Quality Accounts
2015/2016

Delivering Outstanding Patient Care
April 2016
QUALITY ACCOUNTS

What are the Quality Accounts and why are they so important?

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

The purpose of the quality account is to enable:

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

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

- Patient safety.
- The effectiveness of treatments that patients receive.
- Patient feedback about the care provided.

Our Quality Account contains information about the quality of our services, the improvements we have made during 2015/16 and sets out our key priorities for the forthcoming year. The report also includes feedback from our patients on how well they think we are doing.
Foreword from Acting Chief Executive John Grinnell during 2015/16

The delivery of outstanding patient care remains the core target of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust. This is supported by the Trust's five-year 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 and challenges in 2015/16, as well as sharing our priorities for 2016/17 and we hope that this will provide our patients, their families and carers with confidence in the quality of our services.

During the last year, we have been the subject of a Care Quality Commission inspection, the results of which were published in March. Overall, the Trust was rated as ‘Requires Improvement’ though we were rated as ‘Good’ for the care provided by our staff and also for the quality of our surgical services.

Good care is at the heart of what we do so it is an important message to take out of this report, that this is an area where we are most definitely getting it right. The report also raises some issues that we must improve upon. We do not seek to dismiss these challenges, and have already begun work on delivering a detailed action plan to make improvements which will benefit our patients.

The last year has also seen us working with Monitor, our health care regulator, to address historical challenges around our Referral To Treatment performance, which has seen a number of patients waiting longer than we would have expected to access our services. Monitor have found us to be in breach of aspects of our operating licence as a result of these difficulties, and we have been working closely with them and other external stakeholders to establish a sustainable recovery plan.

As we reflect on the last 12 months, there is much we can look back on with pride. 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.

The Trust has continued to use the “Safety Thermometer” to monitor incidents of harm to patients in the course of their hospital treatment and has consistently scored over 98% of patients having received “no new harms” whilst at the Trust, which exceeded the target of 95%. Learning from all patient safety incidents is promoted throughout the Trust with examples of good practice shared at a variety of meetings.

Our £15.1 million theatre and ward development is close to completion and this will bring tremendous benefits for our patients. It includes four new clean air Theatres, a High Dependency Unit and an Admission on Day of Surgery Unit. A new dedicated Bone Cancer Centre with inpatient and clinic facilities and a flexible multi-use ward will sit on the first floor.

We gained some much-deserved national recognition in the past year as well, with Rebecca Warren – Ward Manager of the Midland Centre for Spinal Injuries – winning the Clinical Leadership Award at the prestigious Patient Safety Awards 2015. Rebecca was praised for building sustainable systems and processes, creating a team ethos which improves patient care and staff experience.

The Trust has continued to use a ward-based nursing assessment process, ‘STAR’ (Sustaining quality Through Assessment and Review), to provide assurances with regard to 14 standards based upon national recommendations. All seven adult inpatient wards have been assessed, with five wards achieving the maximum four-star status in 2015/16.

We have pledged our support to NHS England’s Sign up to Safety campaign in the last year. We know we have a strong track record on delivering safe care and avoidance of harm, but we also know there is no room for complacency. As part of this campaign, we have made five key safety pledges which focus on specific clinical areas where local data shows that we can make improvements.

The most recent national staff survey found that 93% of staff would recommend the hospital to their family and friends as a place to come for treatment; this is the joint highest score in the NHS. Staff are very proud of the service that they deliver, giving patients even more confidence in the care and treatment provided by the hospital.
The Trust also continues to receive excellent patient feedback and is one of the top performing NHS Trusts in the country. This is reflected in sources including the National Inpatient Survey and the Friends and Family Test.

This Quality Account demonstrates our commitment to ‘Delivering Outstanding Patient Care’ to all of our patients.

I am pleased to confirm that the Board of Directors has reviewed the 2015/16 Quality Accounts and confirm to the best of my knowledge that the information contained in the document is an accurate, true reflection of our performance.

John Grinnell
Acting Chief Executive during 2015/16
Forward Look from Chief Executive Mark Brandreth 2016/17

It is a privilege to be the Chief Executive of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust. At the time of writing I have been in post for a matter of days, but already I have been inspired by the care and pride displayed by our staff.

As I look ahead to my first year in post, it is clear that we have challenges around our access targets that we must address, and improvements we want to make on the back of our CQC Report. These are certainly priorities for me, but we will only do that if we recognise importance of our people. We are rightly known for the high quality of care we provide and the outstanding outcomes we deliver. That is down to the talented people we have working here, and now we must continue to adapt and listen to our patients and each other.

Everything we do falls into three key domains:

- Caring for our patients
- Caring for our staff
- Caring for our finances

These are themes to which I will return over and over again during the course of the next year. If we are getting it right in each of these areas then we will not go far wrong.

There is much to be excited about in the next 12 months as well, not least the opening of our £15.1 million Theatre and Ward Development in the autumn. It is truly state-of-the-art and will have a real impact on how we can provide even safer care.

I am confident that when I come to write this foreword again in 12 months’ time, I will be able to reflect on a year where we met our challenges head on, celebrated our many successes and made real progress towards our vision of being the leading centre for high quality, sustainable orthopaedic and related care in the UK.

Mark Brandreth
Chief Executive from 1 April 2016
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Our Priorities

Review of Last Year’s Priorities

Last year we set ourselves the following three key priorities:

- Zero Tolerance of wrong site procedures
- Implementation of the STAR assessment in Theatres
- Rollout of dementia-friendly environment across the organisation

Zero Tolerance of wrong site procedures

Why this was a priority
Wrong site surgery is on the list of Never Events set out by the Department of Health. During 2013/14 and 2014/15 the Trust had two Never Events, as well as four serious incidents, which, although not classed as Never Events, involved patients being given wrong site nerve blocks. A number of changes were implemented and the Trust processes were recently audited by the Trust’s Internal Auditors, who gave a finding of significant assurance with minor improvements. The Trust would like to ensure that these changes are sustainable and therefore set a priority of ensuring zero tolerance to wrong site procedures in 2015/16.

All wrong site procedure incidents are reported as Serious Incidents; these are reported to the Board on a monthly basis, with the Quality & Safety Committee reviewing the subsequent investigation report.

What we did in 2015/16
During 2015/16 work was undertaken to ensure that the WHO (World Health Organisation) checklist procedures carried out prior to surgery were fully embedded in the Trust. In addition, a procedure in relation to checking levels prior to commencing spinal surgery was agreed with other Trusts in the Specialist Orthopaedic Alliance and implemented.

How we did in 2015/16
During 2015/16 we had no Never Events or wrong site procedures

Implementation of the STAR Assessment in Theatres

Why this was a priority
Part of our Quality Strategy 2014-2017 is to provide care to our patients, which is safe, effective, caring and responsive to the needs of the population we serve. This links into one of our strategic aims 'to be the provider of choice for patients through the provision of safe, effective, high quality orthopaedic and related care'.

The STAR (Sustaining Quality Through Assessment & Review) assessment is a trust-wide uniform approach in monitoring quality standards of patient care, and offers managers and their staff a structure of expectations for their wards and department. It provides assurance for staff, patients, relatives, visitors and the senior management team that there is a practical robust system in place which monitors compliance against national standards.

How we did in 2015/16
The department had their first assessment in November 2015 and each of the three areas achieved two Stars with actions identified for improvement. Following reassessment in March 2016, each area achieved three Stars across the 14 standards covering aspects of the Environment, Care and Leadership.

The STAR assessment is an ongoing process with a number of actions completed since its introduction to the theatre/anaesthetics and recovery areas. Some improvements include; the purchase of new trollies for each bed space, decluttering of areas, actions to reduce ward noise levels, staff training on adult safeguarding mental capacity and DoLS (Deprivation of Liberty Safeguards) which include in-house teaching on audit days to ensure information is cascaded.

The development of Quality and Safety Board for staff information which displays visually to all staff how the department is performing regarding infection control audits and cleanliness, number of incidents recorded, and any themes and lessons learnt which is shared with staff. Development of the safety
crosses specific to this area which monitors safety incidents which allow the team to focus on timely solutions which are within the sphere of influence to improve performance.

The theatre department is also trialling in line with the WHO (World Health Organisation) Surgical Safety checklist the Team Briefing Boards which is being championed by one of the anaesthetist and selected orthopaedic surgeons. Staff are very enthusiastic and have welcomed its implementation to help them continually improve on the safe high quality care they strive to deliver to patients.

Roll-out of the dementia friendly environment across the organisation

Why this was a priority
Dementia generally causes progressive changes in how people interpret what they see hear and feel. People with dementia often find it difficult to orientate to an unfamiliar environment and have a reduced stress threshold to environmental challenges.

As the King’s Fund report (2012) highlights, the design of the built environment can significantly help in compensating for the memory loss and communication problems associated with dementia, as well as supporting the continued independence of people in hospital who have dementia. New projects are demonstrating that relatively inexpensive interventions, such as changes to lighting, flooring, and improved signage can have a significant impact. (Taken from Dementia: Commitment to the care of people with Dementia in hospital settings RCN Jan 2012)

Linking in with these principles are other initiatives and standards for which the Trust needs to provide evidence of compliance, for example the Care Quality Commission (CQC) standards, Patient Led Assessment of Care Environment (PLACE), productive ward initiatives, and STAR (Sustaining Quality Through Assessment & Review) assessment. Undertaking this as a priority will raise more awareness of the importance of creating a dementia friendly environment and improving care of people living with dementia.

What we did in 2015/16
During 2015/16 a dementia friendly environment has continued to be on the Trust’s agenda in relation to new builds, and refurbishments within patient and visitor areas. Ward areas have more awareness of what is important for patients with memory problems which has continued to be highlighted through additional dementia awareness training, and the introduction of dementia friends training for non-clinical staff. Creating more awareness through enhancing staff knowledge has been extremely positive.

Implementation of the blue butterfly scheme for patients with a known dementia, or those who have a memory problem but do not have a diagnosis, gives all staff more awareness of what support is required to care for these patients. The carers leaflet and passport has been developed and is now in circulation for both patients and relatives or their carer this is to support the revised Carers Policy.

There have been some clinical ward areas where decoration has been reviewed and more appropriate colours to help orientation have been put in place, such as the Midland Centre for Spinal Injuries, and Ludlow ward who have reviewed and adapted one of their bed areas with en-suite bathroom facilities to be more dementia friendly.

The refurbished main corridor has been improved by having new flooring with good contrast between floor and walls to improve visibility. There has also been improved lighting on the corridor to try and help minimise glare, and shadows. Curtains on wards are plain blue which is more calming for patients with cognitive problems. In the theatre recovery area in main theatres, the environment is being reviewed to ensure patients are not exposed to too much noise, and new signage has been put up within this area for staff to be more aware of this.

Orientation clocks have been introduced on care of the elderly ward, and other wards. These clocks have large faces and calendars that show the correct date, which can help people to remain aware of the season, time and place.

Pictorial signage on toilets and bathrooms has been implemented on care of the elderly ward, which needs to be reviewed trust wide, and rolled out further. This initiative will be linking into the new building projects as these are developed.
How we did in 2015/16
There has been some positive work in improving the environment in some areas within the Trust, however there needs to be further work undertaken as part of a continued journey. What has supported this is a focussed approach, influenced by national and local agendas.

A service evaluation will be undertaken in 2016/17 to establish how dementia friendly environment is developing, and its effectiveness in improving the patient experience.

Our Priorities for 2016/17
In line with the Trust’s Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders (including the Patient Panel and commissioners), the Trust has identified the following three key priorities for 2016/17:

Safety

A decrease in the number of spinal infections
The first step in the treatment of surgical site infections (SSI) is in their prevention. This encompasses meticulous operative technique, timely administration of intra operative antibiotics, and a variety of preventive measures aimed at neutralizing the threat of bacterial, viral, and fungal contamination posed by operative staff, the operating room environment, and the patient's endogenous skin flora.

To reduce the incidence and consequences of surgical site infection, the Trust will perform weekly audits using the High Impact Intervention: Care bundle (which are a set of national standards defined by the Department of Health) to prevent surgical site infection. Regular auditing of the care bundle actions will support cycles of review and continuous improvement to ensure appropriate and high quality patient care. This will be measured through the surgical site surveillance programme and reported through the Infection Control Committee.

Effectiveness

All mandatory training and appraisals to be at 90%
The Trust has seen a steady improvement over the last two years towards achieving the 90% compliance target for statutory/mandatory training and appraisals for all staff at the Trust. These improvements have been created through the promotion and positive link made between the annual incremental pay progression only being awarded upon the completion of these Trust requirements, in accordance with Annexe W of the Agenda for Change Terms and Conditions.

The Trust will continue to actively pursue the target of 90% compliance target for statutory/mandatory training and appraisals for all staff at the Trust with the support of managers and the Senior Management team and compliance will continue to be reported and discussed at divisional performance reviews and at Executive meetings.

Patient Experience

Patient experience of the pre-op pathways
The Trust has started work on a pre-op pathway redesign, which is aimed at improving the patient experience. Patients are triaged as green, amber and red, based on the medical history of the patient and the complexity of their surgical operation. For patients rated as green and undergoing a local anaesthetic, the Trust aims to increase the number of telephone pre-op assessments that are undertaken each week. In addition, the assessment part of the patient journey for these patients will start at the decision to treat stage; this will be piloted with the Upper Limb Team.

The Trust will measure the number of patients going through this alternate pre-op pathway by tracking the activity in separate telephone clinics and aims to have 20% of pre-op patients going through this pathway by year-end.

The information will be reported via the weekly activity monitoring meeting and the Pre-operative Redesign Task and Finish Group. The patient experience will be assessed by asking a question at the end of the telephone contact to establish feedback from the patient on the quality of this new service.
STATEMENTS OF ASSURANCE FROM THE BOARD

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

Review of Services
During 2015/16, 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 2015/16 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 2015/16.

The data reviewed covers the three dimensions of quality:
- patient safety
- clinical effectiveness
- patient experience

Clinical Audit
During 2015/16, four national clinical audits and two national confidential enquiries covered NHS services that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

During that period, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:
- National Confidential enquiry-National Sepsis Audit
- National Joint Registry (NJR)
- Rheumatoid and early inflammatory arthritis
- Elective surgery (National PROMs Programme)
- Comparative audit of Bedside Transfusion Practice

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 2015/16 are listed below alongside that number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

<table>
<thead>
<tr>
<th>Eligible to participate</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Yes</td>
</tr>
<tr>
<td>Sepsis</td>
<td>Yes</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Yes</td>
</tr>
<tr>
<td>Rheumatoid and early inflammatory arthritis</td>
<td>Yes</td>
</tr>
<tr>
<td>Comparative audit of Bedside Transfusion Practice</td>
<td>Yes</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
There was one national clinical audit report relevant to The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2015/16.

The reports of 26 local clinical audits were reviewed by the provider in 2015/16 and The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in appendix A to improve the quality of healthcare provided.

**Research**

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2015/16 that were recruited during the year to participate in National Institute of Health Research (NIHR) Portfolio research (approved by a Research Ethics Committee) was 588 against a target of 1250 (47%). There were a number of reasons for this low uptake including the pool of appropriate patients to get involved in the research projects and the infrastructure to support this. For 2016/17 the Trust hopes to increase the number of patients involved in NIHR Research projects.

