

Appendix 1



**Royal National Orthopaedic Hospital NHS
Trust**

Quality Account 2022-23

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Part 1: Statement of Quality from the Chief Executive

It is with great pride that I reflect on the past year, and what our staff have achieved in the face of a number of ongoing challenges across the NHS. RNOH has continued its journey of recovery from the effects of the COVID-19 pandemic.

I am proud of all our achievements. We have been:

- Recognised as the 9th best orthopaedic provider in the world, the best in the UK and the only UK orthopaedic hospital in the top 50 (Newsweek 2022).
- Recognised in the top 9 NHS performers nationally for patient experience scoring highly for our involvement of patients in decisions about their care, ensuring patients know how to reach us if they're worried after they have left the hospital and for our doctors communicating in a way that is easy for patients to understand.

These are just a few highlights. The fact that our patients receive some of the best care in the NHS in England is down to the dedicated staff here at RNOH.

We are committed to providing our staff with the very best staff experience in the NHS. Our staff survey continues to be amongst the best in London and nationally. RNOH scored:

- Above the NHS national averaged across all areas of the staff survey
- Ranked number one across London Acute Specialist Trusts
- Ranked number one across London Trusts for staff engagement, morale and safe and healthy
- Ranked number one across North Central London, in all but one category – recognition & reward where we placed third. Recognition & reward scores were a concerning theme across the NHS alongside burnout scores.

However, improvement is required to ensure all our staff and patients experience the very best at RNOH.

Through the latter part of 2022/23 the Trust prepared for the launch of its new divisional structure, which went live on 1 April 2023. The structure creates divisions called RNOH Specialist Services (within which Children's Services currently sits), RNOH Local Services, and RNOH Private Care. It allows clinical and non-clinical leaders the freedom, authority and accountability to act to support the organisational strategy, which in turn focusses on growth, efficiency, and people, underpinned by some key enablers, including partnership working, system leadership and infrastructure. With RNOH Local, through our hub in Enfield, we are providing our first local service for patients to access specialist MSK services without the need to see a GP first. This and other innovations are supported by the new structure.

As part of our partnership work as part of the North Central London integrated care system and UCL Health Alliance, RNOH is innovating for the future. We are leading system change for musculoskeletal patient pathways. We're looking holistically at the patient pathways to deliver better and more efficient patient care - getting help to those that need it more quickly. We're excited that UCL Health Alliance has been selected

for NHS England Provider Collaborators Innovator Scheme which will help to accelerate their plans for innovations which benefit the residents we serve. This is a real opportunity for us to affect change for our local population and be a test bed for system-wide change and innovation.

As part of RNOH's infrastructure developments, throughout this year, we have been planning the expansion of our theatre capacity with four new theatres to reduce elective care waiting times and assist in our growth plans.

Investing in our digital infrastructure is key to driving forward our ambitions. This year we have already put in place Electronic Prescribing and Medicines Administrations (ePMA) and Discharge Summaries for all patients across the Trust and launched Pathpoint for the management of referrals and patient-reported outcomes (PROMS) and Pathpoint for Pre-Operative Assessment and digitising consent. These are significant milestones in improving patient safety and continuous learning.

Our next phase will see a programme focused on bringing Electronic Patient Records (EPR) to RNOH and work is already underway hand in hand with clinicians. This will truly transform our working practices.

It is important that we remain focussed on those areas where similar to the rest of the NHS, there continues to be room for improvement, including stress, frustration and ill health as a result of pressures at work. RNOH has worked hard to continue to close the gap between the experience of staff with protected characteristics and other staff, especially those with disabilities, and this focus will remain.

It is also important to mention that, after three years at RNOH, Dominic Dodd stepped down as Chair at the start of April 2023 to focus on his role as Chair of UCL Health Alliance. He will continue to be involved with RNOH through his role in UCL Health Alliance, the collaborative based in North Central London and of which RNOH is a member.

Dominic's time leading RNOH's board of directors has seen a major change in the RNOH leadership team and strategy, as well as all the challenges of the pandemic. He has been instrumental in helping to set the direction of the Trust over recent years and in establishing the Trust as an important partner in the care of our local populations, as well as those patients that we see nationally. I am extremely grateful for all that Dominic has done for us over these recent years and I look forward to continuing to work with him in his role at UCL Health Alliance.

I am incredibly proud and privileged to lead RNOH as it continues to strive to deliver exceptional high-quality care and treatment for its patients.



Paul Fish
Chief Executive

Part 2: Introduction

2.1 Royal National Orthopaedic Hospital

The Royal National Orthopaedic Hospital NHS Trust provides world leading healthcare for children and adults suffering from neuro musculoskeletal (nerve, muscle, soft tissue and bone) conditions. We provide a comprehensive and unique range of neuro-musculoskeletal healthcare, ranging from acute spinal injuries to orthopaedic medicine and specialist rehabilitation for chronic back pain sufferers.

As a National Centre of Excellence, RNOH treats patients from across the country, many of whom have been referred by other hospital consultants for second opinions or treatment of complex or rare conditions.

A large number of orthopaedic surgeons receive training at RNOH, and our patients benefit from a team of highly specialised consultants, many of whom are internationally recognised for their expertise.

RNOH has a long track record of innovative research, focused on musculoskeletal as well as neuro-musculoskeletal conditions, rehabilitation, peripheral nerve injury repair, sarcoma detection, surgical treatments and much more. Together with our research partner, University College London's Institute of Orthopaedic and Musculoskeletal Science, our work has led to the development of new devices and treatments for some of the most complex orthopaedic and musculoskeletal conditions.

2.2 The Quality Account

Every year, the Trust is required to produce an account of the quality of the services it provides. This is an important way for NHS services to share information with the public about the quality of care they provide and demonstrate the work being undertaken to improve services.

RNOH is committed to continuously reviewing and improving the quality of its services to ensure our patients have the very best experience of care and successful clinical outcomes. Within this document, the Trust provides information about how we have performed against National Quality Indicators for Patient Safety, Clinical Effectiveness, and Patient Experience. We also outline our Quality Improvement Priorities for 2023/24 and review our progress against last year's priorities.

2.3 What is Quality?

High-quality care in the NHS means that patients have a good overall experience of care, which is clinically effective and delivered safely. An organisation committed to delivering high-quality care is always striving to be even better. At RNOH, we are committed to being a world-leading orthopaedic hospital with the best patient care and staff experience in the NHS.

This means:

- Achieving even better clinical outcomes
- Providing even safer care
- Exceeding the expectations of our patients and their families

Knowing that we are delivering the best care requires continuous measurement. We do this in many ways, including a comparison with our peers through participation in National Clinical Audits and benchmarking our practice against guidance from the National Institute for Health and Care Excellence (NICE). We also undertake many local clinical audits based on best practice guidelines. This helps us understand more clearly what we do well and what we could improve. We are also able to understand the impact of our clinical interventions from our patient's perspective through our Patient Reported Outcome Measures (PROMs) and Patient Outcome Data (POD).

Safe care ensures avoidable error and harm have been effectively removed. Safe care can be measured in a number of ways, for example by looking at our rates of hospital-acquired infections, thrombosis, pressure damage and falls. It can also be analysed in relation to the rates of incident reporting within the hospital. We know that when staff are focused on improving the safety of care provided, we can expect to see high levels of incident reporting. Each incident report provides further opportunities for quality improvement and learning within the hospital.

RNOH places great importance on ensuring patients and their families have a good experience. We continue to work to find better ways of getting patient feedback to improve our services. In a recent National Inpatient Survey, RNOH is one of three Trusts in England to be classed as having better than expected results. This is a testament to the hard work and dedication of our multi-professional teams and their commitment to providing world-class specialist treatment to our patients.

Delivering high-quality care means being able to recognise that in the provision of complex specialist services, we do not always get it right. Being open and honest with our patients, our regulators and ourselves, when we get things wrong, is the most important step we can take to improve the quality of our care and be even better.

2.4 Quality Highlights of 2022/23

Over the past year, we have undertaken work across the Trust to improve the quality of our care and services. This section provides some notable highlights of our quality improvement work:

2.4.1 Access to Care

In 2022/23 we improved our bed use by creating a dedicated day case unit, enhancing our discharge processes and aligning our care processes.

One of our quality priorities in 2022/23 was to ensure the length of stay for our patients was optimal, recognising the negative effects of long stay for inpatients. We have reduced the overall length of stay for all our NHS Adult patients by 13% and thereby created additional capacity for care.

We introduced a new dedicated Adult Day Case Unit which has allowed us to offer a more patient-focused day case experience to our patients as well as making effective use of our resources. We have seen an increased proportion of day case activity across all our specialities. As we have increased our day surgery rate, we have also closely monitored the patient experience through Friends and Family survey response, complaints and readmission rates. We are confident that there have been no systemic negative effects for patients.

The pathway work across the hospital incorporated areas where we felt we could offer better quality care to our patients through day case provision and reducing unnecessary time in hospital. For example, the clinician-led joint replacement quality programme has reduced elective & non-elective length of stay by 1.8 days (total hip replacements reduced from 5.7 to 4.2 days and total knee replacements reduced from 6 to 4.9 days).

Teams throughout the Trust have continued to develop patient-focused quality initiatives related to reducing unnecessary hospital stays, for example, the limb reconstruction team have successfully shorted the time in hospital for our patients through a telemedicine education programme.

2.4.2 Patient Information and Engagement

In 2022/23 the Co-production Group, which features equal numbers of patients and staff working as a single team, continued to contribute to the development of Trust programmes of improvement and transformation, with patient coproduction partners joining programme groups as full members. The Patient Charter has become embedded in the Trust as part of our recruitment, interview and induction processes,

and this year the Trust's Ward Accreditation quality scheme was updated to reflect the Patient Charter.

One example from 2022/23 of co-production in action was our 'Waiting Well' project. The pandemic has led to longer waiting lists, and we know that patients can worry that they have been forgotten. Using a co-production volunteer, services developed an approach where volunteers contact patients on the waiting list. Our volunteers take time to speak to patients, update records and pass on messages or questions to the clinical team. One department has reported a decrease in queries from dissatisfied patients as a direct result of this initiative.

We have also updated the Trust welcome booklet. Funded by the RNOH Charity and produced by staff, volunteers, patients and relatives, it gives information about our site and the additional services and facilities such as the Trolley Shop run by the volunteers, Horatio's Garden, and our chaplaincy service. It also contains our Patients Charter so that patients and carers know what standards we expect to deliver.

This year we have recruited dedicated Patient Safety Partners (PSPs) to participate in key governance committees and groups focusing on safety, risk, and quality. The role helps us ensure we focus on the voice and needs of the people who use hospital and community-based health services. This includes patients, family members, carers and the public. The PSPs are actively involved in the design of safer healthcare at all levels within the Trust, participating in investigations, developing policy and contributing to the Trust strategy and objectives.

In 2022, we established fortnightly Safety Learning Walks to support the delivery of safe and effective care and bring greater focus to the patient experience using our Patient Charter as a guide. Safety Walks use a variation on mystery shopping observational approaches to understand what service users and carers experience when they are in a healthcare setting. This approach leads to immediate feedback on areas of excellence and opportunities for improvement.

2.4.3 Patient Safety

We have recruited three Patient Safety Specialists who are registered with NHS England and provide dynamic senior patient safety leadership. Each Patient Safety Specialist is dedicated to providing expert support to the Trust and has direct access to the Trust Executive Team, creating a clear link from the board to the organisation for patient safety issues or concerns.

Patient Safety Specialists also help with the implementation of the NHS Patient Safety Strategy and other national safety priorities. The specialists have close links with the NHS England and NHS Improvement National Patient Safety Team who host a national network for Patient Safety Specialists, including regular meetings and information sharing through a dedicated online forum.

In 2022/23 we have taken forward significant preparatory work for the implementation of the national Patient Safety Incident Response Framework (PSIRF) which will change the way we learn from safety events in the organisation. For example, by increasing the emphasis on systemic quality improvement work in response to system issues. This year we have planned the delivery of a

comprehensive training programme for Learning Response Leads and Oversight Leads in this area of work.

Additionally, this year we have successfully implemented the national Learn from Patient Safety Events (LFPSE) system. This is a new national NHS service for the recording and analysis of patient safety events. The service aims to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year and help make care safer.

2.4.4 Digital

2022/23 saw the successful delivery of a number of projects:

- introduction of our electronic Prescribing and Medicines Administration system, ePMA. This is already having an impact and is expected to reduce medicine errors and improve processes throughout the Trust.
- implementation of Pathpoint throughout the Trust. This is an electronic data collection system which allows us to robustly and reliably gather Patient Reported Outcome Measures, better measure complexity and streamline our referral processes.
- integration with the London Care Record, allowing clinicians to view consolidated patient data from multiple health and care sources across London. This helps service integration, improves shared care decision making and moves closer to seamless care for patients.

2.4.5 Allied Health Professions

Allied Health Professions at RNOH is a diverse group of professionals with specific knowledge, skills and areas of expertise. They make a significant contribution to the delivery of high-quality care across the entire patient pathway.

In 2022/23 the 10th Annual Therapies Research and Audit Day showcased work across the range of Allied Health Professions in therapies, including presentations from colleagues from other NHS organisations with whom we have worked collaboratively on research this year and students who have been working on various research and quality improvement programs.

Allied Health Professions continue to deliver significant research outputs which benefit the quality of care provided by staff. In the last year, there have been 20 scientific abstracts accepted for national and international conferences, 11 peer-reviewed publications in scientific journals, the publication of three book chapters, one PhD award and six successful research grants totalling £220k.

Teams are aiming for continuous quality improvement and to make changes that benefit our patients across the patient journey. Examples from this year include:

- digitised patient information in the orthopaedic oncology team to make it more accessible to our patients
- new Cauda Equina Syndrome rehabilitation pathway in the spinal cord injury centre
- new hemi-pelvectomy rehabilitation pathway in orthopaedic oncology

- developments of the myeloma pathway driven by Specialist Orthotist

A major development this year is the Allied Health Professions-led community musculoskeletal hub in Enfield. This is helping to address the NHS backlog, health inequalities, and inequity of access. The hub, a collaboration with multiple primary and secondary care partners in North Central London, is delivering innovative patient pathways and has a research academic embedded in the team to rigorously investigate the impact of the innovations. There has already been a significant impact in reducing the number of patients waiting to see a spinal surgeon, and we have improved the quality of life for those waiting for an orthopaedic procedure such as a hip or knee replacement.

