to embed a strong safety culture in the Trust, where everyone takes responsibility for their actions, including patients and their visitors. This is aligned to the Trusts core values and ambition to reduce preventable harm.

The Trust has continued to undertake internal PLACE assessments during Covid. With the lifting of restrictive measure full Place assessments will be reinstated following risk assessment. The PLACE assessments will provide incentive for improvement by presenting a message, directly from patients, about how the environment or services might be enhanced ensuring that every patient should be cared for with compassion and dignity in a clean, safe environment.

Learning from Patient Feedback/Changes in Practice or Service Improvement

The Trusts collects patient experience data as an active part of monitoring the quality of care which provides an important “health check” of the services we provide as well as promoting a strong culture of listening to patients. It provides a valuable insight into how we can improve and design services better improving services.

The Trust recognises the opportunity patient feedback provides to identify areas for improvement and it is for this reason it committed to increasing the percentage of complaints with resultant action plans.



Patient Stories

How we use Patient Stories?

The Trust regularly listens to patient stories and the Board welcomes hearing about both positive and negative experiences.

Stories help patients tell their experience in a constructive way to help us re-design and improve services according to their varying needs. Sharing any lessons learnt through positive stories is valuable way of promoting good practice and to take forward suggestions for improvement with Clinical teams.

The monthly Trust Board meetings start with a patient or staff story. This can be told by the patient or carer or staff member attending the meeting or by sharing the story in writing.

Covid-19 has brought challenges with presenting patient stories at Board due to the meetings being held virtually but the Trust has introduced video patient stories to ensure the patient voice can still be heard by the Board.

How are patient stories collected?

The Clinical Governance Team contact patients following either a PALS contact, complaint or a referral from a department of a suitable patient story. We also invite patients who have made a complaint to ask if they want to do a patient story.

Patient consent is always obtained so that the patient is aware that their story is being shared across the Trust. They are asked if want a reply and whether to share their story anonymously or not.

Examples of the Patient Stories shared at Trust Board

Three patient stories have been shared at the Trust Board meeting between April 2020-March 2021 with actions identified for improvement as below:

- Following a patient having wrist surgery as a day case patient in March 2020 improvements have been made on keeping patients better informed about waiting times in the Baschurch Unit. As wells staff offering patients a bed to wait if one is available rather than the waiting room if the wait is causing them concern.

- A digital patient story was shared at the January 2021 Trust Board meeting from a hand trauma patient who had two operations. The patient was happy with their overall care and improvements have been made to the COVID screening processes to reduce staff handling of paper questionnaires as well as a fast-track process for low risk patients on a green pathway.

- A patient story was shared at the March 2021 Trust Board meeting from a patient who had spinal surgery in November 2020.They reported on the little things that make a big difference including staff going the extra mile and friendly staff. The patient felt that there was not much we could improve on apart from more signage to advise patients that assistance was available if the walk from the main entrance to Menzies was causing difficulties. A poster has since gone up to advise this.

Patient Friends and Family Test

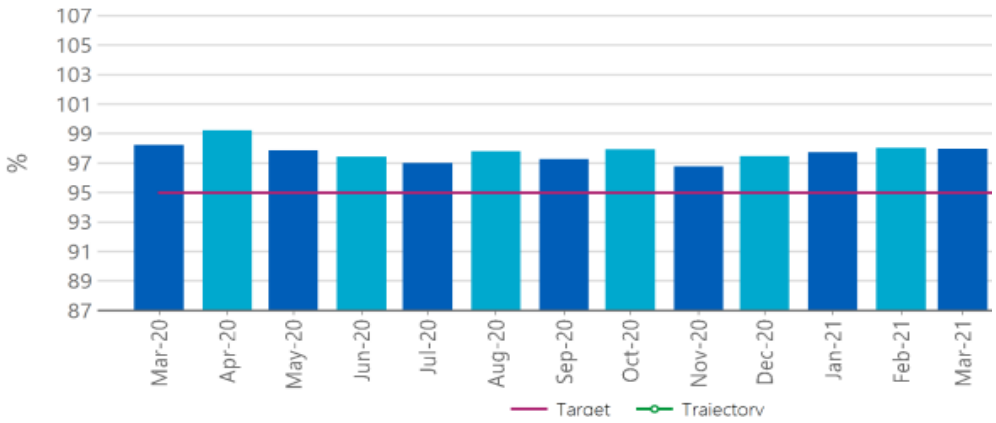
The FFT question “Overall, how was your experience of our service” was updated nationally in April 2020 and was designed to be a quick and simple mechanism for patients and other people who use NHS services to give their feedback.