The Trust recruited to 27 NIHR Portfolio clinical research studies in five specialities during 2015/16, which is an increase of three studies compared to 2014/15. This included commercially, academic and RJAH Trust sponsored studies.

During 2015/16, research at RJAH contributed to 14 publications, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

“The Trust’s Research Strategy is directed at harnessing involvement in research to create a culture of enquiry and excellence amongst staff aimed at delivering world class care for our patients.”

**Commissioning for Quality & Innovation (CQUIN) Payment Framework**

A proportion (2.5%) of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust contracted income from England in 2015/16 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. Further detail of the 2015/16 agreed goals and new schemes agreed for 2016/17 are available electronically in the Trust Board Papers section of the Trust website http://www.rjah.nhs.uk/About-Us/Publications.aspx and are set out in this report.

The final value of the CQUIN scheme for Shropshire and collaborative commissioners in 2015/16 was circa £952K, and the scheme overseen by Specialised Commissioner for our Spinal Injuries service was worth an additional circa £261K. For specialised services the percentage attributed to CQUIN is 2.4%.

Summaries of the 2015/16 schemes are set out in the following tables:

<table>
<thead>
<tr>
<th>Goal Name</th>
<th>Description of Goal</th>
<th>Goal Weighting (% of CQUIN scheme available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Kidney Injury (AKI)</td>
<td>Develop action plan to ensure patients treated for AKI have had the necessary tests recorded in their discharge summary.</td>
<td>10%</td>
</tr>
<tr>
<td>Dementia</td>
<td>To screen patients aged over 75 admitted as an emergency, ensuring support for carers, and providing clinical leadership to ensure training for staff.</td>
<td>10.5%</td>
</tr>
<tr>
<td>Medicine Management</td>
<td>Utilisation of national tool for medication errors and harm.</td>
<td>14.5%</td>
</tr>
<tr>
<td>Goal Name</td>
<td>Description of Goal</td>
<td>Goal Weighting (% of CQUIN scheme available)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Rollout of Nursing Assessment and Accreditation System</td>
<td>Theatres to be assessed against standards, with a target of green status by Q4.</td>
<td>15%</td>
</tr>
<tr>
<td>DVT Information</td>
<td>Patients/carers are offered verbal and written information on VTE prevention prior to admission.</td>
<td>15%</td>
</tr>
<tr>
<td>Prevention of site infection</td>
<td>In line with best practice standards to document temperature intra operatively for all adult inpatients (excluding Day case).</td>
<td>15%</td>
</tr>
<tr>
<td>End of Life</td>
<td>Adopting principles of the AMBER bundle (The AMBER care bundle ensures patients are treated with dignity and respect and receive consistent information from their healthcare team about treatment options. It encourages carers and relatives to be fully involved in making decisions and knowing what is happening with their care)</td>
<td>10%</td>
</tr>
<tr>
<td>Reduction of VTE Incidents</td>
<td>Reduction in VTE incidences measured in between occurrence.</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

**2 CQUIN Scheme coordinated by West Midlands Specialised Services**
(Value £259K)

<table>
<thead>
<tr>
<th>Goal Name</th>
<th>Description of Goal</th>
<th>Goal Weighting (% of CQUIN scheme available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute SCIC Outreach to newly injured patients</td>
<td>Provide SCI service as a face to face outreach to newly injured patients within 5 days of referral.</td>
<td>80%</td>
</tr>
<tr>
<td>Highly specialised services clinical outcome collaborative audit workshop</td>
<td>Trust to report on activity against CQUIN for this quarter</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Outcome of CQUIN Schemes**
The Trust and the CCG have yet to agree the final CQUIN outcome for 2015/16. The Trust has fully achieved both the CCG and NHS England CQUIN targets at the end of Quarter 3. We are anticipating fully achieving all CQUIN targets for the year.

**2015/16 CQUIN Scheme**
The final payment for the CQUIN scheme in 2015/16 was £983k from our English CCGs and £259k from our specialised commissioners.

**2016/17 CQUIN Scheme**
The value of the schemes in 2016/17 will be 2.5% of total contract value. The CQUINs and their goal weighting have yet to be agreed, a summary of the goals identified so far for the new schemes are listed in the tables below (draft).
Schemes coordinate by Shropshire CCG: (£1,065K)

<table>
<thead>
<tr>
<th>Indicator Number</th>
<th>Indicator Name</th>
<th>Description</th>
<th>Indicator Weighting</th>
<th>Expected Financial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>NHS Staff health and wellbeing</td>
<td>Introduction of health and wellbeing initiatives</td>
<td>0.25%</td>
<td>£106,882</td>
</tr>
<tr>
<td>b</td>
<td>Healthy food for NHS staff, visitors and patients</td>
<td>Healthy food for NHS staff, visitors and patients</td>
<td>0.25%</td>
<td>£106,882</td>
</tr>
<tr>
<td>c</td>
<td>Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff</td>
<td>Improving the uptake of Flu vaccinations for frontline clinical staff</td>
<td>0.25%</td>
<td>£106,882</td>
</tr>
<tr>
<td>b</td>
<td>Timely identification and treatment for Sepsis in acute inpatient settings</td>
<td>Timely identification and treatment for Sepsis in acute setting of care</td>
<td>0.25%</td>
<td>£106,882</td>
</tr>
<tr>
<td>a</td>
<td>Reduction in antibiotic consumption per 1,000 admissions</td>
<td>Reduction in antibiotic consumption per 1,000 admissions</td>
<td>0.20%</td>
<td>£85,506</td>
</tr>
<tr>
<td>b</td>
<td>Empiric review of antibiotic prescriptions</td>
<td>Review of percentage of antibiotic prescriptions reviewed within 72 hours</td>
<td>0.05%</td>
<td>£21,376</td>
</tr>
<tr>
<td>L1</td>
<td>Improved RTT administrative processes for referral management and booking</td>
<td>Standardising of Referral process including Booking and Scheduling processes</td>
<td>0.31%</td>
<td>£132,534</td>
</tr>
<tr>
<td>L2</td>
<td>Advice and Guidance</td>
<td>Improving GP access to information in support of MSK conditions in Primary Care</td>
<td>0.31%</td>
<td>£132,534</td>
</tr>
<tr>
<td>L3</td>
<td>Clinical and governance ownership</td>
<td>To assess a number of quality indicators, set their baselines and agree trajectories for improvement</td>
<td>0.31%</td>
<td>£132,534</td>
</tr>
<tr>
<td>L4</td>
<td>Learning from Outcomes</td>
<td>The aim of this indicator is to support the learning process following Serious Incident, Never Events and complaints</td>
<td>0.31%</td>
<td>£132,534</td>
</tr>
</tbody>
</table>

Please refer to Supporting Documents for detail of each Indicator

| Total            |                                                                                     |                                                                                                               | 2.50%              | £1,064,546               |

**Statements from the Care Quality Commission**

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 2015/16.

During October 2015, the CQC carried out an inspection of the Trust. The Trust was given an overall rating of Requires Improvement, with the breakdown of ratings show in the table below:
In response to the inspection report, the Trust has already made a number of improvements and has in place a robust action plan to make further improvements and address the issues highlighted by the CQC. Completion of actions is being monitored by the Quality & Safety Committee. A number of actions have been completed and good progress is being made on the remaining actions. To date progress has been made in the following areas:

- Paediatrics
- Infection Control
- Patient Privacy and Dignity.

Regular updates on progress have been presented to staff and patient groups and we have good engagement in the work from the local Healthwatch, CCG, CQC and NHS England. The Quality and Safety Committee have now increased their meeting schedule to meet ten times per year.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2015/16.

**Data Quality**

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2015/16 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:

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

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

- Continue to raising 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
- Continue to provide a robust audit framework that is closely monitored and updated as new key performance indicators are agreed with key stakeholders, with the aim of ensuring the data is of an agreed acceptable level regarding quality and robustness. Also setting of internal KPIs in areas of concern, to help monitor, review and recognise to then enable us to mitigate, improve and report on data quality
• Continue to drive forward the key themes within the Data Quality Policy: Governance, roles and responsibilities, culture and awareness, training, monitoring, issue management and audit. Make certain that these elements are incorporated across the Trust and used to promote a strong Data Quality culture.

• 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.

• To ensure continued compliance with the Information Governance Toolkit minimum Level 2 for data quality standards.

**Information Governance Toolkit Attainment Levels**

The Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust’s Information Governance Assessment Report score overall for 2015/16 was 89% and was graded green (‘Satisfactory’).

**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 2015/16.

An audit of 200 sets of case notes was carried out by an external company (JW Clinical Coding Limited) as part of the Information Governance process following NHS data sharing protocols. This audit reconfirmed the high standards achieved by the coding team – an extract from the report summary is shown below:

**Audit Results**

<table>
<thead>
<tr>
<th>Primary diagnosis correct</th>
<th>Secondary diagnosis correct</th>
<th>Primary procedures correct</th>
<th>Secondary procedures correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>94.75%</td>
<td>100%</td>
<td>98.89%</td>
</tr>
</tbody>
</table>

The figures far exceed the recommended 95% accuracy for primary diagnoses and procedures and 90% accuracy for secondary diagnoses and procedures required for Information Governance purposes at Level 3.

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

• Continuing with its ongoing programme of internal data quality audits and implementing actions arising from these as appropriate.

**Performance against the relevant indicators and performance thresholds set out in Appendix A of the Risk Assessment Framework**

As a Foundation Trust the Hospital is required to provide Monitor with a quarterly return detailing the Trust’s performance against the national targets and core standards as outlined in Monitor’s Compliance Framework for 2015/16. As part of this return, Monitor requires the Trust to confirm its service performance against the main targets and indicators set out in the 2015/16 Risk Assessment Framework. In August 2015 Monitor published a revised Risk Assurance Framework which removed the admitted and non-admitted metrics as national targets.
The Board of Directors is assured of its position with the quarterly submissions via the existing reporting structures in place, supporting the sign off of the Trust declarations. These include the integrated balanced scorecard, reports made directly to the Board and those reviewed by delegated committees of the Board. The table below sets out the final quarter and year-end position against the targets and indicators that are relevant to the Trust:

<table>
<thead>
<tr>
<th>Target/Indicator, as set out in Risk Assessment Framework</th>
<th>Referral to treatment time, 18 weeks in aggregate, incomplete pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18+</td>
</tr>
<tr>
<td>January</td>
<td>794</td>
</tr>
<tr>
<td>February</td>
<td>808</td>
</tr>
<tr>
<td>March</td>
<td>742</td>
</tr>
<tr>
<td>2015/16 Annual Average</td>
<td>781</td>
</tr>
</tbody>
</table>

The Trust had identified an issue in its 18 week Referral To Treatment (RTT) incomplete pathways reporting during 2014/15 and a report was commissioned by Deloitte LLP and issued in July 2015. During 2014/15 it came to the attention of Trust management that as a result of validation and exclusion processes, the published indicator had included data for pathways for which the 18 week deadline did not apply and excluded other pathways to which the 18 week deadline did apply. Following a report that the Trust commissioned from Deloitte to review internal processes, the Trust has identified that there are potential inaccuracies relating to our reported RTT incomplete pathways performance during the first three quarters of 2015/16. The inaccuracies have meant we do not comply with the RTT indicator for the first three quarters of 2015/16 and we are therefore only reporting performance for the final quarter of 2015/16. Underlying challenges include demand for services; particularly complex diagnostic imaging, pressure on certain surgical sub specialities due to an increase in referrals and assurances around our validation processes. In January 2016 the Trust was found to be in breach of its licence in particular around RTT performance and have produced an action plan to address the issues.

This plan identifies key milestones, underpinned by a number of actions, many of which have been completed. The overarching ‘RTT Recovery Plan focused on immediate actions, sustainability/medium terms actions and strategic actions.

Of the immediate actions pertaining to RTT recovery, the following have been completed:

- Access Policy fully updated to reflect English RTT and Welsh rulings
- Bespoke training programme devised due to the unique complexities of Welsh and English regulations.
- Standard Operating Procedures defined, documented and circulated through a comprehensive training programme
- Roll out of training focusing on high impact areas, or areas where there are identified training needs through historical analysis, followed by full roll out across all areas of the organisation. Training programmes are also bespoke to individual cohorts of staff depending on their role in the organisation.
- Reporting and governance structures relating to RTT strengthened
- Operational Team established
- Line of site and clear escalation through robust performance meetings on a weekly basis (PTL, RTT comm cell, RTT Senior Manager Recovery Monitoring Meeting)
- Fortnightly review of data quality, with a primary function to determine the effectiveness of the training programme, and a secondary function to identify any themes in errors or individuals to enable responsive correction and/ or training
- Development of tracking capability for high risk error areas, e.g. electronic referrals – clock starts
Next steps in terms of action plan and delivery of assurance:

- Full roll out of training across all areas of the organisation
- Quarterly data quality audit programme
- Implementation of randomised spot checks between formal quarterly updates
- Inclusion of access policy training within Trust Induction Programme for all staff (where relevant to their role)
- Continuous monitoring of training programme against KPIs, with up to date data base of staff trained by individual and location – this mitigates errors when personal move from one department to another or change roles within administrative functions.

The other risk assessment framework indicators were all met as demonstrated below.