2.4.6 Volunteer Services

Volunteer numbers continue to rise, with 220 volunteers across the Trust and a further 30 in the recruitment process, sourced from the local community. This is now higher than the pre-pandemic level.

In addition to our regular volunteering roles (the buggy service, mealtime support, welcoming volunteers, and general administrative roles), the team is continuously developing new volunteering roles that enhance the patient experience. These include our bi-weekly boredom-buster trolley offering patients free puzzles, colouring, crosswords, books and magazines as well as a selection of games to play with volunteers.

Many of our volunteer roles are being enhanced. For example, nutrition support volunteers are undergoing training on how to feed a patient who needs additional help. This role has been developed from our traditional mealtime buddy role and improves the quality of care for some of our patients. Working closely with the dieticians, infection control and improvement team, a training video has been developed to teach volunteers how to undertake the task of a mealtime volunteer. This ensures our training is consistent and of a high quality. Volunteers who show aptitude, and a desire to support the patients further, can undertake additional training in supporting patients who require help to feed themselves. This will be undertaken with the knowledge of the nurse in charge of the ward. This role supports the patients but also the ward in saving nurse time.

We have a large site at Stanmore and our buggy service is one of the most popular volunteer services. We have transported over 128,000 passengers since the service started and this year invested in two new lithium batteries resulting in a more reliable service. This year we have only had to cancel three shifts due to adverse weather.

We're committed to ensuring our roles are both fulfilling for volunteers and valuable to our patients and staff.

Patient feedback on the Patient Transport Buggy:

“Just wanted to say, this is the most brilliant idea...I brought my Mum to the hospital, I had just parked up in the Main Car Park, and I was helping my Mum out of my car, when the guy driving the buggy, pulled up right by my car to offer us a lift, which was just absolutely wonderful, so helpful and kind.... that buggy was a life saver for my Mum and when we left Outpatients, the Security Staff called for the Buggy again, to take us back to my car, just brilliant”.

Feedback from an external non-patient visitor:

“The volunteer driving apparently acted as a wonderful advocate of the hospital and gave her the full history of the Trust (!) And a great first impression. That kind of experience really sets up the day perfectly and is priceless. Can you please feedback and thank the team as they do a fantastic job and play a unique role in the Trust that no one else can do!”

Feedback from staff:

“The volunteers are a great support to us on the London Irish ward. We are a busy 32 bedded ward with very complex patients who can require a lot of extra support and reassurance, and this is where the volunteer service come in so well. They not only spend time helping give out meals, but also answer phones when we are busy and relay messages to anxious relatives, they help with supplying meals and ensuring patients have everything they need at hand.

2.4.7 Research Champion

The Research Champion is a new role which has been co-produced with patients and lay-partners. Research Champions are patients and others who support and have input into research projects, giving a unique insight and perspective into how we address research proposals.

2.4.8 Pharmacy

RNOH’s Pharmacy Department has continued to develop the medicines optimisation agenda, with patient safety and patient experience at the forefront.

Medicines safety

There has been a 38% reduction in medicines-related incident reporting levels during 2022/23. This is due to a reduction in medication errors since the Trust-wide implementation of the electronic Prescribing and Medicines Administration system (ePMA).

The Medicines Safety Dashboard continues to be utilised by more staff and has received positive feedback. We are now exploring ways to improve the dashboard tool by incorporating ePMA metrics.

Medicines optimisation clinics and telemedicine clinics

The Pharmacy Team work closely with clinical colleagues to optimise medicines using a variety of clinics, both virtual and face-to-face.

Pharmacists and pharmacy technicians are providing ongoing access to medicines and advice, monitoring for adverse effects through telephone clinics to specialist clinical services such as bone and joint infection and long-term pain. In long-term pain clinics, a pharmacist is also facilitating trials of analgesics to determine their usefulness in individual patients. These telephone clinics have received positive feedback from patients and clinical staff.

This year we have specifically focused on opioid de-prescribing. This work has involved ongoing reviews and guidance to patients, educating patients about the importance of optimising opioid use as part of looking after their overall health, what they may expect during the process of reducing opioid doses and how they can manage any withdrawal symptoms and increases in pain as a result of this process. Of the 102 patients reviewed throughout 2022/23 (224 appointments), 66 were referred to the clinic for opioid reduction support and observation. 38 successfully reduced their opioid use and 15 patients were discharged after completely discontinuing their opioid use.

Improving timely discharge

Pharmacy is a vital part of a high-quality and timely discharge for patients. This year we have:

- Trained more pharmacists to facilitate prescribing in clinical areas and prescribe discharge medicines
- Increased the medicines available in clinical areas to maximise patient discharge directly from the wards
- Facilitated the Pharmacy Team to dispense “to take away” medicines in designated pharmacy rooms in each clinical area. This improves efficiency and turnaround times as it reduces the time taken for the prescription to be delivered to and from the Pharmacy department
- Supported the training of more porters to undertake any pharmacy-related duties

As the redevelopment of the Pharmacy premises continues, work has begun to refurbish the patient waiting area and to create a designated room to carry out patient consultations. This will allow patients to discuss their medicines confidentially in a comfortable environment.

Homecare medicines services

The Pharmacy homecare medicines service supported 440 patients during 2022/23, a 17% annual increase.

Our new complaints database, to track and report on complaints relating to the homecare providers, processed 35 complaints in the first year. Learning such as better communication, change of processes and identifying trends has contributed to improving patient care and safety.

Part 3: Progress against 2022/23 Quality Priorities

3.1 Length of Stay

The 2022/23 quality priority target was a 0.5 day reduction in Length of Stay against the pre-pandemic baseline. We achieved a 0.4 day reduction overall as shown in the table below.

Average NHS Adult LOS (All) Including day cases – Full year Comparison			
	2019/20	2022/23	% change
All	3.1 days	2.7 days	↓13%
Elective	2.1 days	1.9 days	↓9.5%
Non- Elective	34.9 days	26.4 days	↓24.4%

Table 3.1.1 Length of stay comparison with 2019/20

We achieved a significant improvement in non-elective length of stay and improvements in day cases as a result of following the plan laid out in the Quality Plan last year:

- Prioritised clinical pathway efficiency programmes in Joint Replacement, Foot and Ankle and Upper Limb to increase day case rates and reduce the length of stay to at or below national benchmarks where they exist.
- Focus on enhancing discharge culture – a peer review was completed in June 2022 and implemented in July and August 2022.
- Ensured appropriate cohorting of patients to facilitate specialist nursing and therapy support for rapid patient recovery – in place from May 2022.
- The new Adult Day Surgery Unit opened in May 2022, promoted a day case ethos and increased day case rates.
- Improvement work on the pre-operative assessment pathway, including introducing a digital tool across the organisation to manage referrals, flow and thorough assessment, was completed in September 2022.

3.2 Theatre Productivity

Theatre productivity remained the focus of the improvement workstream during 2022/23. As proposed, the work focussed on:

Eliminating avoidable cancellations (targets = on the day cancellation reduced to 0.8% of all admissions, 1-14 days avoidable cancellations reduced to zero). Earlier in the year we were able to understand the reasons for cancellation much more clearly and we have remained in the best 25% for avoidable cancellations across the NHS. However, we have not managed to get avoidable cancellations below 1.5% on a quarter-by-quarter basis. This will remain a priority for the coming year, led by the Theatre Improvement Group and overseen by the Improvement and Transformation Performance and Accountability Group.

3.3 Improving patient experience

3.3.1 Patient Co-production

2022/23 was a successful year for patient co-production.

What we achieved in 2022/2023

Our 2022/23 Quality Plan	What we achieved in 2022/23
Embed the Patient Charter by making it part of the recruitment, induction and annual review	This was completed by December 2022 and now features as a core part of the Trust's ways of working
Complete and implement the Co-production Group's <i>RNOH Co-production Guide</i> , launching in the summer of 2022.	The co-production approach has been developed by the groups actively engaging in projects, programmes and in ward improvement work.
Ensure that a patient co-production group member joins the decision-making groups of all our improvement work streams.	Patient co-production group members have joined some of the improvement workstreams, but not yet all. In 2022/23 we have learned how best to engage at both strategic level through programme groups and at an action level in the project groups. This is at the expected level this year.
Complete a programme of co-production work with our patient co-production team to improve the information and expectation-setting for patients before their surgical intervention so that they understand the benefits of, for example, early mobilisation.	This year we have co-produced work across the patient journey, including working on specific patient information leaflets. Group members have also been active in the projects improving the patient experience and the general information offered.

3.3.2 Enhancing the patient referral experience

Our primary quality priority to enhance the referral process in 2022/23 was the planned implementation of Streamlining Processes to Achieve Clinical Excellence through Digitisation Programme (SPACED). This was to address the unwarranted variation, duplication and disparity in processes, and risks around the quality of referrals including lack of clinical information and risk of referrals being lost.

What we achieved in 2022/2023

Our 2022/23 Quality Plan	What we achieved in 2022/23
All teams across the Trust will be using the Pathpoint platform to process referrals, tertiary, external and ERS by June 2022	This was staged throughout the calendar year with cohort 1 going live from May onwards and cohort 2 completing in November 2022
Release administrative resources for value-added work by reducing manual,	The administrative saving on manual, time-consuming work due to the

time-consuming work by December 2022.	automation is equivalent to one Band 3 and one Band 4 role.
Standardise the process across all teams in the RNOH dealing with referrals from triage to booking by August 2022.	Due to the project work, processes were reviewed and improved resulting in reduced time to manage, reduced staffing requirements and increased output.
Reduce our environmental impact by eliminating the need to print off ERS referrals for triage by July 2022.	We have eliminated printing in key parts of our processes saving over £10,000 a year in ink and paper and associated environmental impact.

3.4 Improving patient safety

In 2022/23 we aimed to improve patient safety by developing and implementing the NHS Safety Strategy including embedding the Patient Safety Incident Response Framework (PSIRF) and designated Patient Safety Partners (PSP).

We have appointed and embedded Patient Safety Partners in our organisation. Two were appointed initially with scope for further appointments in the future.

The preparation for the PSIRF transition has met all planned deadlines and is on track for full implementation.

We have increased the number of reported patient-safety incidents and near misses while reducing the rate and percentage of patient-safety incidents resulting in death.

An open and fair learning environment leads to the best quality patient care. We build this through our incident reporting, which is actively promoted through staff training and further embedded by our collaborative approach to the management of incident investigations.

Our 2022/23 Quality Plan	What we achieved in 2022/23
Maintain the rate of clinical incidents between 30-80 incidents per 1000 bed days.	The quarterly averages have been maintained between 48 and 57 incidents per 1000 bed days in line with our targets
Reduce year-on-year incidents resulting in avoidable severe harm or death.	Of 2240 incidents in-year, one was reviewed as severe and there were five inpatient deaths (22 deaths in total including community associated and inpatient), a year-on-year reduction
Publish and promote the monthly clinical incidents per 1000 bed days rate on the Trust balanced scorecard	This has features on the Trust scorecard throughout the year
Lead patient safety activities (including incident reporting) on World Patient Safety Day (September 2022).	The fourth annual World Patient Safety Day was held in September 2022 in collaboration with the Pharmacy team to

	<p>raise awareness on this year's theme, Medication Safety.</p> <p>We conducted a variety of engagement and competition activities followed by a safety culture survey for the second year running to assess the organisation's safety awareness. The results were shared trust-wide and presented to the clinical safety committee.</p>
<p>Deliver incident management training at staff induction and to staff. Develop and offer essentials for patient safety training modules to staff via ESR in line with the NHS Patient Safety Syllabus training programme.</p>	<p>Level 1 and 2 training has now been fully embedded on ESR</p>

3.5 Reducing healthcare-associated infections and prompt treatment of identified infections

The Infection Prevention and Control Team works across the whole organisation to maximise the safety of our patients. In 2022/23 we worked to reduce both healthcare-associated Gram-negative bloodstream infections and inappropriate antimicrobial prescribing by 50% in line with the NICE guidelines on the Prevention and Control of Healthcare-associated Infections and the Care Quality Commission's Regulations for Service Providers and Managers – Safe Care and Treatment. Our target limit is 5 gram-negative bloodstream infections.

The end of year counts are:

- E coli BSI = 1 case (threshold of 4)
- Klebsiella sp = 0 cases (threshold of 3)
- Pseudomonas a. = 1 case (threshold of 2)

3.6 Harm Free Care

A culture of harm-free care across clinical teams reduces avoidable harm and helps drive continuous quality improvement. It improves our patients' experience and outcomes by reducing errors which lead to harm.

This year we focused on Pressure Ulcers and Falls.

As described in the quality priorities for 2022/23 we

- Set up dedicated Pressure Ulcers, Falls and VTE groups led by senior clinicians, whilst improvement in catheter care undertaken at the ward level
- Worked to create conditions for delivery of harm free care and linked this to continuous quality improvement
- Established and trained Pressure Ulcer champions

- Worked to establish a Falls Study Day and reviewed environmental factors which contribute to Falls

Established groups will work towards clear targets and delivery during 2023/24.

Part 4: Quality Priorities for 2023/24 and Statement of Assurance from the Board

4.1 Quality Priorities for 2023/24

This year we have established four key areas for quality priorities:

- enhancing access to services
- safe and effective discharge
- harms free care; and
- patient co-production.

To deliver on these quality priorities we are supported by a programme of organisation-wide culture change, building on existing programmes such as Civility Saves Lives, promoting Human Factors training and embedding human factors in improvement and safety work and a new Safety Conference.

Enhancing access to services

Background/Summary

The quality of our patients' experience is affected by how they access our services. This includes the overall waiting times which have risen across the NHS, as a result of service disruptions including the pandemic and workforce disputes, and the information that patients are offered and able to access whilst waiting.