The collection of FFT data was paused nationally from April 2020- November 2020 due to the Covid-19 pandemic. However SMS texting of patients to invite them to complete a FFT survey electronically (after discharge or clinic appointment) continued where this had been set up for a cohort of departments. The use of paper surveys and iPads to collect the data was also discouraged due to Infection control reasons.

In December 2020 further department were added to the SMS texting process to cover most wards and clinics.

For 2020/21, 9008 patients completed a FFT survey and 97.7% of patients (inpatients and outpatients) said they would rate their experience as good or very good.

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



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

The FFT data is collected in real time using the IQVIA feedback system. Staff are sent an email alert as soon as a low score is received as feedback is immediately uploaded and available for staff to respond and action for their department.

The suggestions for improvements or negative comments are shared with the relevant clinical areas to ensure that any areas for improvement can be addressed.

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

	2016/17	2017/18	2018/19	2019/20	2020/21
National Average	96%	96%	96%	96%	95%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	75%	64%	76%	73%	41%*
Robert Jones and Agnes Hunt	100%	99%	99%	99%	98%

* National data for Dec 20-Feb 21)

The slight decrease in the FFT score for 2020/21 from 2019/20 is due to more low scores being received from outpatient areas clinics compared to previous years, 0.63%.

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

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

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

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

Back to the Floor / Virtual Visits

During 2017-18 the Trust introduced back to the floor events whereby senior managers went to work in departments for the day. This interaction, as with the patient safety walkabouts, provided opportunity for staff to provide feedback on their experiences of working in the department. Equally it enables senior managers to speak with patients being cared for in those areas to hear first-hand experiences. These events have continued with two further events held during 2018-19 and one held in 2019-20. During 2020-21 the Trust introduced virtual visits in place of back to the floor to ensure that departments could showcase their services and have the opportunity to discuss any concerns they may have with the senior team.

Freedom to Speak Up Guardians

The Trust has in place three Freedom to Speak Up Guardians (FTSUG), Liz Hammond, Hilary Pepler and Jan Greasley. Liz Hammond is contracted for 7.5 hrs a week to the FTSUG role.

All referrals via the RJAH FTSUG e-mail address, the RJAH FTSU App and personal one to one's are dealt with by Liz Hammond, Hilary Pepler and Jan Greasley.

The majority of the concerns, during Covid Pandemic of 2020, are in relation to PPE and social distancing issues. FTSU has received 6 patient safety related concerns, 8 bullying and harassment concerns and one case of detriment has been recorded.

FTSU Concerns are acknowledged within 48 hours.

Every concern has been escalated with appropriate action taken. Feedback and regular support have been given to those that raised a concern.

All responses have been accurately documented either via the App log and the Excel encrypted spreadsheet.

The Guardian reports to the People Committee on a yearly basis on any themes and trends identified from the referrals and comparisons are drawn with similar size Trusts.

Regular bi-monthly updates are given to the executive FTSU Lead, Sarah Sheppard,

Since April 2020- April 2021 there have been a total of 33 concerns raised via the App, the FTSU Trust e-mail address and face to face. Below is data provided to the National Guardians Office.