<table>
<thead>
<tr>
<th>Target/Indicator, as set out in Risk Assessment Framework</th>
<th>Threshold /Target</th>
<th>Average for 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 62 day waits for first treatment (from urgent GP referral)</td>
<td>85%</td>
<td>93.75%</td>
</tr>
<tr>
<td>Cancer 31 day wait from diagnosis to first treatment</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer 2 week (all cancers)</td>
<td>93%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target/Indicator, as set out in Risk Assessment Framework</th>
<th>Threshold /Target</th>
<th>Year-end Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile – meeting the C. Diff objective</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>Achievement of the 6 criteria for meeting the needs of people with learning difficulties</td>
<td>All six criteria achieved</td>
</tr>
</tbody>
</table>
## National Quality Indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Trust score for 2015/16</th>
<th>National Average</th>
<th>Royal National Orthopaedic Hospital NHS Trust</th>
<th>The Royal Orthopaedic Hospital NHS Foundation Trust</th>
<th>Highest score (where applicable)</th>
<th>Lowest score (where applicable)</th>
<th>Trust statement</th>
<th>Trust score for 2014/15</th>
<th>Trust score for 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent people from dying prematurely</td>
<td>Mortality</td>
<td>15</td>
<td>Not applicable</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>0.519</td>
<td>0.359</td>
<td>The standardised mortality rates for hospitals, produced nationally by Dr Foster are not applicable to small specialist Trusts like The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, because the numbers of deaths that occur are too small for change to be statistically significant. However, there has been ongoing monitoring of all deaths which occur within the Trust for some years</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>Patient reported outcome scores (EQSD) for primary hip replacement surgery</td>
<td>0.444</td>
<td>0.454</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>0.519</td>
<td>0.359</td>
<td>The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this score 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 &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, 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.</td>
<td>0.414</td>
<td>0.442</td>
</tr>
<tr>
<td>Helping people recover from episodes of ill health or following surgery</td>
<td>Patient reported outcome scores (EQSD) for revision hip replacement surgery</td>
<td>0.350</td>
<td>0.279</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td></td>
<td>0.236</td>
<td>0.253</td>
</tr>
<tr>
<td>Domain</td>
<td>Indicator</td>
<td>Trust score for 2015/16</td>
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</tr>
<tr>
<td>Patient reported outcome scores (EQ5D) for primary knee replacement surgery</td>
<td>Published scores not available for 2015/16</td>
<td>0.334</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>0.412</td>
<td>0.207</td>
<td></td>
<td>0.321</td>
<td>0.330</td>
<td></td>
</tr>
<tr>
<td>Scoring indices – higher is better</td>
<td>2014/15 score was 0.321</td>
<td></td>
<td>2014/15 score was 0.276</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient reported outcome scores (EQ5D) for revision knee replacement surgery</td>
<td>Published scores not available for 2015/16</td>
<td>0.235</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>0.179</td>
<td>0.289</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Scoring indices – higher is better</td>
<td>2014/15 score was 0.179</td>
<td></td>
<td>2013/14 score was 0.185</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient reported outcome scores (Oxford score) for primary hip replacement surgery</td>
<td>21.097</td>
<td>22.088</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>24.667</td>
<td>18.130</td>
<td></td>
<td>20.617</td>
<td>21.529</td>
<td></td>
</tr>
<tr>
<td>Scoring indices – higher is better</td>
<td></td>
<td></td>
<td>2014/15 score was 21.193</td>
<td></td>
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</tr>
<tr>
<td>Patient reported outcome scores (Oxford score) for revision hip replacement surgery</td>
<td>Published scores not available for 2015/16</td>
<td>13.00</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>8.811</td>
<td>10.492</td>
<td></td>
<td>8.811</td>
<td>10.492</td>
<td></td>
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<tr>
<td>Scoring indices – higher is better</td>
<td>2014/15 score was 8.811</td>
<td></td>
<td>2014/15 score was 13004</td>
<td></td>
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<td></td>
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<tr>
<td>Scoring indices – higher is better</td>
<td>2014/15 score was 14.331</td>
<td></td>
<td>2014/15 score was 16.219</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patient reported outcome scores (Oxford score) for revision knee replacement surgery</td>
<td>Published scores not available for 2015/16</td>
<td>11.116</td>
<td>Published scores not available for 2015/16</td>
<td>Published scores not available for 2015/16</td>
<td>8.376</td>
<td>9.269</td>
<td></td>
<td>8.376</td>
<td>9.269</td>
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<tr>
<td>Domain</td>
<td>Indicator</td>
<td>Trust score for 2015/16</td>
<td>National Average</td>
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<tr>
<td></td>
<td>Scoring indices – higher is better</td>
<td>2014/15 score was 8.376</td>
<td>2013/14 score was 6.867</td>
<td>2013/14 score was 8.347</td>
<td>2014/15 score was 16.744</td>
<td>2014/15 score was 8.376</td>
<td>Published data not available for last three years 6.63 in 2011/12</td>
<td>Published data not available for last three years 11.45 in 2011/12</td>
<td>Published data not available for last three years 7.94 in 2011/12</td>
<td>Published data not available for 2014/15</td>
</tr>
<tr>
<td></td>
<td>Scoring indices – lower is better</td>
<td>Published data not available for last three years 10.86 in 2011/12</td>
<td>Published data not available for last three years 10.68 in 2011/12</td>
<td>Published data not available for last three years 7.94 in 2011/12</td>
<td>Published data not available for 2014/15</td>
<td>Published data not available for 2014/15</td>
<td>Published data not available for last three years 6.32 in 2011/12</td>
<td>Published data not available for last three years 5.46 in 2011/12</td>
<td>Published data not available for last three years 3.75 in 2011/12</td>
<td>Published data not available for 2014/15</td>
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<td></td>
<td>Scoring indices – lower is better</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
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<td>Published data not available for last three years 1.78 in 2011/12</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
<td>Published data not available for last three years 1.78 in 2011/12</td>
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<tr>
<td></td>
<td>Ensuring that people have a positive experience of care</td>
<td>Published data not available for 2015/16 2014/15 score was 79.8</td>
<td>Published data not available for 2015/16 2014/15 score was 68.9</td>
<td>Published data not available for 2015/16 2014/15 score was 78.7</td>
<td>Published data not available for 2015/16 2014/15 score was 77</td>
<td>Published data not available for 2015/16 2014/15 score was 86.1</td>
<td>Published data not available for 2015/16 2014/15 score was 59.1</td>
<td>The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this percentage 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 Trust has a robust patient experience programme in place, that facilitates learning and implementing changes based on patient experience The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, Published data not available for 2015/16 79.8</td>
<td>Published data not available for 2015/16 81.6</td>
<td>Published data not available for 2015/16 81.6</td>
</tr>
<tr>
<td>Domain</td>
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<tr>
<td></td>
<td></td>
<td>93%</td>
<td>69%</td>
<td>89%</td>
<td>83%</td>
<td>96%</td>
<td>38%</td>
<td>The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this percentage is as described for the following: • The Trust has in place a number of initiatives to ensure that staff feel supported and valued. The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services: • Putting in place an action plan to address issues arising from the staff survey results</td>
<td>93%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99%</td>
<td>95.9% (to Feb 16)</td>
<td>96% (to Feb 16)</td>
<td>98% (to Feb 16)</td>
<td>N/A</td>
<td>N/A</td>
<td>The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this percentage is as described for the following: • The Trust has a robust patient experience programme in place, that facilitates learning and implementing changes based on patient experience The Robert Jones &amp; Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services: • Continuing with existing patient experience initiatives • Further developing the Trust patient experience strategy</td>
<td>April to August 2014 - 91.2%</td>
<td>September 2014 – March 2015 - 99%</td>
</tr>
<tr>
<td></td>
<td>Treating and Venous</td>
<td>99.9%</td>
<td>95.8% (to)</td>
<td>99.8% (to)</td>
<td>98.9% (to)</td>
<td>100% (to)</td>
<td>76.5% (to)</td>
<td>The Robert Jones &amp; Agnes Hunt</td>
<td>99.85%</td>
<td>100%</td>
</tr>
<tr>
<td>Domain</td>
<td>Indicator</td>
<td>Trust score for 2015/16</td>
<td>National Average</td>
<td>Royal National Orthopaedic Hospital NHS Trust</td>
<td>The Royal Orthopaedic Hospital NHS Foundation Trust</td>
<td>Highest score (where applicable)</td>
<td>Lowest score (where applicable)</td>
<td>Trust statement</td>
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</tbody>
</table>
| caring for people                          | thromboembolism (VTE) Risk Assessments                                    |                          | January 2016     | January 2016                                   | January 2016                                   | January 2016                    | January 2016                    | Orthopaedic Hospital NHS Foundation Trust considers that this percentage is as described for the following reasons:  
  - The Trust has clear processes in place for ensuring that a VTE risk assessment is carried out for all patients.  
  The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services:  
    - Continuing to carry out regular audits and monitoring any instances of non-compliance |
|                                            | Scoring indices – higher is better                                        |                          |                  |                                                |                                                  |                                 |                                 |                                                                                                                                            |
|                                            |                                                                           | Published data not available for 2015/16 | 2014/15 score was 3.8 | Trust has had no cases of Clostridium Difficile in 2015/16 | Published data not available for 2015/16 | Published data not available for 2015/16 | Published data not available for 2015/16 | The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this percentage is as described for the following reasons:  
  - Data is monitored and reported on monthly basis  
  - The Infection Control team work closely with ward staff and the microbiology department at the Royal Shrewsbury Hospital to ensure good practice in relation to infection prevention and control |
<p>|                                            |                                                                           | Published data not available for 2015/16 | 2014/15 score was 4.5 |                                               |                                                  |                                 |                                 |                                                                                                                                            |
|                                            |                                                                           |                          |                  |                                                |                                                  |                                 |                                 |                                                                                                                                            |
|                                            |                                                                           | Published data not available for 2015/16 | 2014/15 score was 6.2 |                                               |                                                  |                                 |                                 |                                                                                                                                            |
|                                            |                                                                           | Published data not available for 2015/16 | 2014/15 score was 0 |                                               |                                                  |                                 |                                 |                                                                                                                                            |
| Rate of hospital-acquired Clostridium Difficile amongst patients aged 2 and above | Scoring indices – lower is better                                         |                          |                  |                                                |                                                  |                                 |                                 |                                                                                                                                            |</p>
<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Trust score for 2015/16</th>
<th>National Average</th>
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<th>Lowest score (where applicable)</th>
<th>Trust statement</th>
<th>Trust score for 2014/15</th>
<th>Trust score for 2013/14</th>
</tr>
</thead>
</table>
| Rate of patient safety incidents           | Published data not available for 2015/16 2014/15 rate was 27.7 | Published data not available for 2015/16 2014/15 rate was 75.8 | Published data not available for 2015/16 2014/15 rate was 19.3 | Published data not available for 2015/16 2014/15 rate was 19.1 | N/A | N/A | The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:  
  • The Trust actively encourages reporting of all incidents and near misses to ensure a learning culture throughout the organisation | 27.7 | 8.5 |
| % of patient safety incidents that resulted in severe harm or death | Published data not available for 2015/16 2014/15 rate was 0.06 | Published data not available for 2015/16 2014/15 rate was 4.8 | Published data not available for 2015/16 2014/15 rate was 0.81 | Published data not available for 2015/16 2014/15 rate was 0.22 | N/A | Published data not available for 2015/16 2014/15 rate was 0 | The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services:  
  • Weekly and monthly reviews of all patient safety incidents  
  • Discussions of learning from incidents | 0.06 | 0.04 |

Data has been taken from the Health & Social Care Information Centre, the NHS Staff Survey, NHS England, the National Reporting & Learning System and the Health Protection Agency. Not all 2015/16 national comparative data was published at the time of producing the report so the data is not available to include.
Local Quality Indicators

Patient Safety

Medicines Safety Thermometer
The Medicines Safety Thermometer is a measurement tool for improvement which focuses on medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework.

The Medicines Safety Thermometer data collection has continued for 2015-16. Monthly data from all wards is submitted to a national database which supports sharing and learning with other organisations. For the last 12 months we provided monthly figures for the number of submissions and the harms.

We have continued to collect monthly data and upload to the national database and have introduced formal reporting of any harms as identified in relation to the nationally identified critical medications. These medications are Anticoagulants, Opioids, IV/SC Sedatives and Insulin. The data we have submitted shows we had zero harms in relation to the identified high risk medications.

From April to March 2016 the Trust complied with the reporting of harms to the National Database.

Medication Report
Medication incidents (Datix reports) continue to be monitored, with monthly reporting to the Board of Directors. Reporting to the Board continues to be based on the level of harm.

During 2015/16 we have had 218 medication related incidents reported. Of these 218 incidents 150 resulted in an unintended change to the patient’s treatment shown in Chart 1.

![Chart 1](image)

Of the 150 incidents, we reported the following harms: 15 low harm, zero moderate harms and zero severe harms (see Chart 2). The harms reported have been where patients have required a further blood test or closer observations/monitoring, when otherwise this would not have occurred.

These incidents are discussed at weekly Pharmacy meetings, the weekly and monthly Incident Action Review Committee (IARC), the Senior Nurses and Allied Health Professionals (SNAHP) meeting and the Medicines Safety Committee. This ensures staff are aware of the harms that have occurred and that any learning points are shared. These incidents are also used to support staff training.

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1 Unless otherwise stated, all data for local quality indicators is gathered and reported internally.
Medication incidents are categorised as shown in Chart 3 into Prescribing, Administration, Dispensing and other incidents. The Trust continues to promote openness and transparency in the reporting of incidents.

As part of ongoing work to improve patient safety, deliver harm-free care and linking with the Trust’s Quality Strategy, we continue to promote the reporting of near misses (e.g. incidents which had the potential to result in patient harm, but did not, due to early identification of the problem).

We have included this message as part of the ward STAR accreditation system within the development of the medication collaborative. The STAR (Sustaining Quality Through Assessment & Review) is a performance assessment framework linking to the 6 C’s Compassion in Practice, Essence of Care standards and Care Quality Commission (CQC) Fundamental standards.

The collaborative will need to be worked through prior to applying for a higher level within the STAR process, that being Silver Star status. The collaborative includes

- Tips for patient involvement within incident investigation
- Supporting evidence to use a Plan Do Study Act (PDSA) change cycle
- Case studies
- Non administration of medication support posters
- Missed dose posters
- Near miss posters
- Patient questionnaire for safer medicines management

The collaborative work will be shared and assist in the prevention of future harms, linking to our Sign up to Safety Campaign safety pledges and also the Trust’s compliance with the CQC fundamental standards.

**Incidents**

The Trust continues to use the Datix system which allows all employees to report incidents on the Trust intranet. An investigation is completed for all incidents reported.
Lessons learned from investigations are shared with ward and departmental managers and disseminated to Divisional meetings, as well as relevant Trust Committees. Datix also allows real-time monitoring of trends for analysis at Divisional Meetings and other Trust committees. The number of graphic dashboards has been extended to include Safety Thermometer incidents such as falls and pressure sores. Datix information also informs several key performance indicators in monthly reports to the Board of Directors and then to Commissioners.

The overall number of incidents reported year on year continues to rise (2365 in 2015-16 compared with 2027 last year) reflecting growing awareness of the value of reporting and faith in the quality of data held. CQC findings identified the need to increase reporting of non-clinical incidents and a programme of targeted training for non-clinical staff began in November 2015, which has so far included switchboard, catering and estates.

All Incidents reported from April 2013 to March 2016 (source: Datix)

Patient safety incidents, including near misses, are reported externally via the National Reporting & Learning System (NRLS) to the National Patient Safety Agency (NPSA), which releases data quality and patient safety reports every six months, grouped by type of Trust. The most recent dataset published (September 2015) relates to patient safety incidents occurring between October 2014 and March 2015.
RJAH performance is shown against 18 other acute specialist trusts. Our reporting rate, which had steadily improved over the last two years from average to top quartile, appears to have decreased, but this reflects the NPSA’s change in measurement. Previously the reporting rate was based on the number of incidents per 100 admissions: now it is based on the number per 1,000 bed days. We have more long stay rehabilitation patients than many other specialist acute trusts. For further comparison purposes, the chart above has been annotated to show selected trusts in our cluster.

**Serious Incidents**

A serious incident is any incident occurring during NHS care, that results in an unexpected/avoidable death or severe harm to patients, staff or members of the public, a Never Event (as defined in the Never Events Framework), a scenario that prevents, or threatens to prevent, an organisation’s ability to continue to deliver healthcare services, or any allegations or incidents of abuse.

There were 14 Serious Incidents (SIs) reported in 2015/16, two of which were subsequently downgraded (both unexpected deaths), after the coroner confirmed that the patients had died of natural causes. The following graph shows the breakdown of SI categories over the last four years.
A full root cause analysis was undertaken for each incident and action plans were put in place as appropriate. The action plans are monitored through the Trust's Governance & Risk Management and Quality & Safety Committees.

**Hospital-acquired Infection**
Since 2006 the Trust has had no MRSA blood stream infections (where the MRSA bacteria enter the patient’s blood, leading to serious illness). MRSA is a well-known health care associated infection. It is estimated that 3% of people carry MRSA harmlessly on their skin, but for hospital patients the risk of infection may be increased due to wounds, or invasive treatments which make them more vulnerable. Serious MRSA infection may result in MRSA blood stream infections (bacteraemia). The Trust’s MRSA blood stream infection target for 2015/16 continued to be zero.