One of our quality priorities for 2023/24 is therefore to reduce waiting times and we have identified a target that goes beyond the national minimum expectations. We are also keen to improve the quality of our patient experience at follow up where we have a large number of patients who have exceeded the clinician-identified target date.

Under this quality enhancement workstream, we also want to undertake work to improve how our patients get information about their care. We know from our ongoing analysis of complaints and issues raised with our Patient Advice and Liaison Service (PALS) team that this causes anxiety and affects the quality of our service.

Key deliverables/targets

- Reduce the number of patients who have an overdue follow up appointment by 25%, from 11,000 to 8,250 by March 2024.
- Exceed the national target of treating all patients waiting over 65 weeks by further reducing by 60% the number of patients waiting 52 weeks for their operation from 120 to 48 by March 2024.

Monitoring arrangements

Continuous monitoring at a Unit level for individual teams and the weekly Access & Waiting Lists meeting.

Reporting arrangements

Reports will be presented at the Quality and Performance subcommittee chaired by the Chief Executive.

Safe and Effective Discharge

Background/Summary

A safe and effective discharge is one in which patients are clear about their journey and expectations and go home at the optimum point for their ongoing recovery.

Our work on safe and effective discharge in 2022/23 has identified areas for improvement that will enhance the quality of our patient care. By optimising this patient experience, we will also expect to see a reduction in our length of stay enabling us to treat more patients and support the delivery of our improved access quality target.

The target improvement areas for this year are:

- Enhancing our early discharge planning
- Developing holistic needs assessments
- Ensuring comprehensive discharge planning through multidisciplinary and multi-agency discharge meetings
- Further improve rehabilitation information provided to post operative patients.

Key deliverables/targets

- Ensure patients have the opportunity to join the programme and project steering groups as equal members
- Co-produce a minimum of 2 quality improvements focussed on improving patient experience
- Promote learning from co-production projects across the Trust
- The top five rehabilitation pathways will have new rehabilitation information developed through patient co-production and shared with patients by the end of 2023/24.

Monitoring arrangements

Through the Flow workstream of the Transformation Programme, and every six weeks at the Improvement and Transformation Performance and Accountability Group

Reporting arrangements

Reports to the Transformation and Efficiency board chaired by the Chief Executive.

Harms free care

Background/Summary

A culture of harm-free care across clinical teams reduces avoidable harm and helps drive continuous quality improvement. It improves our patients' experience and outcomes by reducing errors which lead to harm. This is a long-standing quality priority for RNOH and in 2023/24 we will continue to progress in all areas of harm-free care, with particular focus on reduction in pressure ulcers and urinary tract infections for our inpatients as priority areas.

We will ensure documentation, protocols and training are in place to support consistent evidence-based catheter care and reduce prolonged/unnecessary indwelling catheter usage and catheter related incidents.

In 2023/24 we will implement training and assessment around the Pressure Ulcer core curriculum for all appropriate staff. We will develop and roll out improved assessment and preventative care plans and implement PURPOSE T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool). Alongside this, we will develop a robust process for data assurance.

Key deliverables/targets

- Develop baseline measures and develop the documentation for audit and measurement across harms free care targets
- Evidence-based catheter care protocols in place across all wards by September 2023
- PURPOSE T in place by September 2023

Monitoring arrangements:

Monitoring at the nursing quality meeting, Unit / Divisional Quality Boards and dashboards.

Reporting arrangements:

Regular reports will be presented at the Integrated Governance and Risk Committee.

Patient Co-production

2022/23 will be the third year of the very active co-production group. Co-production is in place across a range of existing Trust projects, and we have been able to demonstrate the positive effects of having patients co-producing at the heart of our improvement work.

The aim of the coming year will be to recruit more co-production patient members and better communicate the impact of this work. We also aim to increase the number of patient co-production members involved at a steering group level on key Trust projects and increase the patient engagement and feedback within projects, so that we have both co-production and patient engagement happening across our organisation's change quality and change work.

Key deliverables/targets

- Co-production patient as part of the core steering group on three of the Trust priority transformation workstreams
- An annual report detailing the impact of the co-production work

Monitoring arrangements

The Patient Co-production Group monitors the impact and implementation of patient co-production at monthly meetings.

Reporting arrangements

Every six weeks progress will be reported to the Transformation and Efficiency Board.

4.2 Statement of Assurance from the Board

All providers of NHS services are required to provide certain mandatory reporting elements within their annual Quality Account. This section of the account contains the required mandatory information and, where necessary, an explanation of our quality governance arrangements relating to these indicators.

4.2.1 Review of services

During 2022/23, the Royal National Orthopaedic Hospital (RNOH) provided 33 NHS services. RNOH has reviewed the data available on the quality of care in all these NHS services.

The 33 clinical services provided by the RNOH are:

- Anaesthesia
- Children and Young People Service
- Chronic Pain Management
- Clinical Neurophysiology
- Clinical Pharmacy and Medicines Optimisation
- Clinical Psychology
- Foot and Ankle Service
- Functional Assessment and Restoration (FARs)
- Histopathology Services
- Infection Service
- Imaging Services
- Limb Reconstruction
- London Spinal Cord Injury Centre
- Metabolic Bone Disease
- Myeloma service
- Neuro urology
- Nuclear Medicine
- Orthopaedic Medicine
- Orthopaedic Oncology Service
- Orthopaedic Specialist Hip and Knee Services
- Orthotics Service
- Peripheral Nerve Injury Service
- Psychiatry
- Plaster Theatre Services for Adults and Children
- Plastic Surgery
- Pre-operative Assessment Service
- Prosthetic Rehabilitation Service
- Rehabilitation and Therapy
- Rheumatology
- Shoulder and Elbow Service
- Spinal Surgical Service
- Tissue Viability Nursing Service
- Urology

4.2.2 Participation in Clinical Audits

Clinical audit is a quality improvement process that seeks to improve patient care. In our commitment to providing high quality patient care, the Trust implements a clinical audit programme that involves participation in National and Local clinical audits.

Participation in the National Clinical Audit and Patient Outcomes Programme (NCAPOP)

The National Clinical Audit and Patient Outcomes Programme (NCAPOP) consists of audits and clinical outcome review programmes that have been commissioned by NHS England (NHSE) in partnership with Healthcare Quality Improvement Partnership (HQIP). The programme comprises national audits related to some of the most commonly occurring conditions. All NHS Trusts are required to participate in these audits and patient outcomes programmes that apply to their services. These audits provide the Trust with benchmarked reports on their compliance and help to identify any necessary improvements for patient care.

In 2022/23 RNOH participated in 12 National Clinical Audits & Clinical Outcome Review Programmes. The table below (4.2.2.1) outlines the details of the Trust's participation.

Programme Title	Number of eligible cases required	Percentage submitted
Case Mix Programme (CMP) <i>Intensive Care National Audit and Research Centre (ICNARC)</i>	1039	100%
Transition from child to adult services study <i>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</i>	5	100%
Elective Surgery National PROMS Programme (2022-2023) <i>NHS Digital</i> <i>*(Based on manual figures. Awaiting update from NHSD)</i>	767	-
British Spine Registry	836	100%
Mandatory Surveillance of bloodstream infections and Clostridium difficile infection <i>Public Health England</i>	8	100%
National Early Inflammatory Arthritis Audit (NEIAA) <i>British Society for Rheumatology</i>	23	100%

Programme Title	Number of eligible cases required	Percentage submitted
National Comparative Audit of Blood Transfusion: 2021 Audit of Blood Transfusion against NICE Guidelines	30	100%
NAP7: Perioperative Cardiac Arrest	5	100%
National Joint Registry (NJR): Hip, knee, ankle, elbow and shoulder joint replacements <i>Healthcare Quality Improvement Partnership (HQIP)</i>	890 (Hip & Knee) (others 216)	100%
Perioperative Quality Improvement Programme (PQIP) <i>Royal College of Anaesthetists</i>	104	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme <i>SHOT</i>	4	100%
Surgical Site Infection Surveillance Service <i>Public Health England</i>	24	100%

Table 4.2.2.1. National Clinical Audit & Outcome Review Programme participation

Table 4.2.2.2 below details the reviews and summaries of National Audits and the corresponding actions taken to improve the quality of care. Findings and learning from all National Audits are shared at various forums.

National Early Inflammatory Arthritis Audit (NEIAA)

The NEIA audit aims to improve the quality of care for people living with inflammatory arthritis. The audit collects data at three time points across 12 months, assessing waiting times, time to treatment, clinical response to treatment, provision of education and patient-reported outcomes.

The audit demonstrated that at RNOH:

- Patients are given prompt education about their condition and drugs in addition to the informal education provided at clinic appointments.
- Treatment targets are set and agreed
- There is a rheumatology helpline which is monitored by the Clinical Nurse Specialist Team

The following actions are being undertaken to improve outcomes

- Developing care pathway to increase the proportion of patients achieving remission within 3 months of diagnosis
- Establishing a system to support the rapid initiation of Disease-modifying Antirheumatic Drugs (cDMARDS)
- Barriers to collecting and submitting comprehensive audit data have been addressed by oversight from a Clinical Nurse Specialist

British Spine Registry

The British Spine Registry was set up by the British Association of Spine Surgeons to monitor outcomes of spinal procedures, collecting insightful data, to better understand the diagnosis made, procedures undertaken, techniques used, patients' experience and the resulting quality of life.

At RNOH, comprehensive data is submitted to the registry regularly which is contributing to improving understanding of a variety of spinal procedures at the National level, resulting in improvement in patient outcomes.

Mandatory Surveillance of bloodstream infections and Clostridium difficile (C. diff) infection
Public Health England

Mandatory surveillance began in response to increasing rates of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia across the NHS in England and has subsequently been rolled out for other Healthcare Associated Infections (HCAIs). It has been mandatory for NHS acute trusts to report all cases of MRSA bacteraemia since April 2004.

At RNOH, there were 2 incidents of gram-negative bacteria blood-stream infections (BSI), 2 of Staph aureus BSI & 4 counts of C. diff infections reported by the Trust from 1st of April 2022 to 31st of March 2023.

Following actions are being undertaken to improve outcomes

- The Infection Prevention and Control Team (IPCT) continues to monitor and report BSIs & C. diff infections to UK Health Security Agency (UKHSA) Data Capture System (DCS) monthly.
- A root cause analysis (RCA) is held with the multi-disciplinary teams (MDT) for each incident and an incident report is logged on the Ulysses reporting system. These incidents are monitored by the Incident Review Group (IRG). Actions and learning are fed back to the Infection Prevention and Control Committee (IPCC) and the Integrated Risk and Governance Committee (IGRC).
- RCA outcomes are presented to MDTs through divisional meetings. The Divisional Leadership Teams (DLT) then report back to IPCC and the IGRC after actions are completed before these incidents are closed.

National Joint Registry (NJR): Hip, Knee & Ankle replacements

The National Joint Registry monitors the performance of joint replacement operations to improve clinical outcomes.

At RNOH, we continue to have a robust system for data submission to the National Joint Registry. The Trust's results for primary hip replacements are within the national average. The revision results for knee have shown improvements and the mortality rate remains low.

In response to the findings in the latest report, the Trust has taken actions for improvement.

Following actions are being undertaken to improve outcomes:

- There is a new departmental policy that all patellae are resurfaced at primary Total Knee Replacement, in line with NICE guidance (NG 157, 2020).
- Pre- and post-operative radiographs of hip and knee replacements are being reviewed weekly.
- Pre-operative, Review and Complex Case MDT will produce a written record and be attended by all joint replacement surgeons.
- There will be a yearly review meeting of all Consultants to review NJR Consultant level reports. The pre-and post-operative images will be shared with the group to raise awareness.
- The Journey II prosthesis is no longer used.

National Clinical Audit & Clinical Outcome Review Programme

Implications for practice at the RNOH

Perioperative Quality Improvement Programme (PQIP)

PQIP aims to review the perioperative care of patients undergoing major non-cardiac surgery. PQIP measures complications, mortality and patient-reported outcomes to deliver real benefits to patients by supporting clinicians in using data for improvement. Since 2018, 903 patients from RNOH have been recruited to this programme.

At RNOH, there is an increase in individualised risk assessments which supports shared decision-making between patients and clinicians. The data also demonstrated a low number of complications resulting in patients' satisfaction with their anaesthetic provision.

Following actions are being undertaken to improve outcomes:

- Individualised risk assessments are now part of the pre-assessment booklet. This has resulted in improvements in standardised assessment and documentation of risk
- Frailty scores are now recorded at pre-assessment resulting in over 90% of patients having frailty scores assessed

National Diabetes Inpatient Safety Audit

The National Diabetes Inpatient Safety Audit measures the frequency of avoidable diabetic-related harms in inpatients.

At RNOH, there was no harm to any of our inpatient diabetic patients in this reporting period.

Following actions are being undertaken to improve outcomes:

- There are networked blood glucose meters on the wards for staff to use which are connected to a web based application to facilitate high quality point of care blood glucose testing.

National Comparative Audit of Blood Transfusion: 2021 Audit of Blood Transfusion against NICE QS 138

The National Comparative Audit of Blood Transfusion is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.

The Trust scored higher than the national compliance levels. We were 100% compliant across 3 quality statements and 50% compliant against the quality statement four (as compared with 26% nationally) which related to documenting both written and verbal consent.

Key messages from the report have been taken into account and actions put in place.

Following actions are being undertaken to improve outcomes:

- Written information regarding transfusion is provided to patients at pre-assessment. A further piece of work to reflect this on the consent form is needed.
- Nurses are being reminded to document verbal consent to transfusion in medical records.
- Monitor compliance in national re-audit 2023

Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
SHOT

SHOT collects information on transfusion reactions and adverse events from all healthcare organisations in the United Kingdom that are involved in the process of blood transfusion. At RNOH, four SHOT reports were entered during 2022.