Quarterly FTSU Data April 2020-March2021				
Size of organisation	Less than 5,000 (small)	April-June	July-Sept	Oct-Dec	Jan-March
		Q1	Q2	Q3	Q4
Number of cases brought to FTSUGs / Champions per quarter		9	5	12	7
Of which there is an element of					
Number of cases raised anonymously		6	2	4	4
Number of cases with an element of patient safety/quality		1	2	0	3
Number of cases with an element of bullying or harassment		1	0	5	2
Number of cases where people indicate that they are suffering detriment as a result of speaking up		0	0	1	0
Other		2	1	4	0
Numbers of cases brought by professional group					
Administrative/clerical staff		0	1	2	0
Allied Healthcare Professionals (other than pharmacists)		1	0	2	1
Board members		0	0	0	0
Cleaning/Catering/Maintenance/Ancillary staff		0	0	0	0
Corporate services		0	0	0	0
Dentists		0	0	0	0
Doctors		0	0	1	0
Healthcare assistants		0	0	1	0
Midwives		0	0	0	0
Nurses		2	1	2	3
Other		6	3	4	3
Pharmacists		0	0	0	0

There has been a marked increase in the number of staff using the FTSUG's compared with 2019-20 where a total of 14 cases have been recorded.

Data continues to be submitted for each quarter to the National Guardians' Office regarding the numbers of referrals.

The FTSUG, Liz Hammond, has attended the monthly Regional Network meetings and the bi-monthly National Guardian Regional meetings.

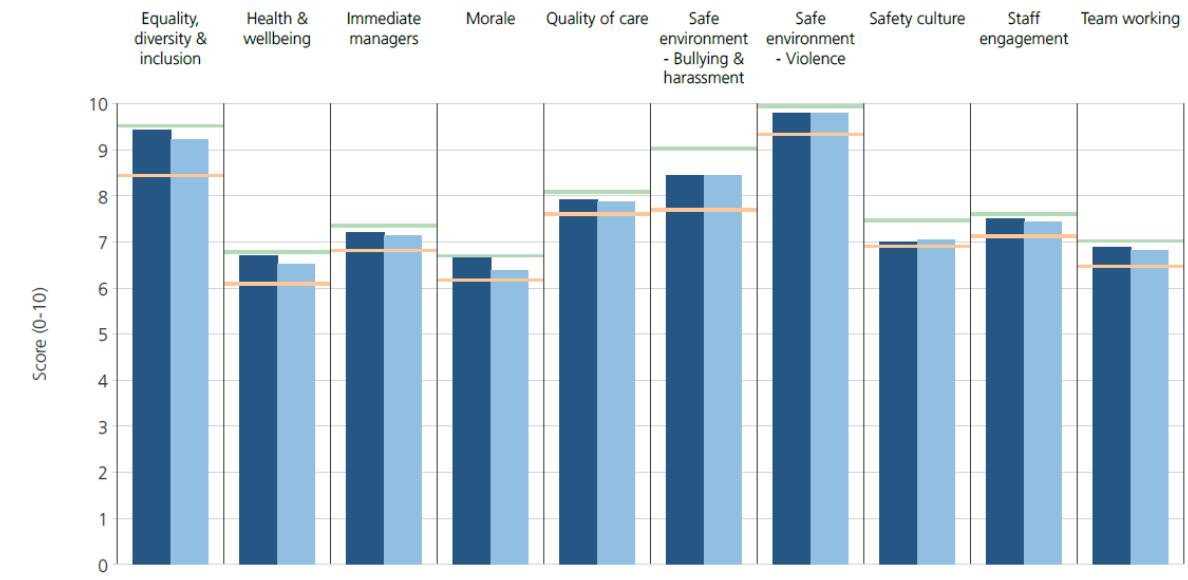
National Quality Indictors

Staff Survey results

Further improvements were seen within the 2020 NHS Staff Survey. 95.5% of respondents would be happy with the standard of care provided if a friend or relative needed treatment and 79% of respondents would recommend the Trust as a place to work. 87% of responses agreed the care of patients/service users was the organisation's top priority.