**MRSA screening compliance**
Identification of MRSA carriers is a key component in the process of reducing the risks of infection and spread and it is national policy that patients are screened to identify any carriers. The Trust’s MRSA screening compliance remains above the national target of 95%.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible patients</td>
<td>958</td>
<td>1024</td>
<td>1164</td>
<td>1111</td>
<td>976</td>
<td>1058</td>
<td>1152</td>
<td>1045</td>
<td>889</td>
<td>1009</td>
<td>1017</td>
<td>1062</td>
</tr>
<tr>
<td>Screened for MRSA</td>
<td>958</td>
<td>1024</td>
<td>1164</td>
<td>1111</td>
<td>976</td>
<td>1058</td>
<td>1152</td>
<td>1043</td>
<td>889</td>
<td>1009</td>
<td>1016</td>
<td>1062</td>
</tr>
<tr>
<td>% achieved</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.8%</td>
<td>100%</td>
<td>100%</td>
<td>99.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia
MSSA, or Methicillin Sensitive Staph Aureus, is the more common sensitive strain of Staphylococcus Aureus. Up to 25% of us carry this organism on our skin. Mostly it causes us no problems but it can be a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes, the infection can escape into the bloodstream, producing a “bacteraemia” (i.e. bacteria in the blood). Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected lines that are used to administer medication, and other health care interventions. The Trust has been asked by the Department of Health to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that it can review the sources and identify potentially avoidable cases. So far no targets have been set and the Trust does not have easily comparable information with other hospitals. However interventions to further reduce infections are being put into place as new information is gained.

The Trust has seen no cases of hospital acquired MSSA bacteraemia in 2015/16, compared to three cases in 2014/15, four in 2013/14 and three in 2012/13.

Clostridium Difficile
Clostridium difficile (C. difficile) is a bacterium that is found in people’s intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies).

C. difficile causes disease when the normal bacteria in the gut are disadvantaged, usually by someone taking antibiotics. This allows C. difficile to grow to unusually high levels. It also allows the toxin that some strains of C. difficile produce to reach levels where it attacks the intestines and causes mild to severe diarrhoea.

The Trust has seen zero cases of hospital acquired C difficile in 2015/16 against a ceiling of two, compared to two cases in 2014/15.

Surgical Site Infections and general Surveillance (SSI)
Surgical site infection (SSI) is a type of healthcare associated infection in which a wound infection occurs after an invasive (surgical) procedure. At least 5% of patients undergoing a surgical procedure develop a surgical site infection.

The Trust undertakes targeted surveillance of surgical wounds across the organization. Surveillance of SSIs provides data that can both inform and influence practice to minimize the risk of SSIs, as well as communicate more clearly the risks of infection to patients. Consumer demand for information about the performance of healthcare providers has also led to compulsory public reporting of data on HCAIs including SSIs.

In England, the reporting of rates of SSIs became compulsory in April 2004. National surveillance systems provide standardised surveillance methods that enable hospitals to benchmark their rates of SSI. Such benchmarking can be a powerful driver for change but requires participating hospitals to use uniform methods of finding and defining cases of SSI that are likely to reliably identify a large proportion of infections, and a reliable approach to analysing rates of SSI.

The Trust had an increase in surgical site infections in 2015/16; at its peak between April and June, 21 patients were identified as having a surgical site infection. To date, the infection rates for total hip and total knee replacements have reduced. Spinal surgical infections continue to be above the Trust and national average for this category of surgery. The infection control team is working closely with Public Health England, and their senior epidemiologist is currently undertaking an epidemiological study of the Trust’s infections to provide the Trust with an in-depth analysis of this incident.
The wound care clinic continues for patients who have concerns about their post-operative surgical wounds. This is proving very successful and is a service that is very much appreciated by patients. The clinic runs for two hours, three times a week. The aims of the wound clinic are to provide an assessable, qualitative, cost-effective and efficient service to clinicians and patients which can prevent re-admissions to hospital.

Another benefit of the wound clinic is that patients can be discharged with mild oozy wounds, where previously they would have had to remain in hospital as the Trust's surgeons did not discharge patients with oozy wounds. The clinic has enabled the Trust to use the PICO device to much success. This not only enhances the patient's journey, it increases the productivity of the hospital. Hospital acquired infections affect not only the patient but their families. Prolonged hospital stay due to infection affects the family and working life of a patient.

Health & Safety
Health and Safety Incidents are monitored on an ongoing basis through the year and reported to the Health and Safety Committee. Those incidents reported that are of a more serious nature and/or result in more than seven days of work as a result of serious injury such as fractures or dislocations are also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). During 2015/16 there was one incident that was reported to the HSE under the requirement of the RIDDOR regulations. This is a reduction from three RIDDOR reported incidents from the previous 12 month period.

The 2015/16 Health and Safety Plan was monitored by the Health and Safety Committee.

Outcomes from the plan include:
- Trust departmental managers attended four day IO SH Managing Safely course
- Datix Lead enrolled on NEBOSH General Certificate in Occupational Health and Safety
- Programme of proactive health and safety inspections implemented across the Trust
- Increase in proactive risk assessments being carried out within the Trust
- A reduction in total harm as a result of health and safety incidents
- Statutory employee health and safety training rated ‘green’ at year end
- Continued engagement with staff side union health and safety representatives
CAS Alerts
The Central Alerting System (CAS) is the web-based portal for distribution of safety alerts from the Department of Health (DoH) to NHS Trusts. The Health, Safety and Risk Officer is responsible for the distribution and administration of the CAS alert system. The following table sets out the Patient Safety Alerts received and the Trust actions:

<table>
<thead>
<tr>
<th>Patient Safety Alert</th>
<th>Trust Response</th>
<th>Alert Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS/PSA/W/2015/005 - Risk of death or severe harm due to inadvertent injection of skin preparation solution</td>
<td>Alert brought to the notice of all relevant personnel in Trust. No previous incidents have occurred within the Trust</td>
<td>Action Completed</td>
</tr>
<tr>
<td>NHS/PSA/W/2015/006 - Harm from delayed updates to ambulance dispatch and satellite navigation systems</td>
<td>Alert acknowledged by Trust. Not applicable to RJAH.</td>
<td>Action Not Required</td>
</tr>
<tr>
<td>NHS/PSA/Re/2015/007 - Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme</td>
<td>Alert brought to the notice of all relevant personnel in Trust. Resources used to support local antimicrobial stewardship programme.</td>
<td>Action Completed</td>
</tr>
<tr>
<td>NHS/PSA/RE/2015/008 - Supporting the Introduction of the National Safety Standards for Invasive Procedures</td>
<td>Alert brought to the notice of all relevant personnel in Trust.</td>
<td>Action Required: Ongoing</td>
</tr>
<tr>
<td>NHS/PSA/Re/2015/009 - Support to minimise the risk of distress and death from inappropriate doses of naloxone</td>
<td>Alert brought to the notice of all relevant personnel in Trust.</td>
<td>Action Required: Ongoing</td>
</tr>
<tr>
<td>NHS/PSA/W/2015/010 - Risk of death and serious harm by falling from hoists</td>
<td>Alert brought to the notice of all relevant personnel in Trust. No previous incidents have occurred within the Trust</td>
<td>Action Completed</td>
</tr>
<tr>
<td>NHS/PSA/W/2015/011 - The importance of vital signs during and after restrictive interventions/manual restraint</td>
<td>Alert brought to the notice of all relevant personnel in Trust.</td>
<td>Action Completed</td>
</tr>
<tr>
<td>NHS/PSA/W/2015/012 - Risk of using different airway humidification devices simultaneously</td>
<td>Alert brought to the notice of all relevant personnel in Trust. No previous incidents have occurred within the Trust</td>
<td>Action Completed</td>
</tr>
<tr>
<td>NHS/PSA/W/2016/001 - Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus</td>
<td>Alert brought to the notice of all relevant personnel in Trust.</td>
<td>Action Completed</td>
</tr>
<tr>
<td>NHS/PSA/W/2016/002 - Risk of death from failure to prioritise home visits in general practice</td>
<td>Alert brought to the notice of all relevant personnel in Trust. No previous incidents have occurred within the Trust.</td>
<td>Action Not Required</td>
</tr>
</tbody>
</table>
**Adult Safeguarding**

The Robert Jones & Agnes Hunt NHS Foundation Trust is an organisation which has a culture that prioritises quality of care, having strong leadership and focus, and good partnership working to promote the well-being, security and safety of vulnerable adults (adults at risk) who are under our care.

The Trust is committed to working with Shropshire and Telford & Wrekin Safeguarding Adults Boards, as well as other partner agencies, to ensure that there are effective robust systems in place to safeguard ‘adults at risk’. The hospital continues to be involved in close networking with the local health economy safeguarding leads and engages in meetings to ensure that effective communication and interagency team working are delivered.

Quarterly Safeguarding Committee meetings within the Trust have continued meeting to discuss children and adult safeguarding issues. The committee has the appropriate accountability for safeguarding across the Trust and reports to the Trust’s Quality and Safety committee.

Throughout 2015/16 the adult safeguarding lead has continued to work with the safeguarding link staff and ward and department managers raising staff awareness about the importance of adult safeguarding within the organisation covering all aspects of protecting adults related to statutory responsibilities, policies and procedures.

Training of staff is key to ensure staff are up to date with any changes, enabling staff to keep safeguarding adults as a priority when in our care, and on discharge to other provider services, working closely with other stakeholders.

Adult Safeguarding Trust-wide Level 1 training is currently at 99.7%, and level 2 training 91.3%.

Deprivation of Liberty Safeguards (DoLs) 77.8% and Mental Capacity 78.3%

Throughout 2015/16 there has been a continued increase in dementia training. The bespoke training from Staffordshire University has helped to equip staff to provide best practice across wards and clinical areas, and to help staff recognise vulnerable adults who are living with dementia and who could be potentially at risk.

Dementia awareness training is currently at 54.7%, and Dementia Friends training has increased its sessions for non-clinical staff and is currently at 66.2% compliant.

The adult safeguarding lead has reviewed the NHS England Accountability, and Assurance Framework (2015), and the statutory requirements of the Care Act 2014 which aims to ensure that roles and responsibilities of individuals and organisations are clearly laid out, and to create a strong multiagency framework for safeguarding. Working closely with Shropshire CCG an action plan has been formulated which will continue to be the focus for our work plan in going forward into 2016/17.

During 2015/16 the Trust has had seven referrals to various Adult Safeguarding teams within the local authority which has been investigated, and action taken to ensure the ‘Adult at Risk’ remains safe. There have been sixteen Deprivation of Liberty Safeguards (DoLs) applications to the Shropshire DoLs team and three to other area DoLs teams.

**Child Safeguarding**

The Trust is committed to achieving good outcomes for children and young people between the ages of 0 and 17 and has a dedicated orthopaedic children’s ward and outpatients department which have systems in place to ensure the child’s welfare remains paramount throughout their stay. Staff are trained to raise concerns and named professionals work closely with staff and other agencies to ensure children are safeguarded whilst in our care.

**The safeguarding team** includes: - The Director of Nursing as the Executive lead, a non-executive lead, and the Named Doctor and Nurse. Our Named professionals are clear of their roles and responsibilities and these are clearly documented in their job description. These named professionals receive regular supervision and are supported by the local designated team for Shropshire, Telford and Wrekin.

**Meetings**

The Trust holds a quarterly safeguarding children’s committee. This meeting reviews any Trust safeguarding cases, updates policies and procedures, reviews training compliance and shares current safeguarding
documents to ensure the Trust meets its full range of obligations within the safeguarding arena. Unfortunately some of these meetings have been missed this year, but plans are in place to re-establish a more robust schedule in the near future.

The named professionals also attend the Health Governance Safeguarding Children Committee in Shrewsbury and the Executive Lead or designated deputy attends the Shropshire Safeguarding Children Board meetings.

The Trust safeguarding intranet page continues to be updated and is a central point for all staff to access safeguarding information and referral material.

**Training**

Training remains high on our agenda and training figures at the end of Mar 2016 are:

- **Level 1** – 99.1%
- **Level 2** – 79.5%
- **Level 3** – 75%
- **Level 4** – 100%

Our target level is 90%. Staff who were out of date at level 2, have been contacted by HR as well as their managers. Level 3 training had decreased and to address this shortfall internally Trust-led level 3 training has commenced; however SSCB training modules for staff requiring level 3 training are still encouraged, due to their multi-agency focus. The Board of Directors also received Adult and Child Safeguarding training in March 2016 and the Named Nurse attended the annual NHS England Safeguarding Conference in March 2016.

**Recognising a child on a Protection Plan**

Within the Trust there is still no “flagging” system in place for highlighting if a child using our services is on a protection plan and we are reliant on the referrers and families to share this information with us. If we have any doubts as to whether a child is on a protection plan we contact the child’s local authority to see if they are known to them. This is a risk we have managed for many years and had hoped that the National Child Protection – Information sharing project (CP-IS) would have reduced this risk, unfortunately this project has been delayed with its “go-live” date of May 2015. The delay is directly related to IT systems within our local Social Care and to date we have no information as to when they will be ready. This system will allow staff to access the patients Summary Care Records and alerts can be accessed as to whether the child is on a Child protection plan or is “Looked After” child (i.e. in care).

In the interim the executive safeguarding team have been liaising with the Designated Nurse for Safeguarding and Social Care and it is hoped that the Trust will get access to the names of children from Shropshire Telford and Wrekin.

During a recent CQC visit, concerns were raised regarding this risk and the Trust has been advised to use our current safeguarding sheet for all paediatric admissions. This document allows us to record if there are any safeguarding concerns apparent on admission and whether the child is on a protection plan. This sheet is currently in all surgical pathways and will now also be implemented for patients coming in for physiotherapy.

**Referrals**

This year we have referred two children to social services and have also given advice to colleagues as well as requested advice from social services and our primary care partners for 12 other cases falling under various aspects of the safeguarding umbrella.

Most cases required minimal intervention, core groups were attended in two cases, and the self-harm pathway was used to assess the level of risk for one child found to be self-harming.

The neuromuscular team have also work closely with various social care teams requesting safeguarding support for many of their children with complex health needs. This year the team have supported ten children with complex care requirements using the Common Assessment Framework (CAF), and four children who were on early help plans.

**Managing allegations**

The Local Area Designated Office (LADO) relating to managing allegations has been contacted for advice regarding one member of staff this year. The referral was accepted but no further action taken. Managing allegations training and the role of the LADO is currently being planned for the human resources and safeguarding teams to ensure staff have a clearer understanding of this statutory role and referral obligation.
Serious untoward incidents & lessons learnt
This year we had one Serious Untoward Incident where a child quickly deteriorated following an admission via clinic, and the KIDS retrieval team were contacted to take the child to the nearest PICU. The child sadly died the following day at Stoke as the result of a fat embolism.

Lessons have been learnt from this incident.
1. Children will no longer be admitted via clinic unless they have been medically assessed and deemed fit for admission in this Trust
2. Students are no longer able to undertake clinical observations unless they are under the direct supervision of their mentor. If the student is deemed competent by their mentor in their 3rd year of training then they will be given a password to use VitalPAC and will undertake routine observations with minimal supervision
3. VitalPAC is now used for all inpatients and this devise works out the child’s early warning score. This is much safer than relying on the nurse to calculate the score and reduces the risk of human error.
4. The importance of clarify parental responsibility on admission so that it is clear who has responsibility in an emergency

This incident was extremely unusual for the Trust and has been particularly stressful for the staff involved. Debrief sessions and Care First support were offered to all staff involved.