Following actions are being undertaken to improve outcomes:

- Key messages and recommendations added to mandatory training and e-Learning
- Reminders to staff that they need to ensure it is safe to transfuse i.e. outside of core hours – only if indicated
- Staff reminded to complete incident forms and to be aware of human factors and the importance of these in investigating transfusion incidents
- Staff training includes reminders to ensure patients' options are discussed at every step of the transfusion process. Information is given at pre-op clinics
- Paediatric transfusion and massive haemorrhage have been included in mandatory training. In addition, staff signposted to additional e-Learning

Surgical Site Infection Surveillance Service

This service allows hospitals to record incidents of post-operative infection. It also helps track patient results and review or change practices to avoid further infections.

At RNOH a total of 24 surgical site infections were reported in 2022 which are detailed below:

- Spine – 7 (0.8%) Deep, 6 (0.7%) Superficial
- Knee- 6 (1.2%) Deep, 1 (0.2%) Superficial
- Hip- 3 (0.6%) Deep, 1 (0.2%) Superficial

Following actions are being undertaken to improve outcomes:

- The Surgical Site Infection (SSI) Surveillance Nurse and Coordinator continuously monitor eligible patient outcomes and report any SSIs quarterly to the UK Health Security Agency (UKHSA) via the SSI portal.
- An incident report is logged on the Ulysses reporting system for any Deep SSIs. Root Cause Analyses (RCA) are completed with the Multidisciplinary team (MDT) to identify any learning. Following the RCA, the incidents are reported to the relevant governance forums.
- RCA outcomes are presented by the divisional leads to MDTs during divisional meetings.

Table 4.2.2.2 National Audit & Clinical Outcome Review Programme Reports Summary

Participation in Local Clinical Audits

The RNOH Local Clinical Audit Programme includes Trust-wide and service-led priorities and includes continuous cycle audits (monthly/quarterly) that routinely assess the quality of current practice and identify areas for improvement.

For the year 2022/23, a total of 76 Local Clinical Audits were registered at RNOH. The table below (4.2.2.3) outlines the summary of some completed audits and actions taken for improvement.

Local Clinical Audits
Hand Hygiene Audit
<p>Hand hygiene audit is carried out to measure compliance against national guidance set by the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections (DoH, revised 2022). The audit captures the World Health Organisation (WHO) recommended 5 Moments of Hand Hygiene or when hand hygiene is expected of a healthcare professional when providing care to patients. The audit is completed monthly in all clinical areas across the trust. The average Trust-wide compliance with the 5 moments of hand hygiene is 91% for the financial year 2022-23.</p>
Actions planned/taken to improve outcomes:
<ul style="list-style-type: none">• Hand hygiene audit outcomes are reported to the Infection Prevention and Control Committee (IPCC)• Hand washing reminders were posted on the exit from recovery and at the entry to the anaesthetic room• Ward managers identify the need for training individual staff and refresher training for all nurses.• The clinical Audit team have conducted training sessions at ward levels for nurses involved in Hand Hygiene audits in the use of Audit R (the Trust digital data collection and reporting system).
Vascular Access Device Care Audit
<p>A vascular access device is an invasive instrument used to obtain access to venous or arterial access (e.g. peripheral cannula, central venous access, etc.). This audit is carried out to show compliance with vascular access device care as per local policy based on national guidelines to reduce the risk of related infections from these devices.</p> <p>The average Trust-wide compliance with vascular access device care was 77% in inpatients for the financial year 2022-23.</p>
Actions planned/taken to improve outcomes:
<ul style="list-style-type: none">• Vascular Access Device Care audit outcomes are reported to the Infection Prevention and Control Committee (IPCC)• The issue of incomplete forms has been addressed via new Visual Infusion Phlebitis (VIP) forms. This has shown a significant improvement.• The documentation process for these devices in patients' notes was reviewed in early February 2023 to improve audit results.

Local Clinical Audits

- The Infection Prevention and Control team is working very closely with the Clinical Audit & Effectiveness team and the relevant nursing leadership teams to identify training needs and implementation of action plans.

Environmental Audit

This audit was designed to ensure clinical areas are compliant with the environmental safety standards outlined in the Trust's Standard Infection Prevention and Control Policy and the cleaning standards set out in the National Standards of Healthcare Cleanliness (NHS England, 2021).

The average Trust-wide compliance with the monthly environmental safety and cleanliness audit was 97% for the financial year 2022-23

Actions planned/taken to improve outcomes:

- The infection Prevention Control (IPC) team continues to work with the Estates administration and the senior nursing teams of each area to monitor the hospitality contract with the current service provider and ensure the Trust's Cleaning Policy is up to date with the provisions set for the National Standards of Healthcare Cleanliness.
- The IPC Lead was part of the team involved in the tender for hospitality services in 2022.
- Environmental and cleaning (quality and frequency) audits are presented by the Estates administration team to the Infection Prevention Control Committee (IPCC).

Combined Nursing Audit

(Nutrition, Pressure Ulcer, Falls, Documentation and National Early Warning Score (NEWS))

This audit was carried out to assess the quality of nursing documentation. Overall compliance for 2022-23 is 93%. There were some updates to the Documentation and Falls sections of the audit to improve the scope of the audit.

Actions planned/taken to improve outcomes:

- Regular spot checks by Divisional Heads of Nursing
- The report is presented in Divisional Quality Meetings
- The audit outcomes and learning are shared at ward meetings & huddles

WHO Safety Checklist

The WHO (World Health Organisation) Safety Checklist was developed to reduce the number of errors and adverse events and increase teamwork and communication in surgery. The purpose of this audit is to monitor compliance with the completion of the checklist monthly. In 2022-23, overall compliance with all standards remained at 99%.

Actions planned/taken to improve outcomes:

- Compliance is reviewed monthly and leads identify and address any missing elements
- Training the staff to complete the WHO checklist completely every month and to escalate any issues
- Results of monthly audits are reflected on Divisional Quality reports

Local Clinical Audits

Audit on the prescriber review of pharmacy interventions on the Electronic Prescribing and Medicines Administration (EPMA) pilot wards

The Electronic Prescribing and Medicines Administration system (EPMA) pilot began on the Spinal Cord Injuries Centre (SCIC) and Jubilee Rehab wards on 19 March 2022. All prescriptions flagged for review should be reviewed within 24 hours. This baseline audit was undertaken to categorize the types of interventions made by the pharmacy and identify whether prescribers were reviewing the prescriptions flagged by the pharmacy for review in a timely manner.

Actions planned/taken to improve outcomes:

- There is an ongoing review of red flags daily and audit findings have been presented at pharmacy learning sessions. This was also presented at doctors' teaching sessions with training on how to filter red badges for their patients.
- The audit findings will also be presented at the Trust Quality Improvement and Audit session in June 2023.

Overprescribing audit- Prescribers' perspective on deprescribing

Deprescribing is the planned process of reducing or stopping medications that may no longer be of benefit or may be causing harm. This audit aimed to gain an understanding of prescribers' confidence in deprescribing medicines at RNOH.

Actions planned/taken to improve outcomes:

- The departments will mandate indications on all medicines prescribed on the Electronic Prescribing System (ePMA) and a deprescribing policy will be produced to improve prescriber's confidence by July 2023
- Education and training provided in doctor's teaching sessions regarding referring patients for a pharmacy review if on multiple medicines.
- The findings of the audit have been shared in the Medicines Safety newsletter.

Local Ionising Radiation Exposure in Theatres

Long term studies on the risks of radiation exposure in orthopaedics are lacking, however, published studies from other healthcare disciplines show an increased risk of thyroid, head and neck cancer, breast cancer and cataracts. At greatest risk are those who are working within 2 metres of the x-ray beam, and this most commonly includes the patient, the surgeon, the assistant, the radiographer, the anaesthetist and the scrub nurse. This audit was carried out to assess compliance with radiation exposure safety in RNOH Stanmore theatres.

The audit recorded 58% compliance towards the standard where all staff working routinely within 2m of the X-ray beam/patient must wear a lead apron of at least 0.25mm lead equivalence and a thyroid shield. In some cases, there were not enough thyroid shields outside the theatre and staff had to search for another place for one.

Actions planned/taken to improve outcomes:

Local Clinical Audits

- The Radiation Safety manager is to educate staff of risks and have a named responsible person to monitor this and upgrade personal protective equipment (PPE)/provide hygiene covers by June 2023

Audit of surgical patients' perioperative temperature readings and factors influencing patient temperatures

NICE (2016) recommends maintaining the patient's perioperative normothermic range (36.5-37.5°C) to reduce the risk of SSI development. This Audit was undertaken to review if the normothermic range is maintained for patients undergoing surgery at RNOH.

The audit identified the average ambient anaesthetic room temperature of 21.5°C which helped maintain patient temperature while exposed during anaesthetic interventions. A total of 94% of patients coming from the admission areas had a temperature of 36.0°C or greater.

Actions planned/taken to improve outcomes:

- Ward managers to ensure patient's temperature is taken and documented on the perioperative checklist within the hour before going to the theatre
- Theatre and anaesthetic staff to ensure their safety checks include a check of the ambient room temperatures for both areas every day.
- Theatre coordinator to trial the use of 3 warming methods for all patients undergoing procedures lasting 60 minutes or longer. The warming methods that can be used include; a forced-air warming device, active fluid warmer and warming mattress.

Nutritional Initiatives

This audit was undertaken to review compliance following the release of new Healthcare Food and Drink legislation (November 2022) and subsequent local initiatives. Local initiatives to improve the nutritional care of patients included the development of local guidelines, revised food record charts, kitchen whiteboards (to record patients' specific dietary requirements), and updated menus. In addition, the Adult and Paediatric Malnutrition Screening Tools (MUST) were re-formatted to facilitate ease of completion, and a Nutritional Care and Action Plan was added to these charts. The audit identified the need to further improve documentation.

Actions planned/taken to improve outcomes:

- To address the documentation issues arising from this audit, the dietetics team have prepared training materials and carried out training at the ward level. Progress will be discussed at the next Nutrition Steering Committee.

Identification of Food and Drug Allergy in Children and young people

Allergic reactions to food and medicines can cause significant morbidity and mortality. It is important that allergies are identified and managed appropriately. This audit was carried out to ensure that we are identifying all children and young people admitted to Coxen Ward/ Children's High Dependency Unit (CHDU) with food and drug allergies and managing them appropriately. There was a strong level of adherence to the standards.

Actions planned/taken to improve outcomes:

Local Clinical Audits

The Nutrition Steering Committee reviews how allergies are displayed in the ward kitchens.

Urinary Catheterisation Audit

Patients admitted to the RNOH often require urinary catheterisation for a number of clinical reasons. Because of the risks associated with an indwelling catheter, it is very important for staff members to perform catheterisation safely, monitor regularly and remove it as soon as it is no longer required. Every episode of care, from insertion to removal, should be documented according to the Trust urinary catheterisation guidelines. This audit was undertaken to review the urinary catheterisation documentation to identify any gaps in safe practice.

Actions planned/taken to improve outcomes:

- There will be regular reminders in ward huddles regarding the completion of insertion documentation
- For urethral catheters inserted in the theatre, daily hygiene records can potentially be started in the Recovery department for the ward staff members to follow through when a patient is brought back to the ward.

Children and young people admitted for Bisphosphonate infusion

Bisphosphonates are drugs that help to strengthen bones and reduce the risk of ne breaking (fracture). RNOH is a centre for treating patients with metabolic bone diseases and one of the treatments provided is Bisphosphonate infusions. The audit was carried out to assess the quality of admitting process and discharge summary completion for these children and young people.

Actions planned/taken to improve outcomes:

- Presented the audit to a Paediatric multidisciplinary meeting
- Discussed during the induction with new Paediatric Senior House Officers (SHOs)
- Training/teaching about Bisphosphonates in December 2022.

Assessing the number of To-Take-Aways (TTAs) are given to the pharmacy 24 hours in advance as per pharmacy guidance

Discharge planning is part of an ongoing process that should start prior to admission, for planned admissions and as soon as possible for all other admissions. This involves building on or adding to any assessments undertaken prior to admission. The purpose of this audit was to ensure that patients' TTAs are being done 24 hours before discharge thus ensuring that patients are counselled on their medicines including likely side effects before discharge or for the Pharmacy to have enough time to order medicines where necessary.

Actions planned/taken to improve outcomes:

- The ward pharmacy team are working to improve communications with the nurses and doctors on the wards for a better discharge process for the patients.

General wastage of medicines in pharmacy

The Department of Health and Social Care estimated that unused medicines cost the NHS around £0.5 billion and around £300 million of dependency-forming medicines each year. This audit was carried out to review the medicine stock

Local Clinical Audits

wastage in the dispensary. There was a 98.5% adherence for the one-month audit. Patients' own medicines were excluded from this audit.

Actions planned/taken to improve outcomes:

- There is an ongoing review of medication to further reduce wastage. This will be reviewed by an annual re-audit.

Consent form completion Audit

This audit was carried out to assess the degree of completeness of written consent forms, especially focusing on the documentation of risks inherent to the specific procedure for Foot and Ankle surgical procedures. This audit highlighted optimal compliance around discussing/documenting intended benefits, ensuring that patients understand the consent, and making sure that consent forms are signed on the day of the procedure. The following areas need further improvement:

- Documenting alternatives to the proposed treatment and patient-specific risks
- Avoiding the use of medical jargon
- Ensuring that consent forms are legible

Actions planned/taken to improve outcomes:

- Audit findings are to be presented to stakeholders to share learning and raise concerns
- The Surgical E-consent is being piloted in the Foot and Ankle Unit as this will improve the accuracy and completeness of consent.

Hypoglycaemia Box Audit

A low blood sugar level, also called hypoglycaemia can be dangerous if not treated quickly therefore timely management is important. This audit was carried out to ensure compliance with National standards in the management of hypoglycaemia and to improve the availability of the hypoglycaemia boxes where required.

The audit highlighted that all relevant areas had the hypoglycaemia boxes in place.

Actions planned/taken to improve outcomes:

- The diabetes screening team is reviewing the content of boxes to include glucagon injections and 10% dextrose.
- Nurse educators to educate staff on the use of the box in hypoglycaemia management.
- Ward managers and clinic leads to ensure ward staff complete daily checks of the box and discard and replace out-of-date contents. Stock replenishment is to be referred to the procurement team.