The response rate, and themed results are detailed below:

Response Rate	2017	2018	2019	2020
	41.5%	44.9%	62%	57%



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.8	7.3	6.7	8.1	9.0	9.9	7.5	7.6	7.0
Your org	9.4	6.7	7.2	6.7	7.9	8.4	9.8	7.0	7.5	6.9
Average	9.2	6.5	7.1	6.4	7.9	8.4	9.8	7.0	7.4	6.8
Worst	8.4	6.1	6.8	6.2	7.6	7.7	9.3	6.9	7.1	6.5
Responses	892	895	898	894	767	898	896	895	897	886

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

Single Oversight Framework

The following section outlines the Trust's performance against the relevant indicators and performance thresholds set out in the NHS Improvement Single Oversight Framework where this data does not appear elsewhere in the report. There was a notable drop in 2020-21 which is a consequence of the Covid-19 pandemic.

Referral to Treatment Times (RTT)

	Info taken from the published annual accounts						
Indicator for Disclosure	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate	**90.89%**	**86.28% (based on Q4 only)**	**88.51%**	**89.49%**	**90.26%**	**88.85%**	**54.41%**
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	**78.95%**	**93.75%**	**92.59%**	**75.76%**	**58.33% with adjusted mitigated position of 73.91%**	**86.84%**	**75.00%**
C. difficile – meeting the C. difficile objective	**2**	**0**	**0**	**0**	**3**	**0**	**0**
Maximum 6 week wait for diagnostic procedures	**99.33%**	**99.8%**	**99.84%**	**99.57%**	**98.97%**	**97.94%**	**59.00%**
Venous thromboembolism (VTE) risk assessment		**100%**	**100%**	**99.9%**	**99.88%**	**99.89%**	**99.74%**

APPENDICES

Statement of Directors' responsibility in respect of the Quality Account

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2020 to March 2021
    - Papers relating to quality reported to the board over the period April 2020 to March 2021
    - Feedback from Shropshire Clinical Commissioning Group dated 22 June 2021
    - Feedback from the Trust's Lead Governor dated 22 June 2021
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey 2020
    - The latest national staff survey 2020
    - CQC inspection report dated February 2019
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

23 June 2021 Frank Collins, Chairman

23 June 2021 Mark Brandreth, Chief Executive

RJAH Quality Account Statement from Shropshire Telford and Wrekin Clinical Commissioning Group 2020/21

Date: 22nd June 2021

NHS Shropshire, Telford & Wrekin CCG response to RJAH Quality Account 2020/21

Shropshire, Telford and Wrekin CCG act as the commissioner for Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)

We welcome the opportunity to review and provide a statement for the Trusts Quality Accounts for 2020/21. The CCG remains committed to ensuring, with partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality and effectiveness, patient safety and patient experience.

In doing so, the Quality Account has been reviewed in light of key intelligence indicators and the assurances sought and given in monthly Clinical Quality Review Meetings (CQRM), attended by commissioners, triangulated with information and further informed through Quality Assurance visits to gain assurance around the standards of care being provided for our population.

Firstly the CCG would like to acknowledge the challenges during 2020/21 the Covid-19 pandemic has bought and acknowledge and commend the actions and contribution of the workforce during this difficult period of time.

The CCG acknowledge these Quality Accounts set out the key achievements in 2020-21, as well as sharing priorities for 2021-22 and that the quality priorities for 2020-21 were set prior to the Covid-19 pandemic and have been worked on throughout the year in order to maintain quality services throughout the pandemic.

In the Quality Account for 2019/20 the Trust set out six Quality Priorities for 2020/2021. The CCG recognises the work undertaken by the trust to improve the quality of patient care, clinical quality, patient safety and patient experience through 2020/21 and the trust have highlighted their improvements in the six priority areas and identified further work that is required to be carried out.

The commissioners look forward to seeing further progress with continued improvements in 2022/23

Whilst reviewing the Quality Account we were pleased to note many of the specific actions that the Trust has taken during 2020/21 to improve its services and the quality of care that it provides. The Trust has worked hard to address key areas to improve patient safety and has continued to strengthen learning from incidents, complaints and feedback; however, the CCG's would like to commend the trust for the following key achievements achieved during 2020/21:

- The Trust has maintained low infection rates, with no MRSA bacteraemia since 2006 and low surgical site infection rates. The trust ensures ongoing monitoring and surveillance of all infections, as well as regular monitoring of ward and department level practices.
- The National NHS Staff Survey provided positive feedback with 57% of staff completing the survey and a record 96% of respondents saying they would be happy with the standard of care provided if a friend or relative needed treatment.
- The Trust remains committed to promoting equality and inclusion for both its staff and patients and in June 2020 the NHS Rainbow Badge was launched. The badge provides staff with a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBTQ+, and acts as visual symbol identifying the person wearing it as someone who is there to listen.
- From April 2020- March 2021 there were zero never events reported.
- For 2020/21, 9008 patients completed a FFT survey and 97.7% of patients (inpatients and outpatients) said they would rate their experience as good or very good.