As in previous years we remain committed to supporting the child and family through difficult times and ensuring the welfare of the child remains paramount at all times, as well as supporting staff that have been involved with any safeguarding incident giving them time to reflect and learn from each individual case.

Resuscitation Training
In line with quality standards identified by the Resuscitation Council UK (RCUK) the Trust provides a resuscitation training service to ensure that staff are trained and updated upon resuscitation practice annually.

The service provides a variety of training courses, from Basic Life Support (BLS) through to Advanced Life Support for both Adult (ALS) and Paediatric patients (EPALS) with the appropriate level of training and proficiency required of staff being identified against clinical roles and expected responsibilities. As a minimum clinical staff are required to undertake BLS training; which encompasses:-
- recognising and confirming cardiorespiratory arrest;
- how to summon help;
- starting CPR;
- attempting defibrillation, using an automated external defibrillator (AED).
- recognising and management of choking
- recognising and managing life-threatening anaphylaxis

Extending beyond BLS capability the service provides enhanced resuscitation training through the delivery of nationally accredited/licensed courses from the Resuscitation Council (UK) comprising of:-
- Advanced Life Support (ALS)
- Immediate Life Support (ILS)
- Paediatric Life Support (PILS)
A summary breakdown of staffing requirements, course capacity and attendance rates is provided in table 1 below. The Trust plans to increase the number of staff trained in 2016/17.

**Table 1  Resuscitation Training provision and attendance rates 2015/16**

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of clinical staff identified</th>
<th>Planned Capacity</th>
<th>Actual trained</th>
<th>%Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Advanced Life Support</em></td>
<td>38</td>
<td>*36</td>
<td>13</td>
<td>*63%</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>313</td>
<td>420</td>
<td>263</td>
<td>84%</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>56</td>
<td></td>
<td>47</td>
<td>84%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>333</td>
<td>498</td>
<td>274</td>
<td>82%</td>
</tr>
<tr>
<td>Paediatric Life Support (PiLS)</td>
<td>141</td>
<td>144</td>
<td>126</td>
<td>89%</td>
</tr>
</tbody>
</table>

*ALS certification is valid for 4yrs – figures provided identify total number of staff identified requiring ALS vs overall compliance to 4yrly revalidation required. The RCUK ALS course is a 2day program, which requires multi-quorum faculty and summates with MCQ exam and practical scenario based assessment.

In addition to the above known planned capacities, BLS training is provided and mandated as a core requirement of induction for clinical staff joining the Trust.

**Patient Led Assessment of the Care Environment (PLACE) 2015**

Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered in the both the NHS and independent/private healthcare sector in England.

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care – Cleanliness; the Condition, Appearance and Maintenance of healthcare premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; the quality and availability of food and drink; and the extent to which the environment supports patients with Dementia.

Assessment teams are required to be trained and be formed with equal representation from Trust staff and external patient assessors. Because the assessors are trained and externally audited, through the patient assessor, the PLACE result is being used as a national benchmarking tool, the latest example of which is the NHS Choices – Hospital Food Standards page. This year patient assessors were recruited from Healthwatch Shropshire and the Trusts patient panel.

The 2015 PLACE assessment was carried out at the Trust between the 2nd and 3rd of June 2015 by two teams, each including two Trust staff members and two patient assessors. All findings were recorded and approved by the patient assessors before committing to the National database. Local actions have been taken through the Infection Control Committee, with the National position published on August 11th.
The Trust achieved the below scores:

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food</th>
<th>Privacy, Dignity and Wellbeing</th>
<th>Condition Appearance and Maintenance</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 RJAH + Trend</td>
<td>99.38% ↑</td>
<td>84.20% ↓</td>
<td>83.61% ↓</td>
<td>80.17% ↓</td>
<td>68.51%</td>
</tr>
<tr>
<td>2015 National Average</td>
<td>97.57%</td>
<td>88.49%</td>
<td>86.03%</td>
<td>90.11%</td>
<td>74.51%</td>
</tr>
<tr>
<td>2014 RJAH</td>
<td>98.88%</td>
<td>90.68%</td>
<td>91.18%</td>
<td>83.78%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Whilst cleaning retained its historically high score there were declines in each of the other metrics:

Food – Whilst the scoring for taste and texture were predominantly “Good” / “Very Good”, the scoring for temperature was predominantly “Acceptable” / “Poor”. Assessors base their scoring on sampling the last meals from the trolley, following patient service. The issue of temperature is initially being addressed through SNAHP, by speeding up the delivery of meals at ward level. A future meal delivery strategy is also being drawn up addressing, in part, the speed of service and thus food temperature for the last person eating.

Privacy, Dignity and Wellbeing – With many questions being “Not applicable” minor perception differences between this year’s assessors and last year’s assessors have impacted the overall score. Physiotherapy in particular dropped by over 40% in this metric on the basis that this year’s assessors felt the space around reception was not sufficient for seating or private conversations. Feedback from these questions is being passed onto Estates for consideration in new projects.

Condition, Appearance and Maintenance – the scoring in this metric was mostly brought down by paint chips on corners (where beds appear to be damaging walls in transit) and lack of solid sided bins, an identified requirement of waste management. Ward managers are being asked to lead on Estates requisition requirements in their areas, such as painting. Facilities have identified bins that address the solid side requirement, whilst also addressing the noise at night feedback from other surveys; Ward managers are being forwarded purchasing codes for their replacement programmes.

Dementia is a new metric for 2015, and the scoring sheet has identified areas of focus; actions were already underway before the audit, the impact of which should be demonstrated in next year’s score. Example of failing questions under this metric are:

- Are all toilet doors painted in, or if unpainted, made of or coated with, a single distinctive colour so as to distinguish them from other doors in the same area
- Are there handrails in corridors
- Is all flooring matt rather than shiny
- Are toilet seats, flush handles and rails in a colour that contrasts with the toilet/bathroom walls and floor

The Mini PLACE programme runs between the annual audits, as with the annual audit patient assessors are invited back to the Trust to monitor our progress against the issues raised.

Duty of Candour

The Duty of Candour legislation was introduced by the Care Quality Commission in November 2014. This legislation states that in any incident where the patient suffered moderate or severe harm, a process needs to be followed to ensure that there is full communication with the patient, including an apology for the harm suffered and an explanation of any investigations undertaken by the Trust into the incident. The legislation defines moderate harm as any harm that is significant but not permanent, and that leads to a moderate increase in treatment, and severe harm as any harm that is likely to affect the patient permanently.
To ensure compliance, the Trust reviewed its existing Being Open policy and incorporated the requirements for Duty of Candour into this policy. In addition, the Datix system was updated to allow staff to record that the process had been followed. Training was provided to all staff via a series of briefings and implementation of the Duty of Candour has gone well. The Trust monitors compliance with Duty of Candour through the Datix incident reporting system and ensures that patients are given a full apology and explanation, both verbally and in writing, if they are harmed.

**Sign up to Safety**
Sign Up to Safety is a national initiative that aims to help the NHS improve the safety of patient care. Organisations are invited to sign up by making pledges under five areas:

1. **Putting safety first.** Committing to reduce avoidable harm in the NHS by half through taking a systematic approach to safety and making public your locally developed goals, plans and progress. Instil a preoccupation with failure so that systems are designed to prevent error and avoidable harm
2. **Continually learn.** Reviewing your incident reporting and investigation processes to make sure that you are truly learning from them and using these lessons to make your organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe your services are
3. **Being honest.** Being open and transparent with people about your progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborate.** Stepping up and actively collaborating with other organisations and teams; share your work, your ideas and your learning to create a truly national approach to safety. Work together with others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system
5. **Being supportive.** Be kind to your staff; help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to work safely and to work on improvements. Thank your staff, reward and recognise their efforts and celebrate your progress towards safer care.

The Trust has made pledges under each of these areas, which are included at Appendix B and in September 2015 the Trust held a Sign Up to Safety Launch day to raise awareness of the initiative and to encourage staff to complete their own individual pledges. There was an excellent response with a number of staff from both clinical and non-clinical signing up to the initiative.

**Clinical Effectiveness**

**The National Institute for Health & Clinical Excellence (NICE) guidance**
In 2015/16 NICE published 142 pieces of guidance, of which there were 45 clinical guidelines and national guidelines, 34 interventional procedures, 49 technology appraisals, four medical technologies guidelines, six diagnostic guidelines, one public health guidance, one highly specialised technology guidance, one health technologies adoption programme guidance, one SRCQS Guidance and 35 quality standards. A baseline assessment was carried out for all guidance relevant to the Trust and where appropriate audits were undertaken to measure compliance are put in place. Audits that have been carried out in 2015/16 in relation to NICE guidance include:

- TAG 304: Total hip replacement and resurfacing arthroplasty for end stage arthritis of the hip
- CG 27: Management assessment of 2 week wait cancer patients
- CG 171: Urinary Incontinence in Women
- CG 103: Delirium-Diagnosis, prevention and treatment
- PH 47: Managing overweight and obesity among children and young people: lifestyle weight management services
- CG 161: Falls
- CG 177: Osteoarthritis within the physiotherapy department
Cancer data (62 days and 31 days)
Data for English patients only, taken from Open Exeter Database

2 week wait - Taken from Report 1.1 - Cancer Two Week Wait

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Total Patients</th>
<th>Treated in Target</th>
<th>% treated in target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>47</td>
<td>47</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>48</td>
<td>48</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>68</td>
<td>68</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>54</td>
<td>54</td>
<td>100%</td>
</tr>
<tr>
<td>Annual</td>
<td>217</td>
<td>217</td>
<td>100%</td>
</tr>
</tbody>
</table>

31 day - Taken from Report 2.1 - 31 Day First Treatment (Tumour)

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Total Patients</th>
<th>Treated in Target</th>
<th>% treated in target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Annual</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
</tbody>
</table>

62 day - Taken from Report 3.1 - Cancer Plan 62 Day Standard (Tumour)

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Total Patients</th>
<th>Treated in Target</th>
<th>% treated in target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>1.5</td>
<td>1.5</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>2</td>
<td>1.5</td>
<td>75%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>1.5</td>
<td>1.5</td>
<td>100%</td>
</tr>
<tr>
<td>Annual</td>
<td>8</td>
<td>7.5</td>
<td>93.75%</td>
</tr>
</tbody>
</table>

Human Tissue Act
The Designated Individual (consultant lead) and Persons Designate (operational leads) have met regularly throughout the year. Each area has an audit programme in place, which has demonstrated excellent compliance with the Human Tissue Act requirements throughout the year. Any non-conformances or other incidents are reviewed at meetings and actions put in place as needed.

Local PROMS
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust does not limit its PROMs data collection to the nationally mandated hips and knees but follows up procedures in other specialties undertaken at the Trust using internationally validated questionnaires to determine the success of these procedures. As the number of Trusts undertaking these ‘local’ PROMs is extremely limited and not all Trusts use the same questionnaires, comparison between the RJAH and other Trusts is not possible however significant improvements are seen in shoulder replacement surgery. Other procedures are in the process of being validated and refined.

The following chart shows the improvements as a result of Subacromial Decompression surgery on shoulders.
Patient Experience

National Inpatient Survey 2015
The Trust had an excellent response rate to the 2015 National Inpatient Survey of 64.6% (considerably higher than the national average). Overall, 95% of patients rated their care as seven or more out of ten, with 49.3% giving the Trust a rating of ten out of ten. Other high scoring areas were:

- Overall: treated with respect and dignity 95%.
- Doctors: always had confidence and trust 96%.
- Hospital: room or ward was very/fairly clean 99%.
- Hospital: toilets and bathrooms were very/fairly clean 99%.
- Care: always enough privacy when being examined or treated 96%.

None of the responses were rated as significantly worse than last year’s survey and nine questions were rated as significantly better.

Patient Feedback Summary
The table below shows overall patient feedback in 2015/16 compared to 2014/15:

<table>
<thead>
<tr>
<th>Feedback</th>
<th>2015/16</th>
<th>2014/15</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints</td>
<td>82</td>
<td>87</td>
<td>-5</td>
</tr>
<tr>
<td>Local resolution</td>
<td>28</td>
<td>54</td>
<td>-26</td>
</tr>
<tr>
<td>PALS Concerns</td>
<td>473</td>
<td>509</td>
<td>-36</td>
</tr>
<tr>
<td>Compliments</td>
<td>2522</td>
<td>1473</td>
<td>+1049</td>
</tr>
</tbody>
</table>
Main reasons for patients contacting the Patient Feedback Team in 2015/16
The main categories for patients raising concerns are set out in the graphs below:

In 2015/16, the Trust received 82 formal complaints, which is a decrease of five (6%) from the previous year showing a slight downward trend.

The total number of complaints received is only a very small percentage (0.05%) of the Trust’s total activity, including inpatients and outpatients, with an average of seven complaints per month.

Of the 82 complaints closed by the end of March 2016 (three were received in March 2016 and have not yet been completed), 35% (28) were considered to be ‘upheld’, 12 (15%) were ‘partially upheld.’ In line with the Ombudsman’s principles a complaint is ‘upheld’ if any single aspect of it is deemed to be well-founded. As of April 2015, complaints will be recorded as being either ‘upheld,’ ‘not upheld,’ or ‘partially upheld.’ This is following the national changes to the NHS complaints reporting system.
Main reasons for making a complaint
The main reasons for patients making a complaint in 2015/16 was the attitude of staff, with 16 complaints (nine relating to medical staff, five to nursing staff, one to an allied health professional and one to a member of administrative staff).

On the whole most categories show a decrease from last year. The number of complaints received regarding the quality of care was 38 (46%) and the number received regarding operational issues was 44 (54%).

Parliamentary & Health Service Ombudsman
Between April 2015 and March 2016 there were no cases that were referred to the Parliamentary & Health Service Ombudsman for an independent review.

During 2015/16 the Ombudsman upheld one case which was registered with them during 2014/15.

Comment Cards
98.8% of inpatients and outpatients have rated the Trust as excellent or good, when asked to rate their overall experience on the Trust comment card. The Trust received 686 comment cards on average per month for 2015/16 which is an increase from last year 2014/15 where the monthly average was 375 cards per month.

<table>
<thead>
<tr>
<th>Patient Advice and Liaison Service (PALS) contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2015/16, there were 1153 PALS contacts. This was a 6%, (62) increase compared to 2014/15; of these contacts, 473, (41%) were PALS concerns and the others were requests for help, advice or information. There were on average 39 PALS concerns received on average per month.</td>
</tr>
<tr>
<td>The top reasons for patients contacting PALS were delays and cancellations for outpatient and inpatient appointments (58%, 273 contacts); the majority of these were for Arthroplasty (hip and knee services) and Spinal disorders specialties. This is followed by some aspect of care, (50) (19 were nursing care issues, 16 were medical care issues, seven were therapy concerns, six medication concerns, and two orthotics concerns).</td>
</tr>
</tbody>
</table>
Locally resolved issues
Where appropriate, members of staff are encouraged to resolve patient concerns as they arise on the ward or in other departments. There were a total of 28 locally resolved issues raised between April 2015 and March 2016. This is a decrease of 26 (48%) from last year where there were 54 local resolutions. The joint top themes were staff attitude 7, (split 43% medical staff and 57% nursing) and communication/information to patients 7.
Changes in Practice as a result of patient feedback raised in 2015/16 – “You said…..We did…."