The assessment of compliance and cost-effectiveness of chemical venous thromboembolism (VTE) prophylaxis post primary hip or knee replacement

Venous Thromboembolism (VTE), a term referring to blood clots in the veins, is a serious but preventable medical condition that can cause disability and death. Patients having major orthopaedic surgery are at risk of venous thromboembolism (VTE). NICE Guidelines offer a variety of options for the prescription of chemical VTE prophylaxis post primary hip or knee replacement. This audit was undertaken

Local Clinical Audits

to review the current practice at RNOH. There was 100% compliance for the use of VTE prophylaxis in the Specialist Hip and Knee Unit.

Actions planned/taken to improve outcomes:

- The results were presented at the Specialist Hip and Knee unit team meeting. There was a consensus that the aspirin regime can be used for low- VTE risk knee replacements throughout the Trust
- VTE risk assessment is currently being reviewed by the VTE lead

Unnecessary blood tests post-operatively after primary arthroplasty

The primary hip and knee surgery pathway requires only haemoglobin (HB), urea and electrolytes post-operation. This audit was undertaken to ascertain how often these tests were performed and if there could be cost savings to the Trust. Of the 40 primary arthroplasties reviewed, C-reactive protein (CRP) was the most frequently ordered blood test in 75% of the cases reviewed.

Actions planned/taken to improve outcomes:

- Information posters on wards detailing what blood tests are required and education of team members
- This information is also included in the induction handbooks for Senior House Officers (SHOs)

Assessment of Height and Weight in Children and Young People in RNOH

The standardised growth charts to track growth in children and young people are an important tool as they help to identify children who are failing to thrive as well as children who are overweight.

The audit identified improvements required in documenting weight, height, centiles and BMI.

Actions planned/taken to improve outcomes:

- Audit findings were discussed in the Paediatric multi-disciplinary team meeting
- A clear pathway for the management of patients falling outside of the normal range of height and weight is being developed.
- Poster reminders regarding height and weight will be provided in the Children and Young people's outpatient department
- Paediatric Clinical Nurse educator and lead nurses are supporting the implementation of audit recommendations.

An audit of the Psychiatry PROMs Pathway for the proactive management of mental health concerns in the adult patient population

Early psychiatry intervention is linked with better patient outcomes. This audit looked at proactively identifying patients requiring psychiatry support via a triage process. All the standards of the audit were met. The audit found that the pathway identified patients who required significant psychiatric support and allowed for a proactive approach. The implementation of Pathpoint has enabled the coordination of patient care through real-time collaboration between distributed clinical and non-clinical teams and also helps triage and prioritise daily workloads, enabling seamless planning of patient care through integrated care pathways. This has resulted in identifying patients (≥ 18 years old) who would benefit from a Rapid Access Psychiatry (RAP) triage appointment.

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CRAB data review – perioperative haemostasis and blood loss management

Haemostasis is the mechanism that leads to the cessation of bleeding from a blood vessel. Perioperative bleeding remains a major complication during and after surgery, resulting in increased morbidity and mortality. CRAB (Copeland's Risk Adjusted Barometer) is a web-based tool to evaluate quality and outcomes in a way which accurately reflects the clinical profile of patients treated. In this audit, CRAB data was used to evaluate haemostasis and blood management for patients undergoing revision hip surgery in a retrospective review of 20 consecutive revision procedures. The audit showed full compliance with the standard of usage of intravenous and topical Tranexamic acid in hip and knee arthroplasty. Low compliance was observed for the consideration of Cell salvage when excessive blood loss is expected to be above 500ml.

Actions planned/taken to improve outcomes:

- Acquisition and use of Aquamantys (haemostasis device intra-operatively) for which a business case is in progress

VTE prophylaxis documentation in the Rehabilitation Ward

According to NICE guidelines, all patients should undergo a risk assessment to identify their risk of VTE and bleeding on admission to the hospital. The risk of developing VTE is highest following major surgery, major injury, or during periods of infection and inflammation. This audit was conducted to assess if the VTE risk assessment is performed within 24 hours and correctly documented for all patients admitted to the rehabilitation ward (rheumatology, shoulder and elbow, Peripheral Nerve Injury). The findings of the audit showed that overall the VTE risk assessment forms are being completed correctly, in line with NICE and Trust guidelines.

All VTE forms audited were signed and dated, had patient details and all sections of the form were completed.

Actions planned/taken to improve outcomes:

- Further information posters will be displayed highlighting the importance of completing the VTE form appropriately.

VTE prophylaxis documentation for adult sarcoma inpatients

The aim of this audit was to ensure that VTE risk assessment is performed within 24 hours of admission and correctly documented for all admitted sarcoma patients. The audit identified the below actions to improve compliance with the standards.

Actions planned/taken to improve outcomes:

- Develop an information sheet detailing the importance of accurately completing VTE forms
- Consultant Lead to engage with all stakeholders to improve compliance

Fasting Audit for Children and Young People on Coxen Ward

Fasting for a procedure adds physiological and psychological stress to patients. By the nature of their size children and young people may suffer from these stresses more than adults. Minimising the impact of fasting by keeping to the minimum safe fasting times before anaesthesia could improve patient recovery and wellbeing.

This audit aimed to determine the actual length of time children and young people fasted, for fluids and solids, compared with the RNOH fasting policy. Fasting for

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fluids and food exceeded the policy minimum desirable times however the audit identified improvements compared to the previous audit.

Actions planned/taken to improve outcomes:

- The audit findings were shared with the ward and the Nutrition Screening committee to take necessary actions and there will be a re-audit.

Audit to review the number of items dispensed via the satellite pharmacy

A Satellite Pharmacy is a work area in a hospital setting under the direction of a pharmacist that is a remote extension of the main pharmacy. The wards based in the Stanmore Building have a satellite pharmacy, which holds several 'To Take Away' (TTA) packs for the ward pharmacy staff to dispense. This eases the pressure on the dispensary team and helps facilitate patient discharge.

The main aim of this audit was to assess the volume of dispensing carried out in the ward satellite pharmacy and to understand the workload and pressures faced by the team while dispensing on the ward. The standard of the audit was that 'All TTA's which can be dispensed via satellite pharmacy are dispensed on the ward'.

The audit identified 99% compliance. The 1% was attributed to staff shortages and technical issues.

Audit of knowledge of Female Genital Mutilation in SCIC staff who catheterise female patients.

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women and can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths.

Healthcare professionals have a mandatory duty to report to the police any cases of female genital mutilation (FGM) in girls under 18 that they come across in their work. The audit identified that staff recognised FGM as a safeguarding issue but required further awareness to meet all the standards.

Actions planned/taken to improve outcomes:

- The Safeguarding Children/Named Nurse has delivered a FGM awareness session to the staff on the SCIC ward.

Expired medicines stocked in clinical areas

Expired medicines are a source of wastage for the NHS. This audit was carried out to review the quantity of medication becoming out of date on the wards.

The audit found expired medicines in some wards with an overall compliance level of 92% against the standard of removing expired medicines from clinical areas and sending them to the pharmacy.

Actions planned/taken to improve outcomes:

The dispensary manager is providing training to staff on the process of removing expired medication from the cupboards or lockers before the end date.

MDT Record Keeping

Record Keeping is an essential part of supporting the high quality of treatment and care at the Trust. It is an invaluable way of promoting communication within the health care teams, practitioners and service users. If not done accurately it can

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affect delays in patient care, which results in inappropriate care and duplicate records, which are all risks to patients. This audit aimed to compare MDT documentation against national and local standards to assure that the Trust was providing high-quality and safe care for patients. The unmet standards have been sent to the clinical units to set up action plans to improve compliance. Some of the standards audited included:

- Entries with the clinician's name printed
- Operation notes signed
- Elective admissions with documented daily review by a doctor
- Significant events documented
- Review of X-ray results documented

The results of the audit showed an improvement over the previous audit. There will be a re-audit in 2023.

Paediatric Was Not Brought (WNB) Audit

A 'Was Not Brought' Appointment (WNB) is defined as a scheduled appointment that is missed without prior arrangements by the parent/carer. All children have the right to have their health needs met. When children fail to attend or WNB this may represent a risk of harm which could be significant. It is therefore important that RNOH monitor the processes to ensure that children who are not attending are appropriately managed. This audit identified some inconsistencies in the following areas of policy i.e.

- WNB letter must be sent to the GP and Parent/Carers
- There should be a referral to the Safeguarding Children team

Actions planned/taken to improve outcomes:

- The Safeguarding Children team will review and disseminate the WNB pathway to all clinical staff. The audit findings were presented at the Paediatric audit meeting, the Trust Quality Improvement and Audit Presentation and Safeguarding Supervision.

Assessing the number of medicines which are due to expire often in the Emergency drug cupboard due to minimal usage

Emergency drug cupboards (EDC) are a shared resource provided by the pharmacy to allow inpatient wards access to a range of drugs they may need to obtain outside of normal pharmacy hours but which they do not usually keep as ward stock. The audit was carried out to assess the number of medicines which are expiring due to minimal usage, to improve processes to reduce wastage and review the EDC stock held.

The audit identified a total of 14 medicines expiring within 3 months bringing the audit compliance to 96%.

Actions planned/taken to improve outcomes:

- The Dispensary Manager will review and exchange medication expiring within 6 months for longer-dated medication.
- A re-audit will be conducted in autumn to measure improvements made.

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Cognitive Screening in Spinal Rehabilitation Patients

The London Spinal Cord Injury Centre (LSCIC) admits patients for rehabilitation for whom the majority of their impairments stem from spinal cord injury. In addition, an increasing number of referrals are received for spinal rehabilitation for patients with pre-existing underlying cognitive impairment relating to ageing or other comorbid medical conditions. The LSCIC has an agreed local pathway for screening for cognitive impairment in patients admitted for inpatient rehabilitation. This audit was carried out to assess and improve compliance with the current cognitive screening pathway for inpatients admitted to LSCIC for their first episode of rehabilitation.

Following a baseline audit and informal qualitative feedback from the junior medical team, further education sessions were provided and the audit was repeated. Although the percentage of qualifying patients who were screened using the Montreal Cognitive Assessment (MoCA) doubled from the first audit to the second, the standards of screening all patients with 6 item Cognitive Impairment Test (6CIT) or MoCA were not completely met.

Actions planned/taken to improve outcomes:

- Continuous educational sessions for junior doctors on cognitive screening as part of a regular teaching programme

Safer use of anticoagulant therapy

Anticoagulants are medicines that help prevent blood clots. They are given to people at a high risk of developing clots, to reduce the likelihood of developing a serious condition such as stroke and heart attack. This audit was carried out to demonstrate compliance against the standards listed in the National Patient Safety Alert on the safe use of anticoagulant therapy (NPSA/2007/18). The Trust was found to be compliant with most of the recommendations.

Actions planned/taken to improve outcomes:

- Audit of anticoagulant services using the British Society for Haematology (BSH) and National Patient Safety Agency (NPSA) safety indicators, will be part of the annual medicines management audit programme.
- Promote safe practice for prescribers co-prescribing one or more clinically significant interacting medicines for patients already on oral anticoagulants.
- Pharmacy managers to review and update SOPs in the dispensary to include instructions to check with patients and ascertain that there are no potentially interacting medicines
- VTE committee and Medicines Safety Committee to update current written procedures and clinical protocols to include instruction to prescribers in relation to significant interacting medicines and the procedures to follow where these are identified.

Shoulder and Elbow Waiting List Audit

The NHS Constitution standards set out that more than 92% of patients on incomplete pathways should have been waiting no more than 18 weeks for referral to treatment

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At the time of the audit, the current waiting time for surgery was an average of 28 weeks. This audit was carried out to explore the factors which contribute to increased waiting times on the surgical waiting list before the surgery.

The audit identified clinical and non-clinical reasons for slightly longer waiting times e.g. Patients' complex needs, patients not wanting surgery anymore, patients unfit to have surgery etc.

Actions planned/taken to improve outcomes:

- The Pre-Assessment team to follow up outstanding investigations and reports from GP and patients, close liaison with the Shoulder and Elbow team scheduler and CNS in difficult or complex cases.

PEWS (Paediatric Early Warning Scoring System) Audit

PEWS is a tool widely used to identify acutely unwell or deteriorating children. A child with a PEWS score of 3 or more should be escalated to the medical team. This audit was undertaken to review our practice. The audit identified that 46% of patients scoring ≥ 3 on the PEWS score were escalated.

Actions planned/taken to improve outcomes:

- MDT teaching session about PEWS escalation Pathway in Line with new national standards.
- Current PEWS escalation pathway posters are to be put up around the unit.
- Increasing awareness about the documentation of details of escalation in the PEWS chart
- Regular simulation training is to be attended by all members of the paediatric staff.

Audit of Clinic letters

Good written communication is essential to good clinical care. Clinic letters are a vital method of communication. Letters convey advice on management and are also an important part of the clinical record providing a summary of the consultation. This audit was undertaken to review the timing of clinic letters and to improve the speed of communication with a standard stating that 80% of letters are to be typed and authorised within 7 days. The audit identified low compliance.

Actions planned/taken to improve outcomes:

- Include this as part of the education/induction when teams rotate with new Specialist Registrars- Clinical Fellows
- Allocated administrative times for letters

Cognitive Screening in Spinal Rehabilitation Patients

There is evidence in the literature of a high prevalence of cognitive impairment in Spinal Cord Injury (SCI) rehab patients. This audit was carried out to ensure we are complying with local policy for screening spinal cord injury (SCI) patients during their rehabilitation admission, to complete a holistic assessment and support their intensive learning during the admission. The results showed more work needed to be done to support the patients.

Actions planned/taken to improve outcomes:

- A working party has been established to review the current pathway and consider the utility of the Six-Item Cognitive Impairment Test (6CIT). The

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team will also review the continued use of the Montreal cognitive assessment (MoCA)

- Standards of audit have been added to junior doctors' induction pack

An audit of day 0 therapy intervention following primary Total Hip Replacement (THR) and Total Knee Replacement (TKR)

NICE Guidelines 2020 states that primary total knee and total hip replacements should be seen on the day or at least within 24 hours of surgery. The RNOH pathway also states that primary TKR and THR should be seen by a therapist on day 0 as part of the enhanced care pathway. This audit was undertaken to check compliance with this.