There are notable areas of success as well as areas that continue to require focus and improvement. 2021/22 will continue to bring challenges for the Trust, as commissioners we believe that the Trust's values will drive forward the objectives and they will continue to improve quality across the breadth of services we commission, their continuous improvement will benefit our patients in the care they receive.

Lead Governor's Submission on the Quality Account Report for 2020-21 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

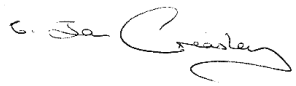
The Quality Account Report 2020-21 demonstrates the continued significant achievements the Trust has made over the last year despite the challenges of Covid-19. This is particularly evident through the Inpatient Survey Results and Staff Survey Results and there is continued evidence of the Trust's work to strive for improvement.

The Governors involvement within the hospital has been challenged and limited by social distancing requirements but where possible we have continued to be involved in meetings and visits virtually and these are welcomed opportunities to provide input on behalf of the Trust's members. Our ability to communicate directly with patients about their experiences has certainly been hampered but we are looking forward to re-instating socially distanced Governor Surgeries for the year ahead.

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

The Council of Governors have been involved in the consideration and agreement of the priorities for 2021-22 and we are looking forward to supporting the Trust with its continued quality improvements.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2020-21.



Jan Greasley
Lead Governor

22 June 2021

Glossary

ADOS	Admit on Day of Surgery
AED	Automated External Defibrillator
AKI	Acute Kidney Injury
ALS	Advanced Life Support
BLS	Basic Life Support
CAF	Common Assessment Framework
CARMS	Clinical Audit Registration and Management
CAS	Central Alerting System
CCG	Clinical Commissioning Group
CKD	Chronic Kidney Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CTPA	Computed Tomography Pulmonary Angiography
Datix	Incident reporting system used by the Trust
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguard
EPALS	European Paediatric Advanced Life Support
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Records
FFT	Friends & Family Test
HCR	Healthcare Records
HSE	Health & Safety Executive
IARC	Incident Action Review Committee
IHCR	Integrated Health Care Record
ILS	Immediate Lift Support
INR	International Normalised Ration
IOSH	Institute of Occupational Safety and Health
KAFO	Knee Ankle Foot Orthoses
KIDS	Kids Intensive Care and Decision Support
KPI	Key Performance Indicator
LADO	Local Area Designated Office
MCQ	Multiple Choice Questions
MCSI	Midland Centre for Spinal Injury
MHRA	Medicines Health & Regulatory Agency
MOPD	Main Outpatient Department
MRSA	Methicillin Resistant Staphylococcus Aureus
MSL	Medical Services Limited
MSSA	Methicillin Sensitive Staphylococcus Aureus
MTC	Major Trauma Centre
NEBOSH	National Examination Board in Occupational Safety and Health
NICE	National Institute for Health & Clinical Excellence
NIHR	National Institute of Health Research
NJR	National Joint Registry
NPSA	National Patient Safety Agency

NRLS	National Reporting and Learning System
NSCISB	National Spinal Cord Injury Strategy Board
OSS	Oxford Shoulder Score
PALS	Patient Advice and Liaison Service
PDSA	Plan Do Study Act
PICU	Paediatric Intensive Care Unit
PILS	Paediatric Immediate Life Support
PLACE	Patient Led Assessment of the Care Environment
PONV	Post-Operative Nausea and Vomiting
PROM	Patient Reported Outcome Measures
RCA	Root Cause Analysis
RCN	Royal College of Nursing