In order to identify any opportunities for learning from patient feedback, an action plan is produced for every complaint and PALS concern. The Patient Relations Manager and the Patient Experience Manager have been attending the Incident Action Review Committee (IARC) and the Senior Nurses and Allied Health Professional (SNAHP) meetings to share good practice of complaint handling and action plan documentation across department ward areas. “You said…We did” posters detailing changes are displayed on ward quality boards.

Below are some examples of changes in practice that have been made as a result of patient feedback since April 2015 across PALS and complaints.

### Changes from PALS Contacts by theme:

<table>
<thead>
<tr>
<th>Communication Issues</th>
<th>Theme</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-Ray</td>
<td>Dec. 2015</td>
<td>X-ray letters have been updated with department location number</td>
</tr>
<tr>
<td>Kenyon-Pharmacy</td>
<td></td>
<td>Staff training to be given on reintroducing patient self-medication</td>
</tr>
<tr>
<td>ADOS</td>
<td></td>
<td>Poster to advertise Chaplaincy service put up in ADOS and ward areas</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Oct. 2015</td>
<td>Physiotherapy telephone is checked every 2 hours throughout the day.</td>
</tr>
<tr>
<td>HCR</td>
<td></td>
<td>HCR Manager to review tone of appointment letters.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient received two consecutive letters which they felt the tone of was inappropriate.</td>
</tr>
<tr>
<td>MOPD</td>
<td></td>
<td>Patients are advised and updated on waiting times in clinic every 20 minutes</td>
</tr>
<tr>
<td>ADOS</td>
<td>Jul. 2015</td>
<td>New poster in ADOS to advise patients of process following concerns over wait in ADOS</td>
</tr>
<tr>
<td>Pre-Op.</td>
<td></td>
<td>Patients who will be non-weight bearing after their operation will be informed how to hire a wheelchair at Pre-op if they will need one at discharge.</td>
</tr>
<tr>
<td>MOPD</td>
<td>Apr. 2015</td>
<td>A poster has been put up in Main Outpatients to advise patients that they can ask staff for assistance if they need food/drink whilst they are waiting especially if they are diabetic</td>
</tr>
</tbody>
</table>

### Clinical

<table>
<thead>
<tr>
<th>Theme</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Op. / Kenyon Ward</td>
<td>Health and Safety Manager to look into using Latex free gloves – Staff to be made aware of patient allergies and that the Trust is not a latex free hospital.</td>
</tr>
<tr>
<td>X-Ray</td>
<td>X-ray paper work/requests reviewed to ensure have correct information about a Patient’s bed/chair transfer to ensure a patient can confidently transfer without assistance otherwise patient need to arrive in X-ray on a bed.</td>
</tr>
</tbody>
</table>
### Changes made from Complaints

Below are some examples of changes in practice that have been made as a result of patient feedback since April 2015 across PALS and complaints.

<table>
<thead>
<tr>
<th>May 2015</th>
<th>June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand &amp; Upper Limb Consultants</strong></td>
<td><strong>Compulsory Equality &amp; Diversity training to all staff (including Consultant and Medical Staff)</strong></td>
</tr>
<tr>
<td>Hand &amp; Upper Limb Consultants were written to by Menzies Unit Manager on 29/05/15 - Booking Clerks emailed and asked if they could send staggered letters with the times dictated by Clinical staff on Menzies.</td>
<td>Undertaking further work to promote our Trust Values which will include value based recruitment, and remind all staff of their duty to act in accordance with our policy and values.</td>
</tr>
<tr>
<td>Signage in Main OPD unsatisfactory. OPD are re-designing the signage, in larger print, laminated and put up in the Department. Completed in June 2015.</td>
<td>Discussions with the Equality and Diversity Steering Group regarding a complaint made and inclusion of these issues in future training.</td>
</tr>
<tr>
<td>Orthotics department reviewing manufacturers of devices to see if alternative companies will give a more timely service that those currently used.</td>
<td>Review of wording in appointment letters when the appointments take</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>July 2015</td>
<td>place either during the evening hours or on weekends, to warn patients that the hospital is quieter during these times. Ward Manager to closely monitor members of staff about whom concerns were raised.</td>
</tr>
<tr>
<td></td>
<td>Staff reminded of the need to keep patients informed about when they can be discharged. Raise awareness with anaesthetists that they do need to try and see patients prior to theatre.</td>
</tr>
<tr>
<td></td>
<td>Further investigation with the Hand &amp; Upper Limb team whether they are able to admit their patients on a 'staggered' basis so that patients undergoing a local anaesthetic do not have to wait until the patients having a general anaesthetic have undergone surgery.</td>
</tr>
<tr>
<td></td>
<td>Any delays in patient transport arriving (whether MSL or Welsh Ambulance services) to Main Outpatients to be reported on Datix so information can be discussed with MSL/Welsh Ambulance.</td>
</tr>
<tr>
<td></td>
<td>Review the Orthotics paperwork to make it clearer when KAFOs are received back that are not fit for purpose. An interim measure has been put in place for the KAFOs to be checked by a senior Orthotist whilst the paperwork is being amended to prevent any further occurrences.</td>
</tr>
<tr>
<td>August 2015</td>
<td>Consultant support with further training following a complaint being raised about his attitude towards patients who were upset in clinic.</td>
</tr>
<tr>
<td></td>
<td>A standard operating procedure is to be created for dealing with telephone enquiries from patients who are experiencing wound problems post discharge.</td>
</tr>
<tr>
<td></td>
<td>A radiologist gave a patient incorrect information about whether to attend two appointments within a short period of time or not. The radiologist has been reminded that if she is unsure or has any doubt then to ask the patient to speak to their consultant/clinician for advice. (Radiology)</td>
</tr>
<tr>
<td></td>
<td>All risk assessments and instructions given to patients on Oswestry Pain Management Programme (OPMP) to be clearly documented in patient notes.</td>
</tr>
<tr>
<td></td>
<td>All patients to have their temperature checked prior to discharge. All patients are to have a set of physiological observations on discharge and this was shared with staff on 17/09/15 in the ward meeting.</td>
</tr>
<tr>
<td>October 2015</td>
<td>New call bells are to be purchased which are suitable for patients with a high spinal cord injury so they are able to summon assistance themselves without needing to ask others to do it for them.</td>
</tr>
<tr>
<td></td>
<td>Importance of staff professionalism to be reiterated at team meeting.</td>
</tr>
<tr>
<td></td>
<td>Housekeepers and ward staff to be spoken to regarding importance of ensuring patients are helped to have drinks.</td>
</tr>
<tr>
<td></td>
<td>Registrars reminded of importance of checking patients’ BMI at pre-op.</td>
</tr>
<tr>
<td>November 2015</td>
<td>Staff supported to improve communication to patients following a complaint.</td>
</tr>
<tr>
<td>Date</td>
<td>Information</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>December 2015</td>
<td>Consultant reminded to check with referrers of patients outside of Shropshire as to whether treatment is required or just a second opinion. Booking Clerks have also been informed that they need to make sure that a GP referral has been received before allocating a non-England resident patient an appointment. Staff reminded to check if letters have already been generated where possible to avoid duplication and confusion.</td>
</tr>
<tr>
<td>January 2016</td>
<td>The Trust's own manufacturing unit made a patient a pair of insoles due to delays from external manufacturers.</td>
</tr>
</tbody>
</table>

**Patient Panel Activities 2015/16**

Since April 2015 members of the Patient Panel have been allocated a specific ward or department, which is working well, with patient panel members visiting their allocated wards and departments between panel meetings. Panel members are involved in lots of activities including attending meetings as the patient representative or involvement in specific projects such as input into the new Theatre Build.

Patient Panel representatives attend many meetings such as the Nutrition Steering group, Clinical Effectiveness Committee, Clinical Audit Committee, Dementia Task and Finish Group, the Medicines Management Committee and the Patient Experience and Communications committee.

Members have had an input into the following projects:
- PLACE audits
- Nutrition audits
- Outpatient improvement plan
- New Tumour/Theatre build
- Joint school
- Hip and Knee Support group
- Butterfly scheme
- Sit and See observations
- Way finding Survey
- Reviewing patient information leaflets and posters
- Chaplain process
- Sign up to Safety campaign
- NICE guidelines for Hip fractures
- Gardening project
- Befriending/supporting patients
- NHS England Open & Honest project
- Always Events
- CQC spot checks
- NHS England National Carers Pilot project
- Recruitment of Chief Executive, Director of Nursing and Director of Operations
Panel activities are broken down into the following projects:

**Patient panel sub groups**

- **The Older people/Safeguarding sub group** is led by the Matron for Quality & Safety and Adult Safeguarding Lead and looks at issues to do with safeguarding adults and patients with dementia.

  Members are involved in the dementia Task and Finish group on Sheldon ward and the Butterfly scheme which enables staff to respond appropriately and positively not only to people with dementia, but also to those with memory-impairment or temporary confusion.

  The Trust is looking at developing Always Event for staff to sign up to that will link in with Trust values. This is also an NHS England initiative these can be monitored maybe as part of the Sit and See project.

- **The Patient Flow/Journey sub group** is led by the Acting Deputy Director of Nursing. The Project Manager for the new Theatre and Tumour Unit regularly attends each panel meeting to go through the development and plans for the new; this includes overall architecture plans, patient flows, and interior and exterior finishes.

  Panel Members are also involved in improving the patient experience in Outpatients through the developing of an action plan looking at the environment, communication and waiting times and attend the Outpatient Working Group.

- **The Patient Experience sub group** is led by the Patient Experience Manager.

  A Patient Experience and Communications committee had been set up to look at monitoring the Patient Experience initiatives set out in the Quality Improvement Strategy 2014-2017 as well as producing a Patient Experience work plan for gathering patient feedback.

  This group will look at trends and themes for continuous quality improvement and provide assurance that actions have been identified from the patient feedback collected.

  A Patient representative on the group said “the meeting was well attended and it was pleasing to note the level of enthusiasm from staff attendance”.

  A Shropshire Local Health Economy Patient Engagement & Experience Leads Group has been re-established to work collaboratively across Trusts and CCG’s to work together on projects, share information and good practice.

  A work plan has been produced on joint ventures such as Customer care training for staff dealing with Cancer patients funded by Macmillan and a campaign to reduce noise at night.

  The Trust has been working with Shropshire Health Youth Champions in a 15 steps challenge project on Alice ward and to review patient leaflets.
The Trust has signed up to Open & Honest Project from September 2015 that is a NHS England project to support organisations become transparent and consistent in publishing safety, experience and improvement data with the overall aim of improving care, practice and culture. The data included in this report will cover; the Safety Thermometer, HCAIs. Pressure ulcers, Falls, FFT, patient experience questions, a patient story, and improvement story.

**The Patient Information/Communication sub group** is led by the Patient Experience Manager. Members have provided valuable input into reviewing patient information leaflets and posters; examples include leaflets from Therapies, Consultants, Outpatients, Complaints, Chaplains, Orthotics.

One member also attends the Pre-op Joint school education session every Monday as the expert patient.

**The Quality and Safety sub group** is led by the Clinical Governance Manager who works with clinical staff and patient panel reps to carry out spot checks using the Care Quality Commission (CQC) Key Lines of Enquiry, which ask five key questions:

- Is it safe?
- Is it caring?
- Is it effective?
- Is it responsive?
- Is it well-led?

These spot-checks are carried out on a monthly basis using a 12 month rolling programme that covers all areas. The group carrying out the spot checks speak to both staff and patients and review documentation. Findings are fed back to the ward or department manager who can then implement any changes as necessary.

**Sit and See Observations of care**

The Sit and See project is now well established across 17 wards and departments and observations are carried out each month. This simple observation tool captures and records the smallest things that can make the biggest difference to patient care, for example a smile, a little banter, a reassuring touch, which can make all the difference to the patient experience. The tool is a simple recording system which can identify positive, passive and poor care.

There are 70 Sit and See observers trained from a selection of clinical and non-clinical staff, including medical secretaries, administration staff, healthcare support workers, trained nurses, Patient Panel members, and Non-Executive Directors. There have been 17 ward/department areas involved in the observation.

Results of the observations are discussed at the time of the observation with the nurse in charge and a follow up report is sent to the manager of the ward or department with action points to take forward. The report is shared with ward/department staff, and is also part of the STAR assessment performance framework as having been carried out on a monthly basis. There is a regular STAR newsletter produced by the Matron for Quality & Safety

The key principles of the ‘Sit & See’ tool:

- Safeguarding adults is about prevention; absence of care and compassion can be the first sign of a failing environment.
- Celebrate compassionate care by highlighting it.
- Identify shortcomings within the context of positive practice.
- Staff see and understand care through the eyes of the patient.
- High quality nursing care requires the use of the head, the heart, and the hands.
- The small things (for the patient) are often remembered more than anything else.
- Captures evidence of care and compassion in a simple way with agreed standard descriptors.
- The tool records positive examples of care as well as passive or poor examples.
- Observation sessions are 15 minutes – 50 minutes in total
Some examples of Positive practice identified from ‘Sit and See’ during 2015/16

- Calm and quiet atmosphere which was appropriate for type of care being delivered
- Supporting small extras - use of patient own toiletries, happy to help with anything extra.
- Environment clean and tidy.
- One of the students interacted well with the patient and was joking with him
- Full explanation of treatment given
- Good staff rapport between staff and also patients.
- Receptionist spoke discreetly with a patient and gave them a good range of options for their next appointment.
- Patients giving excellent reports of care on the ward and the friendliness of the staff.
- Visitors welcomed on to ward
- Physio introduced himself to patient when behind screens, having a good conversation

Examples of Passive and Poor themes across the wards and actions identified:

- Patient comment: “Couldn’t praise the staff high enough – really good care.”
- Observation: Laminated poster was removed.
  Action: Everything was actioned at time of Sit & See
- Observation: H.C.A. walked up ward to sluice wearing no P.P.E. with urine bottle.
  Action: "I've checked it through and all seems fine."
- Observation: From a patients point of view, cramped, no arm rests on high % of chairs & no room to put crutches or sticks down.
  Action: All of the concerns have been discussed with Outpatient Manager and positive action will be taken.
- Observation: RN sneezed into hands and did not witness the use of hand gel/washing hands
  Action: discussed at the time and what we were told was that the staff nurse was coming out of the kitchen and used the personal handgel – but the observer felt it would have been more visual to use the handgel on the wall outside bay 1

**Patient Stories Programme**

A Patient Story is presented to the Quality and Safety Committee and the Board of Directors at the beginning of each meeting. Patients are invited to attend in person to share their experience.

Patient Panel volunteers are involved in collecting patient stories. Stories have been presented from patients attending the Tumour Unit, in the Midland Centre for Spinal Injuries, Sheldon ward, Clwyd ward and Powys ward.

Healthwatch Shropshire attend the Trust once a month to collect patient stories in the main entrance.
The Trust is also part of a NHS England Carers National Pilot Project in partnership with Staffordshire University to collect Carers stories and narratives to analyse what carers are saying around integrated service provision so carers experience smooth transitions of care and easy access between primary, secondary and community treatment settings.