Actions planned/taken to improve outcomes:

- Integration of a twilight service within Therapies to review primary hip and knee patients when returning from theatre to the ward after 16:30.
- A re-audit would be beneficial after the integration of a Twilight service.

Mental Capacity Act Assessment (MCAA) & Deprivation of Liberty Safeguards (DoLS) Staff Awareness Audit

The Mental Capacity Act & DoLS are intended to protect and support those who lack the capacity to make decisions for themselves about their care and treatment. This audit aimed to review staff awareness and application of the Mental Capacity Act (2005) assessments and Deprivation of Liberty Safeguards (2009) processes. The audit identified that improvement was required in the following areas:

- Mandatory training in MCA and DoLS
- Staff understanding of the DoLS

Actions planned/taken to improve outcomes:

- Service leads will ensure staff are fully compliant with their mandatory training
- Safeguarding champions will be reintroduced to promote and support MCA assessments and DOLS applications
- The safeguarding newsletter will be used to raise awareness of MCA and DoLs.

Assessing the appropriateness of radiology requests and the impact of delays on patient care within the Foot and Ankle Unit

The six-week diagnostic wait was initially introduced as a 'milestone' in March 2008 to support the achievement of the 18-week RTT Target. NHS England published new guidance in May 2021 for the prioritisation of waiting lists for diagnostic procedures, which stated that waiting lists should be reviewed and prioritised according to clinical need rather than waiting time in areas where more than half of patients have been waiting for more than six weeks. This audit aimed to assess the effect of delayed imaging on patient care.

The audit identified several areas requiring improvement e.g. assessment for scans within 6 weeks, reporting of scan within 3 weeks, repeat scan when result is expected to influence management and repeat scans without good evidence of change in clinical symptoms.

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Actions planned/taken to improve outcomes:

- A protocol to be put in place to guide better use of repeat scans and re-audit-
- Assess the effectiveness of a protocol for the new Specialist Registrars starting in April 2023 to see if this reduces the number of 'inappropriate' repeat scans

Surgical Consent Audit

Consent is a patient's agreement for a health professional to provide care, treatment or physical investigation. Patients have a fundamental legal and ethical right to decide what happens to their bodies. It is therefore essential that patients have given valid consent for all treatments and investigations and that there is appropriate documentation of this. This audit aimed to assess the documentation of consent in the Trust. The audit identified 91% compliance across all standards.

Actions planned/taken to improve outcomes:

- Consent has been included as part of the medical induction as part of the main Record Keeping audit

4.2.3 Participation in Clinical Research

Clinical research is essential for continuous improvement in healthcare delivery. Each year thousands of patients take part in clinical studies in the NHS. RNOH together with our academic and commercial partners contributes to the development of new projects as well as contributing to the recruitment of studies and trials from other centres. The National Research Recovery Programme led by the National Institute of Health Research (NIHR) is driving research recovery across the NHS in a challenging environment. RNOH has reviewed all relevant studies to maintain research capacity. Our ability to continue in research delivery is key, and our patient recruitment is slowly returning to pre-Covid levels. There is however more work to do in this area. We continue to focus on delivering new studies as well as supporting existing research.

RNOH provides opportunities for clinical research participation to patients and provides access to cutting-edge treatments. This includes patients with rare conditions for whom treatments are currently limited. We provide individual patient solutions as part of our innovative treatment and support international studies for patients with extremely rare conditions.

Participation in clinical research demonstrates RNOH's commitment to improving the quality of care we offer and contributing to wider health improvement. Our clinical staff stay abreast of the latest treatments and their active participation in research leads to successful patient outcomes. We work closely with our university partners to develop new treatments for patients and our collaborations have impacted patient care locally and beyond. Our commitment to producing new ideas across all staff groups to deliver research has the potential to change the way we treat our patients. Actively involving staff and patients in developing and delivering research is essential to capitalising on the benefits associated with being a research-active organisation.

The RNOH was actively participating in 69 neuro-musculoskeletal research studies last year, of which 24 were newly started during the year. This is an improvement from

the previous year and indicates a good research recovery from the impact of the pandemic.

In 2022/23, the number of patients receiving NHS services provided or sub-contracted by RNOH saw 550 patients recruited to participate in research approved by a research ethics committee. Of the 550, 449 were recruited into NIHR Portfolio studies. The Research Recovery post pandemic continues to provide some challenges, but the local team has been working hard to continue delivering good quality research and ensure good access to research for our patients. This will be further strengthened by the establishment of a Patient Public Involvement and Engagement (PPIE) group which will ensure that our research is relevant to our patients.

There were over 30 members of RNOH clinical staff participating in research approved by a national research ethics committee, and support for clinical research continues to grow.

Our continued engagement with clinical research demonstrates RNOH's commitment to testing the latest medical treatments and techniques. RNOH collaborates with universities as well as industry partners in delivering cutting-edge technology to everyday care. Our collaborations include international projects with EU funding, and we have also contributed to national projects such as the Perioperative Quality Improvement Programme project.

Case studies

Short Title: Perioperative Quality Improvement Programme (PQIP)

Title: Perioperative Quality Improvement Programme (PQIP) – Orthopaedics Arm

Lead: Dr Rachel Baumber (local and national lead for the orthopaedic arm)

Project: Around 10 million operations are performed in the NHS each year. What happens to these patients? What are the complication rates? What is patient recovery like? Are we providing a good service? Those are some of the questions the programme aims to answer nationally to improve the care and treatment our patients receive.

Short Title: RACER trial

Title: Robotic Arthroplasty: A Clinical and Cost Effectiveness Randomised controlled trial

RNOH Lead: Prof. John Skinner

Project: This is an important national project led by University Hospitals Coventry and Warwickshire jointly with the University of Warwick to determine the clinical effectiveness of robotic surgery.

4.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

The Commissioning for Quality and Innovation (CQUIN) programme supports NHS providers to drive through quality improvements via challenging goals related to patient care. NHS Trusts and Foundation Trusts are financially incentivised for the achievement of these schemes by the opportunity to receive up to an additional 1.25% of their clinical income for full achievement.

Due to COVID, some changes were made to the payment of CQUIN, mainly driven by the way Trusts receive their income. In 2022/23, the Trust was guaranteed to receive 100% of possible CQUIN funding due to the contractual arrangements agreed with commissioners. However, RNOH was still committed to fully participating in all schemes.

For 22/23 the Trust signed up to the required five CQUINs schemes from the national list, and these applied to contracts with both Integrated Care Board and NHS England Commissioners. The schemes are set out in the table below (Table 4.2.4.1):

CQUIN Indicator	CQUIN Goal
1. Flu vaccinations for frontline healthcare workers	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.
2. Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
3. Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.
4. Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24
5. Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.

Table 4.2.4.1: RNOH Agreed CQUINs for 2022/23

Overall CQUIN achievement has been good with some areas for continued improvement as listed in the table below.

Scheme	Achievement	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Flu vaccinations for frontline healthcare workers	Minimum: 70% Maximum: 90%	N/A	N/A	N/A	43% (Not Achieved)
Appropriate antibiotic prescribing for UTI in adults aged 16+	Minimum: 40% Maximum: 60%	29% (Not Achieved)	52% Achieved	75% Fully Achieved	TBC
Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Minimum: 20% Maximum: 60%	80% (Fully Achieved)	87.5% (Fully Achieved)	100% (Fully Achieved)	TBC
Anaemia screening and treatment for all patients undergoing major elective surgery	Minimum: 45% Maximum: 60%	96.38% (Fully Achieved)	92.72% (Fully Achieved)	88.79% (Fully Achieved)	TBC
Supporting patients to drink, eat and mobilise after surgery	Minimum: 60% Maximum: 70%	82% (Fully Achieved)	69.23 (Achieved)	64.44% (Achieved)	TBC

Table 4.2.4.2 RNOH CQUIN 2022/23 Achievements

In summary:

- Flu vaccination for patient facing staff remains challenging and will likely be carried forward to 2023/24
- Antibiotic screening for UTI in 16+ has shown steady improvement during the year which is very encouraging
- Recording of NEWS2 scores was fully achieved
- Anaemia screening was fully achieved and will no longer be a CQUIN scheme in 2023/24
- Good progress was made in supporting patients to drink, eat and mobilise

RNOH remains committed to driving improvements in all of these areas and will continue in 2023/24.

4.2.5 CQC registration and compliance

RNOH is required to register with the Care Quality Commission (CQC) and is currently registered with no conditions attached.

No enforcement action has been taken against the Trust for the 2022/23 year. The Trust continues to meet with the CQC in quarterly scheduled relationship meetings and to answer enquiries as required.

The Trust had a CQC inspection in 2018 with the report published in 2019. The Trust achieved an overall CQC rating of **Good**.

The tables of ratings from the October/November 2018 CQC inspection are presented below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement ↓ Mar 2019	Good ↔ Mar 2019	Outstanding ↔ Mar 2019	Outstanding ↔ Mar 2019	Good ↔ Mar 2019	Good ↓ Mar 2019
Surgery	Requires improvement ↔ Mar 2019	Outstanding ↔ Mar 2019	Good ↓ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019
Critical care	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Services for children and young people	Requires improvement ↔ Mar 2019	Good ↓ Mar 2019	Good ↔ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019
Outpatients	Good Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Overall*	Requires improvement ↔ Mar 2019	Good ↓ Mar 2019	Good ↓ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019

Table 4.2.5.1 Ratings for Royal National Orthopaedic Hospital (Stanmore site)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Overall*	Good ↔ Mar 2019	N/A	Good ↔ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019

Table 4.2.5.2 Ratings for Royal National Orthopaedic Hospital (Bolsover Street site)

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Mar 2019	Good ↓ Mar 2019	Good ↓ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019

Table 4.2.5.3 Overall rating for the Trust

4.2.6 Secondary Uses Service Data

RNOH has submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data¹.

Valid NHS Number

The percentage of records in the published data (as of month 12) which included the patient's valid NHS number was:

- 98.2% admitted for patient care
- 99.2% for outpatient care

Valid General Medical Practice Code

The percentage of records in the published data (as of month 12) which included the patient's valid general medical practice code was:

- 100% for admitted patient care
- 99.9% for outpatient care

4.2.7 Data Security & Protection Toolkit

The Data Security Protection (DSP) Toolkit forms part of a framework for assuring that the Trust is implementing the ten data security standards (see below table) and meeting its statutory obligations on data protection and data security in line with the General Data Protection Regulation (GDPR). The DSP Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health guidance.

All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the Data Security and Protection Toolkit to evidence this by the publication of annual assessments. The Toolkit provides a mechanism for organisations to demonstrate that they can be trusted to maintain the confidentiality and security of personal information. This in turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

The Trust DSP assessment period for 2022/2023 is from 1 July 2022 to 30 June 2023 and therefore the compliance rating has yet to be published*.

****Information accurate at the time of publication, results for the DSP assessment publication after 30 June 2023 can be located***

<https://www.dsptoolkit.nhs.uk/OrganisationSearch/RAN>

¹ Source: NHS Digital Secondary Uses Service (SUS). SUS is a secure data warehouse that stores patient-level information in line with national standards.

Leadership Obligation 1: People
1. Personal confidential data is handled, stored and transmitted securely
2. Staff obligation to handle information responsibly and be accountable for deliberate or avoidable breaches
3. Staff to complete annual data security training
Leadership Obligation 2: Process
4. Personal confidential data is only accessible to staff who need it for their current role
5. Processes are reviewed at least annually to identify and improve processes
6. Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to
7. A business continuity plan is in place to respond to threats to data security
Leadership Obligation 3: Technology
8. Identify and remove unsupported systems
9. A strategy is in place to protect IT systems from cyber threats
10. Suppliers are held accountable via contracts for protecting the personal confidential data

Table 4.2.7.1. NHS Digital Data Security Standards²

4.2.8 The clinical coding error rate

RNOH was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

However, an internal formal clinical coding data quality audit was carried out in January 2023 meeting the requirement of NHS Digital, Data Security and Protection Toolkit.

A total number of 100 Finished Consultant Episodes (FCEs) were audited. The sample was randomly selected from the spells that occurred between the months of September and October (inclusive) 2022.

The audit was undertaken by NHS Digital Terminology and Classifications Delivery Service Approved Clinical Coding Auditor. The table below shows the Data Security & Protection Toolkit requirements and results of the audit over the last two reporting periods:

Diagnosis/Procedure	Level of attainment	
	Mandatory	Advisory
Primary diagnosis	>= 90%	>= 95%
Secondary diagnosis	>= 80%	>= 90%
Primary procedure	>= 90%	>= 95%
Secondary procedure	>= 80%	>= 90%

Table 4.2.8.1. Data Security and Protection Toolkit Clinical Coding Audit Requirements

² Source: Data Security Standards <https://www.dsptoolkit.nhs.uk/Help/2>

Year	Primary Diagnosis Accuracy	Secondary Diagnosis Accuracy	Primary Procedure Accuracy	Secondary Procedure Accuracy
2022/23	96.7%	95.3%	95.6%	95.7%
2021/22	96%	97.8%	96.5%	94.9%

Table 4.2.8.2. RNOH Data Security and Protection Toolkit Clinical Coding Audit Results 2022-23

The Audit demonstrates that RNOH has maintained its high standards of coding quality and achieved excellent coding accuracy. Data quality coding audit percentages achieved correspond to advisory level attainment on the data security and protection toolkit requirements in table 4.2.8.1

4.2.9 Data Quality

The oversight of data quality and its assurance falls within the remit of the Information Quality and Governance Steering Subcommittee. The Information Governance (IG) team work to ensure that high quality data flows are in place to provide better patient care and patient safety.

The data flows play a key part in improving services through informed decision making and can be used to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services.

There are various processes that the Trust uses for assuring, or improving, data quality across the organisation, these include:

- Consistent and comprehensive use of the NHS Number
- Quality assurances of data pre-submission
- Sign off data pre-submission
- Effective tracing of patients on the Personal Demographics Service (PDS) pre-submission
- Data Quality Improvement Plans
- Reporting of data quality
- Routine audit and management of clinical & corporate records
- Audit clinical coding
- Comprehensive clinical coding training
- Incorporate national data definitions, standards, values and validation programs. Local documentation should be updated, as national standards develop
- The use of local and national benchmarking to identify data quality issues and analyse trends

4.2.10 Learning from Deaths

Deaths occurring during 2022/2023

Between 1 April 2022 - 31 March 2023, 22 RNOH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 9 in the first quarter
- 7 in the second quarter
- 4 in the third quarter
- 2 in the fourth quarter

By 31 March 2023, 11 case record reviews and 8 investigations have been carried out in relation to the 22 deaths outlined above. Out of the 8 investigations 2 are still being completed.

In 7 cases, death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 3 in the first quarter
- 3 in the second quarter
- 1 in the third quarter
- 1 in the fourth quarter

Reviews of deaths occurring outside the reporting period

RNOH undertook 4 case record reviews and 1 investigation after 31 March 2022, which related to deaths which took place before the start of the current 2022/2023 reporting period.

None of the deaths before the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.

Method for reviewing deaths at RNOH

Patients who have died within 30 days of attending RNOH for a procedure are subjected to a formal notes review. The data for deaths is taken from the hospital reporting system, called Insight, which itself is fed data via the NHS Spine. This represents the most accurate source of data. Since February 2018, all applicable cases have been assessed using the Structured Judgment Review method as recommended by the Royal College of Physicians.

A multidisciplinary monthly Learning from Deaths meeting, chaired by the Trust Mortality lead, reviews all inpatient deaths and considers community associated deaths for review using the SJR methodology.

Cases are also presented and discussed at the Trust wide bi-monthly Mortality and Morbidity meeting (M&M) or the local Mortality and Morbidity meeting for learning. The bi-monthly meeting is hospital wide and multidisciplinary, with contribution from all members of staff. When issues have been raised at the M&M meetings, the cases

were then proposed for a case review if this was deemed appropriate by the M&M meeting.

Duty of Candour

Duty of Candour meetings have been undertaken where necessary. This has included sharing learning from reviews with relatives and discussion of actions which the Trust has taken.

Key Learning

RNOH has raised the following learning points during 2022/23, as a direct result of what the Trust has learnt from these case record reviews and investigations:

- No deaths were deemed avoidable during this period
- The majority were high risk patients undergoing high risk complex surgery.
- Review of deaths highlighted examples of excellent MDT working and shared decision making, along with a very thorough pre-operative workup and assessment.
- Some areas of improvement were raised related to the documentation of daily medical reviews of patients and communication between RNOH and referring/discharging trusts.

Part 5: Review of quality performance

Quality Account regulations from the Department of Health require Trusts to report performance against a core set of indicators, using data made available to the Trust by NHS Digital where available. RNOH has added several other quality indicators that form part of our quality agenda.

5.1 Patient Safety Measures

5.1.1 Rate of admissions assessed for venous thromboembolism (VTE)

VTE assessment at admission is a national quality requirement included in the NHS Standard Contract 2019/20. NHS Trusts collect and submit data on the number of inpatients (aged 16 and over) who are assessed for risk of venous thromboembolism (VTE). The national target is 95%.

The national VTE data collection and publication was suspended in March 2020 to release the capacity of providers and commissioners to manage the COVID-19 pandemic. The Trust has continued to monitor VTE assessment performance via local data collection to ensure that patients receive high quality safe care. The rate of admissions assessed for VTE was 89.1% for 2022-23.

Indicator	2020/21	2021/22	2022/23
% patients admitted who were risk assessed for VTE	98.7%	87.7%	89.1%

Table 5.1.1.1 VTE Assessment (Local data for 2022/23 as national data suspended)

RNOH considers that this data is as described for the following reasons. The data is a mandatory requirement and is routinely collected by the Trust and submitted to NHS Improvement monthly. This is overseen by the multidisciplinary VTE Group.

The VTE group works to:

- Ensure that the hospital follows national guidance on VTE and meets the requirements of the All-Party Parliamentary Thrombosis Group
- Keep VTE related policies and processes up to date in line with National guidance. Clinical guidelines for VTE prevention and treatment have been updated to encompass the changing patient cohort at RNOH in light of the COVID-19 pandemic and in line with NICE guidance.
- Implement and review mechanisms for VTE related clinical audits
- Complete root cause analysis investigations for all cases of VTE as nationally recommended
- Collate and analyse data on VTE risk assessment, prophylaxis and events including in-depth trend analysis using RCAs finding.

The Trust has taken the following actions to improve the rate of risk assessment and so the quality of care:

- An up-to-date policy on VTE is available to all members of staff via the intranet. The policy is based on the latest NICE guidance and local consensus agreement by clinicians
- Key performance indicators are reported quarterly by the VTE group at IGRC
- All RCAs are presented and discussed at the IGRC meeting
- The Trust has implemented an electronic version of the VTE assessment called eVTE. This has enabled the Trust to audit the accuracy and completeness of VTE risk assessment forms. Since implementation, we have achieved the national target of 95%

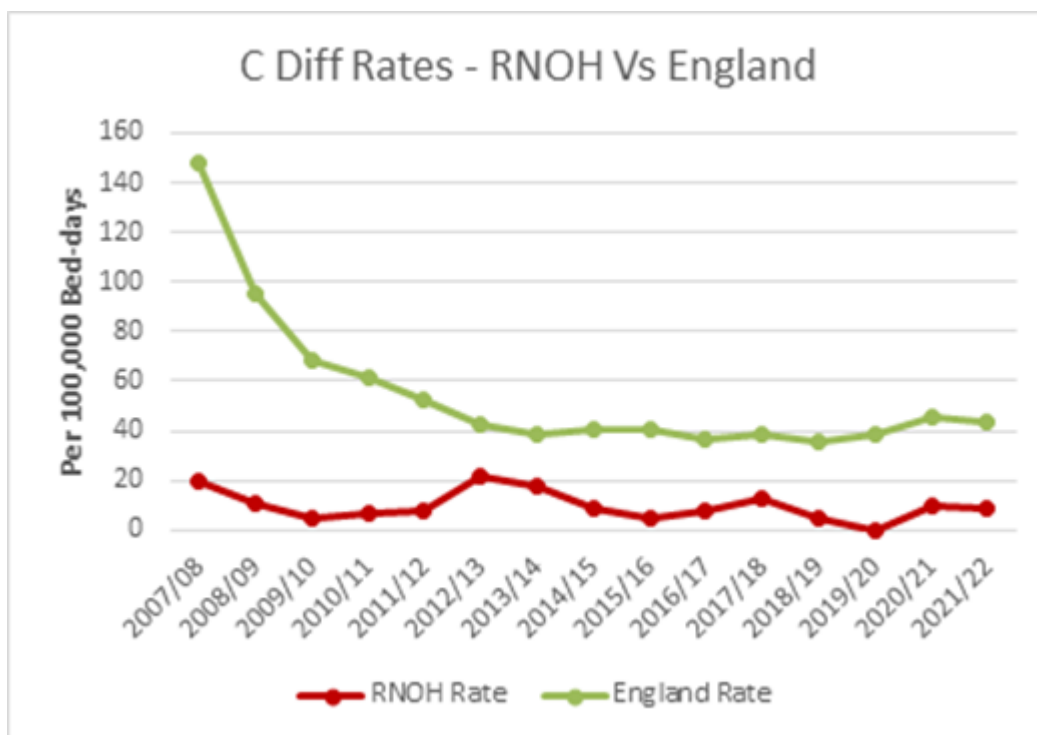
5.1.2 Clostridium difficile infection rate

For the financial year 2022-23, the Trust has reported 4 cases of *C diff* infections against the NHS England and NHS Improvement target threshold of 3 cases.

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
C. diff infections reported by the Trust	5	2	0	3	3	4
Threshold/Limit	2	1	1	1	1	3

Table 5.1.2.1 C.diff infection rates

The Infection Prevention and Control Team (IPCT) continues to carry out improvement work to ensure *C diff* infections acquired in the Trust are kept at a minimum. While the number of cases reported by the Trust has increased in the last three years, it is reflective of the trend reported by primary care and acute hospitals in England.



Graph 5.1.2.1: C diff cases reported by RNOH vs national average per 100,000 bed days.

The graph above shows the RNOH C. diff rate which has remained lower than the national rate of England (national data for 2022-23 not available yet).

The IPCT continues to work to improve outcomes by:

- Robust monitoring and reporting of C. diff infections to the UKHSA via the Healthcare-Associated Infections Data Capture System (HCAI DCS).
- Investigating each case reported using a Root Cause Analysis (RCA) framework with the respective multi-disciplinary teams (MDT) to identify any lapses in care, learn from the incident and highlight good practice. All incidents are reported to the Trust’s incident reporting system, Ulysses.
- RCA outcomes are presented to the MDTs through divisional meetings and actions are assigned to the responsible person. These outcomes are then reported to the Infection Prevention and Control Committee (IPCC) and fed back to the Integrated Governance and Risk Committee (IGRC) to ensure actions and learning from the incident are carried forward to prevent future incidents.

5.1.3 Patient Safety Incident Reporting

The number and rate of patient safety incidents reported at RNOH during 2022/23, as reported via the NHS Improvement National Reporting & Learning System (NRLS), are described in the table below

Incident Reporting							
Indicator	2019/20		2020/21		2021/22		2022/23
	Apr 2019 Sep 2019	Oct 2019 Mar 2020	Apr 2020 Sep 2020	Oct 2020 Mar2021	Apr 2021 Sep 2021	Oct 2021 March 2022	Apr 2022 March 2023
Number of patient safety incidents reported ¹	517	648	669	852	1469	317	3527*
Rate of patient safety incidents reported (per 1,000 bed days)	27.0	24.8	33.4	39.4	62.7	14.04	17.5
% incidents that resulted in severe harm	0%	0.07%	0.5%	0%	0%	0%	0.08%
% incidents that resulted in death	0.2%	0.5%	2.1%	1.1%	0.2%	1.6%	0.3%

Table 5.1.3.1 Patient Safety Incident Reporting

*NRLS data (Actual incidents reported for 2022/23 are 2240. An additional 1287 incidents from previous year were uploaded in 2022/23 as there was a delay in NRLS uploads due to a system update).

RNOH considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

- The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken
- The Trust submits patient safety incident data to the National Reporting Learning System. We are ranked against other Trusts in respect of the rate of reporting and category of harm

RNOH remains committed to delivering the best quality of care and patient experience and working in an open and honest environment; this includes supporting staff to report incidents. Incident reporting is actively promoted through staff training and further embedded by the management of incident investigations.

Internal assurance is provided by the Trust's internal auditors who provided substantial assurance in-year on the incident reporting and lessons learnt arrangements that include a weekly Incident Review Group with oversight of the incident reporting and investigation activity trust-wide. The group receives assurance from divisions and departments on the initial local review of all incidents and discusses by exception in detail those incidents that may potentially meet the criteria for further escalation as Serious Incident or Never Event.

Serious incidents undergo a detailed investigation and a clinical led root cause analysis, the results of which are shared with the patient and relatives. Sharing the learning from patient safety incidents plays an important role in the prevention of future errors and in improving the quality of care. At RNOH, learning is shared widely through a number of routes. There is a monthly Big4 bulletin shared trust-wide covering the 4 key safety topics of the month. The monthly Medicines Matters newsletter shares the key trends and lessons from Medication incidents.

Staff are supported with the management and investigation of incidents. A trust-wide training programme has been ongoing with weekly and monthly sessions. Staff also have access to additional training via the induction programme.

Incident Reporting

The Trust incident-reporting rate is tracked and demonstrates a good and consistent reporting culture.

Staff feel comfortable reporting incidents, and transparency and accountability are valued. By encouraging our staff to report incidents, we are better able to identify patterns and areas for improvement, ultimately leading to a safer environment for our patients. Our focus on patient safety is at the forefront of our mission, and we will continue to prioritise the reporting and analysis of incidents to ensure that we provide the highest quality of care possible.

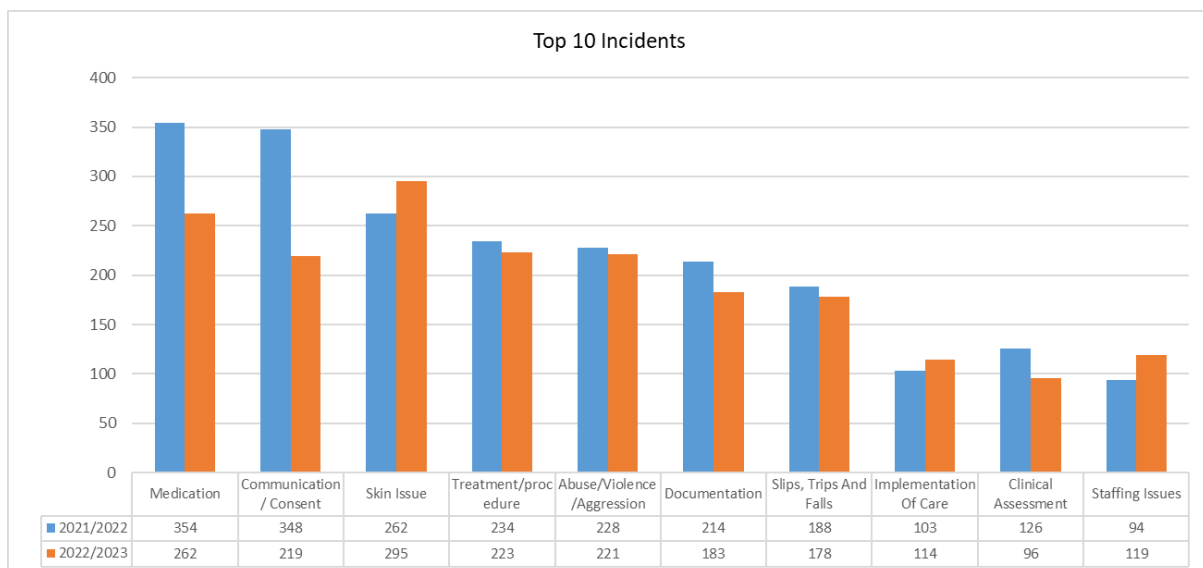
Incident data shows an increase in incident reporting in 2022/23 compared to the previous years. Nonetheless, all types of incidents are logged with a broad spectrum of harm including no harm and low-harm incidents demonstrating a good reporting culture.