**Social Media Comments**
The hospital is now receiving comments via Social Media from Facebook and Twitter. Some examples of comments received via Facebook are as follows:

- “Amazing hospital and amazing staff. The treatment I have received here is second to none”.
- “I stayed in this hospital for two weeks for Physio and Hydrotherapy on Sheldon Ward from the 5th October, the Physios are great and the ward staff were brilliant - best care ever, such a great bunch”.
- “Congratulations to the team, it is definitely the best Spinal Unit”!
- “I am the happy recipient of two new knees in six months. Superb surgeon, very good after care and even good food! A very good hospital, well organised, efficient and still human”.
- “It's a wonderful hospital where people REALLY care; they look after me well when I go there”.
- “My girlfriend has been on Ludlow Ward twice this year for ankle surgery and both times the staff have been amazing! Special thanks to the ward Sister who was so welcoming and friendly. I have worked for the NHS for eight years and I have to say that this is the cleanest hospital I've ever been in. The food menu is huge - you'll be stuck for choice and there are plenty of healthy options”.

**Patients Comments made on NHS Choices Website and Patient Opinion Website**
During 2015/16, 32 comments have been posted on the NHS Choices website and eight on Patient Opinion. The majority of these were compliments.

The concerns raised included the new Pain Management Service - having to be referred to this by their GP, the length of time it takes to receive an appointment with a Consultant and poor communication between RJAH and the Telford Referral And Quality Services (TRAQS) regarding appointments.
**Examples of Positive comments:**

They did a fantastic job on my leg. It needed lengthening with a lot of cosmetic surgery. The op was a success and the aftercare was second to none.

Very impressed with the hospital. Very satisfied with all concerned. Was extremely pleasant and helpful. My husband and I were very impressed with the hospital at RJAH.

It is an excellent hospital and I was dealt with speedily and efficiently

All very efficient and on time. Staff very friendly and nice. My first experience of visiting Gobowen – very nice. Thank you.

Was seen and dealt with straight away

Arrived one hour early, but was seen and dealt with straight away. Very good unit

**Patient Feedback from iPad project**

The Trust has been gathering real-time information relating to patient experience and care delivery as part of the Quality Improvement Strategy to improve Hospital services.

From April 2015 to March 2016, Patient Advice and Liaison Service (PALS) staff and Patient Panel volunteers have interviewed 661 patients asking questions about their patient experience on the wards on the day of discharge.

Six questions are asked about the patient experience such as:

- menu choices
- feeling well cared for
- noise disturbances at night
- being involved and informed about their care
- time taken for call bells to be answered
- frequency of seeing a doctor

Results in 2015/16 show positive overall score and show an improved score for five of the six questions. Results have been shared with ward managers.

**Results below for each question:**

<table>
<thead>
<tr>
<th>iPad results</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who said they always received menu choice requested</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>% who said they were always felt well cared for by nursing staff</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>% who said there was no noise disturbance at night</td>
<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>% who said they were always kept informed about their care</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td>% who said call bells answered in under 5 minutes</td>
<td>88%</td>
<td>83%</td>
</tr>
<tr>
<td>% who said a doctor spent enough time with you to answer all your questions after your operation</td>
<td>97%</td>
<td>96%</td>
</tr>
</tbody>
</table>

**Friends and Family Test (FFT)**

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 ward 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".
The Trust has been collecting FFT data monthly via the Trust current comment cards and electronically using volunteers to collect the data in real time using iPads.

**For Inpatients**
Responses from patients have been extremely positive. The Trust’s average monthly score was 99% of inpatients who would recommend the Trust to friends and family, which is higher than the average score of all NHS Trusts in England which was 95.2% and an increase from 2014/15 which was 98.4%

The RJAH achieved an average monthly rank of 2.6 out of 154 NHS Trusts in England, making the Trust one of the top performing NHS Trusts in the country.

**For Outpatients**
The Trust’s average monthly was 98.6% of outpatients who would recommend the Trust to friends and family.

RJAH FFT results for 2015/16 for outpatients:

The graph below shows a comparison of the RJAH FFT inpatient score against; Trusts in NHS North Midlands, all NHS Trusts in England, the Royal National Orthopaedic Hospital NHS Trust and Royal Orthopaedic Hospital NHS Foundation Trust.
The graph below shows the percentage of in-patients who would recommend the Trust by Ward.

FFT % of in-patients who are extremely likely & likely to recommend the Trust in 2015/16 and 2014/15
Examples of Compliments received in 2015/16

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Alice Ward: “Wonderful, personable staff”.

Clwyd Ward: “The staff are all very friendly which I felt helped with my recovery. This is a happy ward to be in as well as highly professional”.

Gladstone Ward: “Staff are wonderful and treatment has been fantastic. This is the best hospital I have ever been to”.

Kenyon Ward: “Staff very friendly, helpful and attentive. A lovely caring nature shown by all”.

Ludlow Unit: “Excellent stay, superb treatment. Staff exemplary across the board”.

Menzies Unit: “Excellent treatment at RJAH, once again”.

Outpatients: “Very good service and very helpful”.

ORLAU: “Outstanding, relaxed, clean, bright, everyone listens and will help. Made to feel that you care”.

Powys Ward: “Fab team from start to finish, keep up the good work”.

Sheldon Ward: “Treatment by staff on the ward has been excellent. Good selection of food every day”.

Pre-op: “Very happy in the way I was treated by all members of staff and how clean the hospital is”.

Wrekin Ward: “Staff and doctors are always so welcoming and understanding”.

Menzies Unit: “Excellent treatment at RJAH, once again”.

Theatres: “First class hospital. Staff worked hard. Recommend to anyone”.

Delivering Outstanding Patient Care
Workforce Factors

2015 Staff Opinion Survey
In 2015 the Trust achieved, for the second year running, a score of 93% for staff who would recommend the Trust to a friend of relative if they needed treatment (the highest in England). The opinion survey results showed that the Trust has maintained improvements from last year in the key areas and compared most favourable with other acute specialist trusts in England in the following areas:

- staff witnessing potential harmful errors, near misses or incidents in the previous month
- staff suffering work related stress in the last 12 months
- staff experiencing discrimination at work in the last 12 months
- staff working extra hours

Staff Experience has improved in respect:

- Staff motivation at work
- Effective use of patient/service user feedback

Some existing and new themes were highlighted by the 2015 survey as areas for improvement:

- Quality of appraisals
- Reporting good communication between senior management and staff
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Staff confidence and security in reporting unsafe clinical practice

Although the Trust’s overall staff engagement score is reported as below average compared to Specialist Acute Trusts, the Trust has continued to make further improvement compared to last year’s score.

The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was (23%), which is comparable with the national average for acute specialist trusts but showing a small increase from last year (2014).

Although our the score for the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion has decreased; the score for the Trust in 2015 (90%) remains above the national average for acute specialist trusts (88%).
Statement from Local Healthwatch Shropshire

Healthwatch Shropshire is pleased to be invited to consider and comment on the Trust’s Quality Account for 2015-16

We congratulate the Trust on the high scores achieved for both staff and patients who would recommend RJAH as the place to come for treatment to their family and friends. The increase in comment cards the Trust received from patients in 2015/16 compared to 2014/15 is impressive. More detail on how this has been achieved would be an excellent way of sharing good practice.

We were also pleased to see the inclusion of a comprehensive report on the roll out of the dementia friendly environment across the organisation. It would be useful to have some detail on the positive impact this has had on the patient experience by including some case studies. We look forward to the outcomes of the service evaluation being done 2016/17 and we support the priorities that have been identified for the coming year.

Although disappointed in the position that the Trust was in, Healthwatch Shropshire welcomes the work that is being done to resolve the Referral to Treatment issues and would like to continue to be involved with the communication and engagement work.

We are pleased that the Staff Opinion Survey showed the Trust maintaining improvements from last year in key areas. However, the percentage of staff who reported bullying or harassment, although comparable to the national average, appears high. What measures does the Trust plan to implement to improve this figure?

We welcomed the section ‘Changes in Practice as a result of patient feedback’ which demonstrated good, clear examples of positive actions taken. We were similarly impressed with both the positive and negative examples identified from Sit and See and the concise way in which it was reported.

Healthwatch Shropshire contributed to the CQC inspection of RJAH and in response to the action plan will be carrying out Enter & View and ‘Sit and See’ visits to the hospital in the coming months. HWS has regular stands at the hospital to engage with patients and looks forward to continuing to develop its relationship with the Trust.

Jane Randall-Smith
Chief Officer
Healthwatch Shropshire

Statement from Health & Adult Social Care Scrutiny Committee, Shropshire Council

Members of the Committee commented that it would be very helpful to see a structure diagram in the Quality Account, illustrating how Boards, Committees and Groups of the hospital worked together. They noted that a review of structures was underway and welcomed proposals for rationalisation of the number of committees and groups.

(This is available on the Trust website under Board Governance documents http://www.rjah.nhs.uk/RJAHNHS/files/83/8392a40d-2528-4f68-b7d1-f44d3d781c59.pdf)

Members were reassured by and welcomed the actions to be delivered through a Recovery Plan to address the non-compliance with referral to treatment waiting times. They were also reassured by the commitment of staff and the new Chief Executive to meet the challenges and improvements needed, as highlighted in the CQC report.

Members were particularly impressed with the Dementia Training offer available to all employees, and not just clinical staff, through the Dementia Friends Scheme. They also commented positively on the ‘sit and see’ work undertaken.

They noted some electronic systems were no longer fit for purpose and were pleased to note that an IT Manager had been recruited and was currently reviewing all systems. Members would welcome dialogue between the Trust and the Council on the compatibility of information systems.

Members congratulated the Trust for the very positive results from the Friends and Family Test.
The Committee welcomes continued engagement between the Trust and the Health and Adult Social Care Scrutiny Committee in the forthcoming year.

Councillor Madge Shineton
Vice Chairman, Health & Adult Social Care Scrutiny Committee
Shropshire Council

Statement from Shropshire Clinical Commissioning Group

Shropshire CCG acts as the co-ordinating Commissioner working closely with Telford & Wrekin CCGs for Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust and welcomes the opportunity to provide a statement for the Trust’s Quality account for 2015/16.

This Quality Account has been reviewed in accordance with the relevant Department of Health and Monitor guidance and in line with the Gateway Reference: 04730 reporting arrangement for 2015/16 Quality Accounts.

The CCG remains committed to ensuring, with partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, safety and patient experience.

It has been a challenging year for the Trust as referenced in the Quality Account, including the difficulties experience by the Trust, with some patients waiting to be seen longer than expected to access their services, including Referral to Treatment performance. It is recognised by Commissioners that the Trust has demonstrated a renewed focus to address the challenges it has faced in a collaborative manner with both English and Welsh Commissioners, Regulatory bodies and Patient Groups. The CQC inspection carried out in October 2015 rated the Trust overall as ‘Required Improvement’ and whilst it is recognised that the Trust has taken a number of immediate actions to address the areas that required improvement, we would have expected that these actions were given in greater detail in the report.

During 2015/16 SCCG and TWCCG have jointly conducted a number of patient safety and assurance visits to the Trust. This has included a review of the Trusts compliance with the WHO checklist in both its Theatre and Radiology departments and Commissioners are pleased with the measures which have been put in place to improve patient safety in these areas.

We also recognise the work undertaken by the Trust to improve patient experience, including the roll-out of the dementia friendly environment across the organisation and the work undertaken by the patient panel sub groups highlighted in the Quality Account.

We are pleased to see the Trust’s priorities for 2016/17 across the Safety, Effectiveness and Patient Experience domains. We would, however, have expected that mandatory training and appraisal compliance would have been set higher than the 90% compliance target indicated.

We also welcome the forward look from the Trust’s New Chief Executive and the priorities he outlines to ensure that everything the Trust does will fall into three key domains: Caring for patients; Caring for staff and Caring for finances.

The CCGs remain committed to working closely during 2016/17 with the Trust’s Clinicians and Managers, monitoring service delivery and performance through monthly Clinical Quality Review meetings and addressing any issues with regards to the quality and safety of patient care.

In summary, we consider that over all, this Quality Account contains a balanced description of the quality of the services the Trust delivers to its patients and the work it has been undertaking to address its challenges.

Linda Izquierdo
Director of Nursing, Quality and Patient Experience

Accountable Officer
Statement of Directors’ Responsibilities in Respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 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 2015 to March 2016
  - Papers relating to Quality reported to the Board over the period April 2015 to March 2016
  - Feedback from the commissioners dated May 2016
  - Feedback from governors dated February 2016
  - Feedback from Local Healthwatch organisations dated May 2016
  - Feedback from Overview and Scrutiny Committee dated May 2016
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015;
  - The latest national staff survey (2015)
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated May 2016
- 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; we have noted the issue of RTT reporting within the Quality Report.
- 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; a review of the controls on RTT identified that these controls were not working in practice and the results are disclosed in this report. The performance reported for quarter 4 of 2015/16 is accurate.
- 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.
- The Quality Report has been prepared in accordance with Monitor’s Annual Reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the Board

24th May 2016 …… ................................................................. Chairman

24th May 2016 …… ................................................................. Chief Executive
Independent auditor’s report to the Council of Governors of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust’s quality report for the year ended 31 March 2016 (the ‘Quality Report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week Referral To Treatment (RTT) incomplete pathways for 1 January 2016 to 31 March 2016; and
- Cancer 62 day waits for first treatment (from urgent GP referral) for 1 April 2015 to 31 March 2016.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
- the quality report is not consistent in all material respects with the sources specified below:
  - board minutes for the period April 2015 to March 2016;
  - papers relating to quality reported to the board over the period April 2015 to March 2016;
  - feedback from the Commissioners dated May 2016;
  - feedback from the governors dated February 2016;
  - feedback from local Healthwatch organisations, dated May 2016;
  - feedback from Overview and Scrutiny Committee, dated May 2016;
○ the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015;
○ the latest national patient survey 2015;
○ the latest national staff survey 2015;
○ Care Quality Commission Intelligent Monitoring Report dated 3 March 2016;
○ the Head of Internal Audit’s annual opinion over the trust’s control environment dated May 2016; and
○ any other information included in our review.

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports’.

We read the quality report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual’, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the ‘documents’).

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the documents. Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.
Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’.

Deloitte LLP
Chartered Accountants
Birmingham
United Kingdom
24 May 2016
<table>
<thead>
<tr>
<th>Audit Number</th>
<th>Title of Audit</th>
<th>Action Points</th>
</tr>
</thead>
</table>
| 1            | 255 Audit of Medicines Policy | • RJAH to implement electronic prescribing of the EPMA System  
• Promote NPSA alerts and champion safe prescribing  
• Sign up to the national medicine safety thermometer  
• Provide more structured pharmacy support to prescribers  
• Provide clearer evidence of pharmacy intervention to support safer prescribing |
| 2            | 365 A prospective audit of hip screening referrals from the postnatal unit at Wrexham | • Change in policy to scan all babies with abnormal examination findings |
| 3            | 13/14_006 Inadvertent Peri-Operative Hypothermia (NICE CG 65) | • To have a blanket warmer on the wards for pre-operative patients found to be hypothermic  
• No documentation of surgeons and anaesthetist discussion of their preference of not using warming mattress or forced air-warming devices. To include as part of the checklist prior to anaesthesia |
| 4            | 13/14_014 Audit of Clinical Provision in the Oswestry Muscle Team | • Offer annual review appointments  
• Discuss appointment locations and times with the team to arrange sessions at the patient home or in clinic settings as necessary  
• Offer group interventions where possible e.g. Parent support groups |
| 5            | 13/14_034 Long term bladder management in patients with spinal injury sustained in paediatric age group | • Record of renal investigations carried out elsewhere are to be available at MCSI record  
• Improvement needed of record keeping  
• Ongoing training and education of MDT for good record keeping and importance of surveillance to maintain 100% standard |
| 6            | 13/14_046 Audit on the use of biologic drugs in inflammatory arthritis (NICE Guidance) | • All patient related data to be held on the electronic patient record  
• All applications for funding to include baseline and latest DAS 28 scores  
• Clinical reviews to be more regular and rigorous |
| 7            | 13/14_050 Day case Anterior Cruciate Reconstruction | • PONV protocol to be put in place  
• Addition of rescue oromorph doses and antiemetics on TTOs-Work towards standardised TTOs for these patients |
| 8            | 13/14_057 Management and Outcome of Trigger Finger Pathology presenting to RJAH | • To share information about new regulation to ensure best practice tariff and guidelines achieved as per Telford and Wrekin CCG protocol  
• To share the report to all concerned |
| 9            | 13/14_062 Audit of Outreach Services by MCSI | • Referral to be made within four hours of injury  
• Formal entry of referral into NSCISB database within 24 hours  
• Outreach within five days or admission within seven days  
• Documented evidence in medical notes in referring hospital/letter sent from MCSI Consultant following outreach  
• Satisfaction of service users including four major trauma centres to meet regularly with MTC leads to monitor their satisfaction of the service |
<table>
<thead>
<tr>
<th>Audit Number</th>
<th>Title of Audit</th>
<th>Action Points</th>
</tr>
</thead>
</table>
| 10          | Enhanced Recovery Compliance Re-audit            | - To discuss the Joint School education at arthroplasty consultants meeting to decide if this should be compulsory for all patients, or just all patients who have never had joint replacement or if it should remain the patients choice.  
  - Pre-op pregabalin not given by all anaesthetists which has been shown to help and a part of our EPR protocol, or a reason for it not being given after clinical assessment is not being documented.  
  - Post op tranexamic acid-it is not clear if all hips and knees are to get a post-operative dose and if this is to be given, whose responsibility it is to prescribe it. |
| 11          | Urological service provision at MCSI (NICE CG 148) | - Awareness of the recommendations and standards; Need for clearer documentation; Recommended examination for assessment  
  - Documentation of fluid intake/output and residual volumes needs to be more robust, encourage clinicians, nursing staff to document in EPR entries. Discuss with Integrated Healthcare Records / IT regarding plan of implementation of going paperlite |
| 12          | Medicine Safety Thermometer                       | - 100% compliance for the documentation of allergy status on all patients  
  - To improve accuracy of data collection by discussing at pharmacy meeting any changes or unexpected results from data collection  
  - To ensure all patients are seen by a pharmacist within 24 hrs of admission by increasing the number of patients seen by a pharmacist  
  - To reduce the number of unintended omitted doses by continuing to promote the peer review of medication charts following medication administration to reduce unintended omitted doses  
  - To ascertain what is captured by the category other by developing a proforma to capture this information over three-month period  
  - Reduce the number of doses refused by patients by introducing a questionnaire as part of the STAR assessment |
| 13          | Re-audit of Appropriateness and Effectiveness of the care provided to diabetic patients presenting for surgery | - Bluespier to flag up all diabetic patients  
  - Where possible diabetics should be 1st on list, unless there is a patient with other serious co-morbidities  
  - HBA1c of >69 is a high risk for infection and other complications therefore elective surgery deferred until suitably controlled  
  - Diet controlled diabetes if HBA1c> 48 should have treatment completed by GP |
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<tr>
<th>Audit Number</th>
<th>Title of Audit</th>
<th>Action Points</th>
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</thead>
</table>
| 14 14/15_035 | Case note review to seek evidence of compliance using the guidelines for the care of adults with a learning disability on admission to RJAH | - Easy identification of patients with learning disabilities. Explore if the three star symbols can be added to EPR for those patients identified as having a learning disability as we are looking to a paperless system  
- Prompts to be added to pathway to offer the passports  
- New e-learning package to be devised and launched  
- Widen the training catchment group-medical staff to be included in the identification list of staff to complete once new package is approved |
| 15 14/15_036 | Compliance with NICE Guidelines regarding the use of Biologic drugs in the treatment of inflammatory arthritis CCG audit | - Improve compliance with NICE Guidance for future audits. Shropshire CCG has produced funding request templates for the various biologics.  
- Dedicated database to record patients on these drugs and their DAS 28 score.  
- Review patients who did not maintain an adequate response to treatment to see if they would benefit by changing to rituximab in line with NICE Guidance  
- Review patients who are in disease remission and continuing to receive therapy, and consider a ‘drug holiday’ as an evidence-based approach |
| 16 14/15_037 | Gentamycin Prophylaxis before urology procedures in MCSI | - Ensure that MCSI continue high standard of patient care and reduce the potential renal failure as side effects from Gentamycin particularly as there is increased frequency of the early discharge of patients without immediate renal function follow up  
- To have follow up of kidney function for five patients with Stage 2 CKD identified in this study to ensure recovery of renal function  
- Up to date local department policy re antibiotic practice MCSI |
| 17 14/15_046 | Re-audit on Management of older persons with new spinal cord injury at MCSI at Oswestry | - Patients with a history of falls to be referred to a medical team  
- Older persons with acute SCI are not all having their cardiac screening recorded on admission and at discharge. A proposal for an admission and pre discharge check list will be discussed.  
- Patients are not being asked if they wish to attempt CPR when appropriate  
- Patients are not having the appropriate referrals made at discharge, include all documentation needed on referrals for discharge |
| 18 14/15_050 | National Joint Registry Consent Audit | - Surgeons to lead on NJR consent at pre-op assessment  
- Theatre staff to be informed of incorrectly annotating the H1 and K1 forms |
<table>
<thead>
<tr>
<th>Audit Number</th>
<th>Title of Audit</th>
<th>Action Points</th>
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</table>
| 19          | Re-audit Peri-operative management of arthroplasty patients receiving warfarin therapy | • Restart warfarin at 1.5 times the patient’s usual dose for the first two days and then continue according to the INR results with the view to return them to their usual dose.  
• For young patients with minimal or no further comorbidities, apart from the condition for which they are on Warfarin, consider doubling their usual dose for the first two days and then continue according to the INR results with the view to return them to their usual dose.  
• Warfarin should restart on the evening of the surgery for most patients  
• Consider delaying Warfarin until the first day after the operation for elderly patients with significant comorbidities  
• Daily INRs in the morning  
• Use point of care testing devices as the default method  
• Develop an inpatient anticoagulation service to help guide dose adjustments  
• Patients discharged on a sub-therapeutic INR should be prescribed additional VTE prophylaxis to continue on |
| 20          | Re-audit of compliance with NJR data for shoulder and elbow replacement       | • Investigate whether BlueSpier can assist in the process of data collection for the amount of patients entered onto NJR  
• New consented in ADOS on day of surgery, WHO surgical checklist should include NJR consent as well as surgical consent  
• Registrars to check OSS completed in pre-op assessment  
• For pre-op assessment team/registrar to check that OSS completed before leaving consider implementing OSS IPad. New standards for data to be entered onto Quality Outcomes Database within two weeks NJR data to be entered within one month by theatre receptionist |
| 21          | Re-audit of CTPA Studies                                                      | • There are no recommendations for a change in practice following this audit. A repeat audit in three years would be useful to identify any further trends in referral. |
| 22          | Early complications of THR and TKR at RJAH                                    | • Improve attendance in clinic by informing patients at discharge the importance of follow up clinics |
| 23          | Audit of Delirium among in-patients                                          | • Inform all health care professionals involved with patients care during pre-op check up to complete the confusion screening for patients >65 years  
• Check for polypharmacy in patients with delirium by informing medical team at lunch time meeting  
• Inform GP’s about the confusion state at discharge  
• Develop a dementia and delirium care bundle |
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| 24 15/16_017 | Re-audit of Anaesthetic Record Keeping 2015 | • Poor levels of recording items in the dataset, presentation to group and individual data at Anaesthetic Clinical Governance Meeting  
• Use of Abbreviations on Anaesthetic Records, Send an email to department stating not to use abbreviations  
• Different anaesthetists perform poorly in different area. Provide individualised feedback |
| 25 15/16_022 | Re-audit of Documentation of consent for procedures and patient experience of consent | • Letter to all Consultants reiterating consent form requirements and possible extra training around consent for all Consultants and Registrars  
• Discuss with Pre-Op Manager possibility of displaying a consent process flow chart in the Consulting areas |
| 26 CARMS 00326 | Re-audit of the quality of Case Notes | • General awareness and improvement of standards is needed via training and education  
• Implementation of IHCR (Integrated healthcare record) is needed therefore all notes will be available on the EPR system |

12 Service Evaluation projects reports were reviewed by the provider in 2015/16.
Our Trust Pledges

**1. Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.

*We will*

- Continue to monitor harm through the monthly patient & medicines safety thermometer tool, using that 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.

**2. Continually learning.** 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.

*We will*

- Continue to actively participate and share learning with the West Midland Safety Collaborative to promote improvements across the NHS.
- Continue to share learning from incidents and patient feedback at the Incident Action Review Committee.
- Monitor and audit actions arising from SIs and other serious adverse events to ensure that actions have been effective.

**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.

*We will*

- Continue to ensure that Duty of Candour is applied across the Trust.
- Link in with the local health economy to strengthen and develop our learning.
- Provide regular updates to the patient panel of progress against our Sign up to Safety action plan.

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

*We will*

- Introduce change collaboratives for key areas relating to patient harm.
- Celebrate what we do well.

**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 progress.

*We will*

- Continue a rolling programme of themed reviews at the Incident Action Review Committee.
- Where harm has occurred, this will be shared to ensure maximum learning.
- Encourage all staff to sign up to safety and complete personal pledges.
- Have an annual safety culture event to celebrate achievements in safety.
### Quality Accounts Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADOS</td>
<td>Admit on Day of Surgery</td>
</tr>
<tr>
<td>AED</td>
<td>Automated External Defibrillator</td>
</tr>
<tr>
<td>AKI</td>
<td>Acute Kidney Injury</td>
</tr>
<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
</tr>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
</tr>
<tr>
<td>CARMS</td>
<td>Clinical Audit Registration and Management</td>
</tr>
<tr>
<td>CAS</td>
<td>Central Alerting System</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CTPA</td>
<td>Computed Tomography Pulmonary Angiography</td>
</tr>
<tr>
<td>Datix</td>
<td>Incident reporting system used by the Trust</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>DoLS</td>
<td>Deprivation of Liberty Safeguard</td>
</tr>
<tr>
<td>EPALS</td>
<td>European Paediatric Advanced Life Support</td>
</tr>
<tr>
<td>EPMA</td>
<td>Electronic Prescribing and Medicines Administration</td>
</tr>
<tr>
<td>EPR</td>
<td>Electronic Patient Records</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends &amp; Family Test</td>
</tr>
<tr>
<td>HCA</td>
<td>Health Care Assistant</td>
</tr>
<tr>
<td>HCR</td>
<td>Healthcare Records</td>
</tr>
<tr>
<td>HSE</td>
<td>Health &amp; Safety Executive</td>
</tr>
<tr>
<td>IARC</td>
<td>Incident Action Review Committee</td>
</tr>
<tr>
<td>IHCR</td>
<td>Integrated Health Care Record</td>
</tr>
<tr>
<td>ILS</td>
<td>Immediate Lift Support</td>
</tr>
<tr>
<td>INR</td>
<td>International Normalised Ration</td>
</tr>
<tr>
<td>IOSH</td>
<td>Institute of Occupational Safety and Health</td>
</tr>
<tr>
<td>KAFO</td>
<td>Knee Ankle Foot Orthoses</td>
</tr>
<tr>
<td>KIDS</td>
<td>Kids Intensive Care and Decision Support</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LADO</td>
<td>Local Area Designated Office</td>
</tr>
<tr>
<td>MCQ</td>
<td>Multiple Choice Questions</td>
</tr>
<tr>
<td>MCSI</td>
<td>Midland Centre for Spinal Injury</td>
</tr>
<tr>
<td>MHRA</td>
<td>Medicines Health &amp; Regulatory Agency</td>
</tr>
<tr>
<td>MOPD</td>
<td>Main Outpatient Department</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
</tr>
<tr>
<td>MSL</td>
<td>Medical Services Limited</td>
</tr>
<tr>
<td>MSSA</td>
<td>Methicillin Sensitive Staphylococcus Aureus</td>
</tr>
<tr>
<td>MTC</td>
<td>Major Trauma Centre</td>
</tr>
<tr>
<td>NEBOSH</td>
<td>National Examination Board in Occupational Safety and Health</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health &amp; Clinical Excellence</td>
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<tr>
<td>NIHR</td>
<td>National Institute of Health Research</td>
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<tr>
<td>NJR</td>
<td>National Joint Registry</td>
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<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<tr>
<td>NRLS</td>
<td>National Reporting and Learning System</td>
</tr>
<tr>
<td>NSCISB</td>
<td>National Spinal Cord Injury Strategy Board</td>
</tr>
<tr>
<td>OSS</td>
<td>Oxford Shoulder Score</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
</tr>
<tr>
<td>PDSA</td>
<td>Plan Do Study Act</td>
</tr>
<tr>
<td>PICU</td>
<td>Paediatric Intensive Care Unit</td>
</tr>
<tr>
<td>PILS</td>
<td>Paediatric Immediate Life Support</td>
</tr>
<tr>
<td>PLACE</td>
<td>Patient Led Assessment of the Care Environment</td>
</tr>
<tr>
<td>PONV</td>
<td>Post-Operative Nausea and Vomiting</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>PROM</td>
<td>Patient Reported Outcome Measures</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>RCUK</td>
<td>Resuscitation Council UK</td>
</tr>
<tr>
<td>RIDDOR</td>
<td>Reporting of Injuries, Diseases and Dangerous Occurrences Regulations</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to Treatment Time</td>
</tr>
<tr>
<td>SCI</td>
<td>Spinal Cord Injury</td>
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<tr>
<td>SI</td>
<td>Serious Incident</td>
</tr>
<tr>
<td>SNAHP</td>
<td>Senior Nurse and Allied Health Professionals</td>
</tr>
<tr>
<td>SSCB</td>
<td>Shropshire Safeguarding Children Board</td>
</tr>
<tr>
<td>SSI</td>
<td>Surgical Site Infection</td>
</tr>
<tr>
<td>STAR</td>
<td>Sustaining (quality) Through Assessment and Review</td>
</tr>
<tr>
<td>STEIS</td>
<td>Strategic Executive Information System</td>
</tr>
<tr>
<td>THR</td>
<td>Total Hip Replacement</td>
</tr>
<tr>
<td>TKR</td>
<td>Total Knee Replacement</td>
</tr>
<tr>
<td>TRAQS</td>
<td>Telford Referral And Quality Service</td>
</tr>
<tr>
<td>TLS</td>
<td>Total List Size</td>
</tr>
<tr>
<td>TTO</td>
<td>To Take Out</td>
</tr>
<tr>
<td>VTE</td>
<td>Venous Thrombo-Embolism</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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