Top 10 Clinical Incidents (2021/22 – 2022/23)

Data from the previous two years indicate that our most frequently reported clinical incidents have remained relatively consistent and relate to the following categories:

- Medication
- Communication / Consent
- Allegation / Abuse / Aggression related incidents
- Skin Issues
- Treatment / Procedure
- Abuse/Violence / Aggression
- Documentation
- Slips / Trips / Falls
- Implementation of care
- Clinical assessment
- Staffing issues

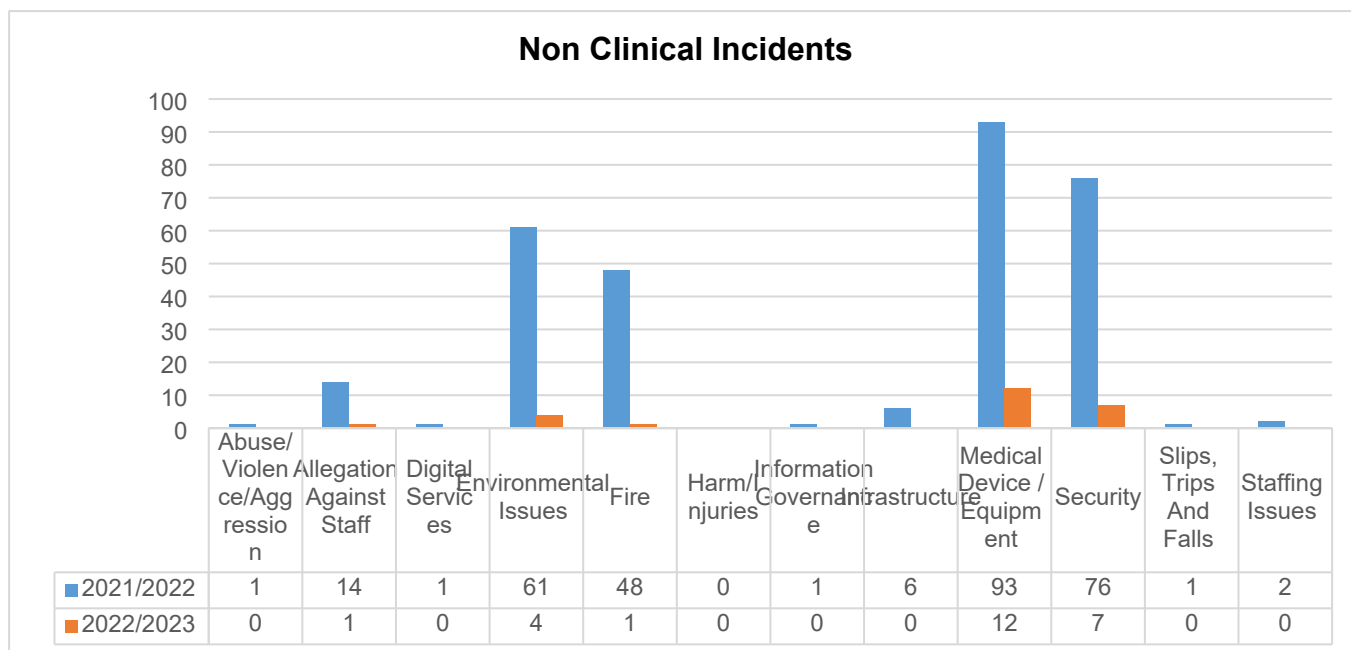
The notable change is around two key categories: Medication and Communication incidents both of which are showing a slight decline in 2022/23 compared to the previous year.



Graph 5.1.3.2 Top ten incidents

Non-clinical incidents (2021/22 – 2022/23)

The chart below demonstrates a significant decline in all categories of non-clinical incidents in 2022/23 compared to the previous year.



Graph 5.1.3.3 Non-clinical incidents

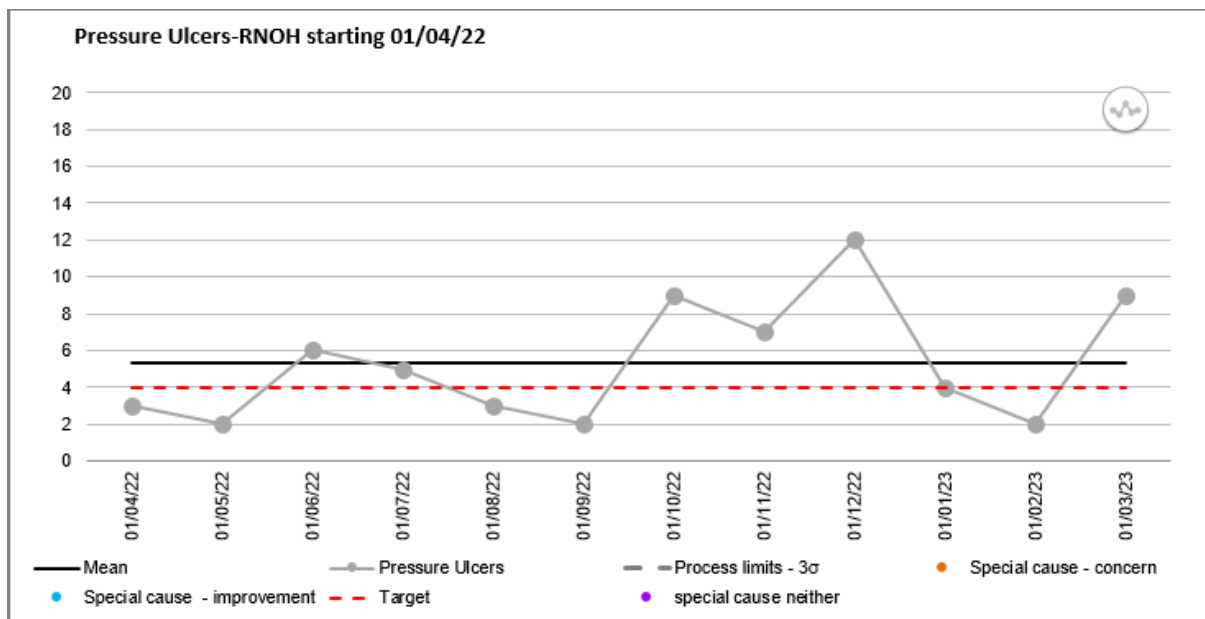
Key achievements in 2022/23

- The successful implementation and roll-out of the national Learn from Patient Safety Events (LFPSE) system
- Planned delivery of a comprehensive training programme for Learning Response Leads and Oversight Leads as one of the key deliverables of the Patient Safety Incident Response Framework (PSIRF) project
- Supporting and mentoring the newly appointed Patient Safety Partners and integrating them into the Trust safety and governance groups.
- Supporting the ongoing implementation of the PSIRF project due for completion and roll-out in Autumn 2023/24
- Conducting the safety culture survey and identifying safety recommendations to enhance the trust's safety awareness
- The development of a Risk Management e-module accessible on the Trust Learning Hub to offer an increased understanding of how to manage risks in the Trust.
- The launch of a new monthly patient safety drop-in session held across all three sites
- The development of a new Patient Safety Intranet page to include news of current patient safety events, updated resources, newsletters, training schedules, guides, policies and much more.
- A Trust-wide refresher training programme for staff on all Ulysses modules including the newly designed LFPSE incident reporting form
- Working with the divisions to reduce the number of outstanding incidents and actions from RCA investigations
- The trust-wide rollout of the Patient Safety Syllabus – Level 1 and Level 2 modules

- Participation in the yearly World Patient Safety Day events with engagement and awareness activities for all staff groups to join in and participate.

5.1.4 Pressure Ulcers

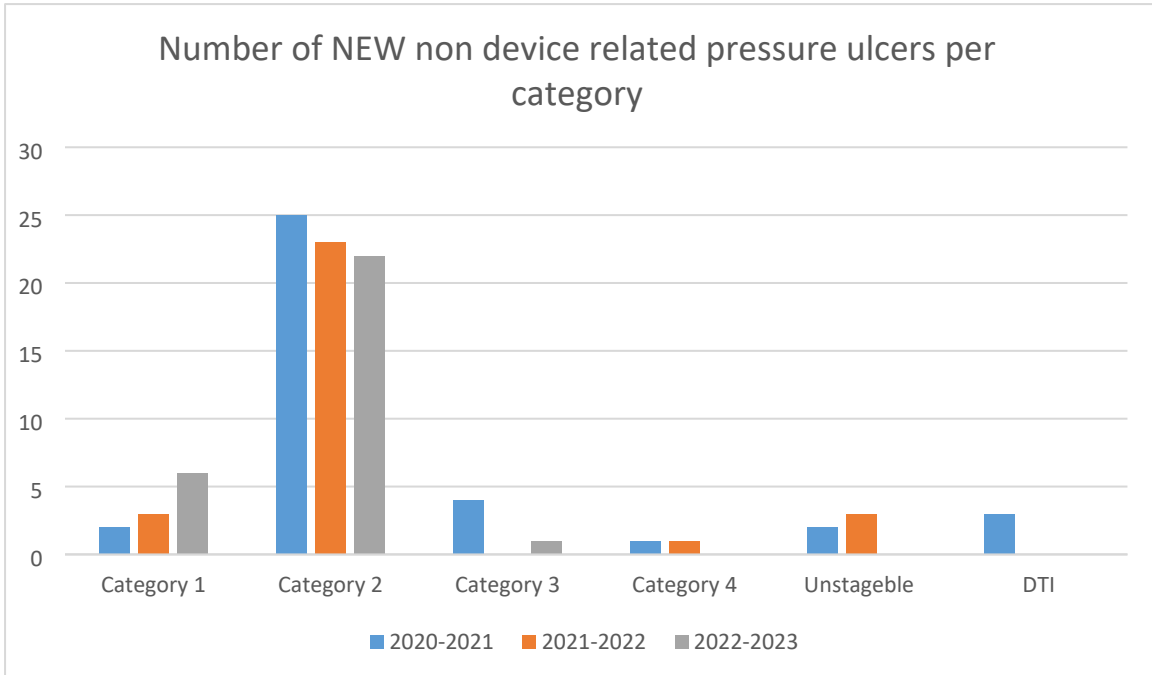
In 2022/2023, 64 new pressure ulcers were validated during the patient’s episode of care at RNOH. This is an increase of 21% when compared to the previous year. The statistical process control (SPC) data shows an increase in the number of pressure ulcers from October to December 2022 and then again in March 2023. This increase in November and December was due to a number of device related pressure ulcers.



5.1.4.1 SPC chart demonstrating the monthly pressure ulcer data

The graph below demonstrates the comparison of the number of new non-device related pressure ulcers per category for the years 2020-2021, 2021-2022 and 2022-2023.

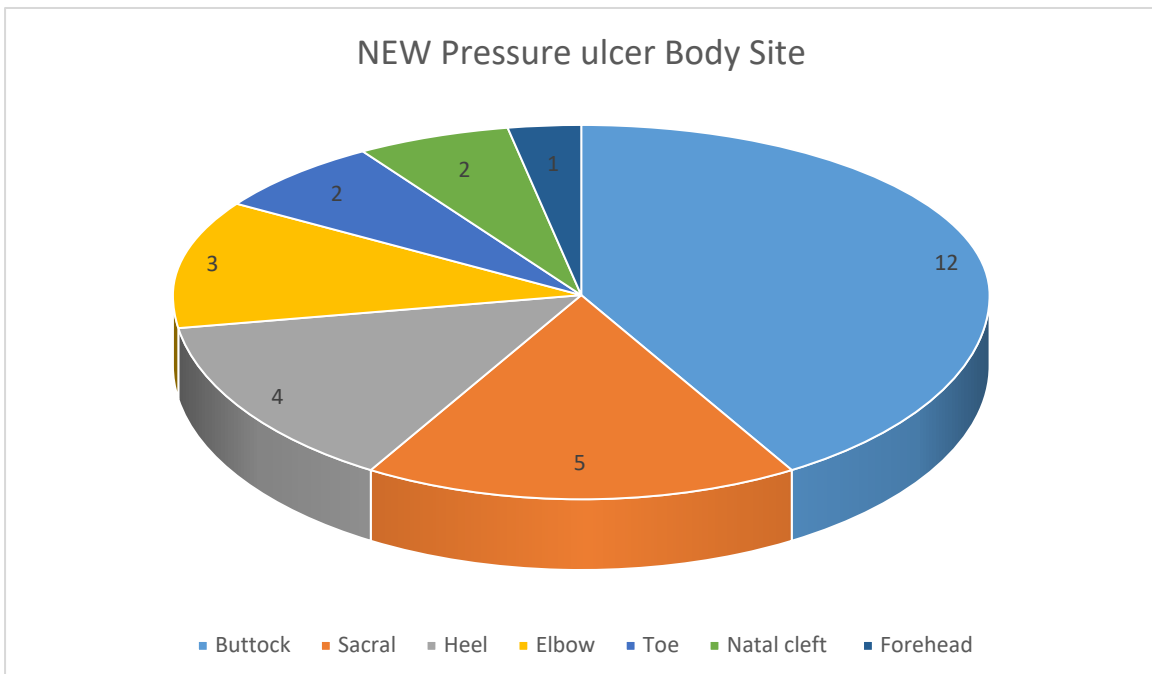
In 2022/2023, RNOH had one reported category 3 pressure ulcer demonstrating a further reduction of pressure ulcer severity and the early identification of the number of category 2 pressure ulcers.



5.1.4.2 Non-Device related new pressure ulcers

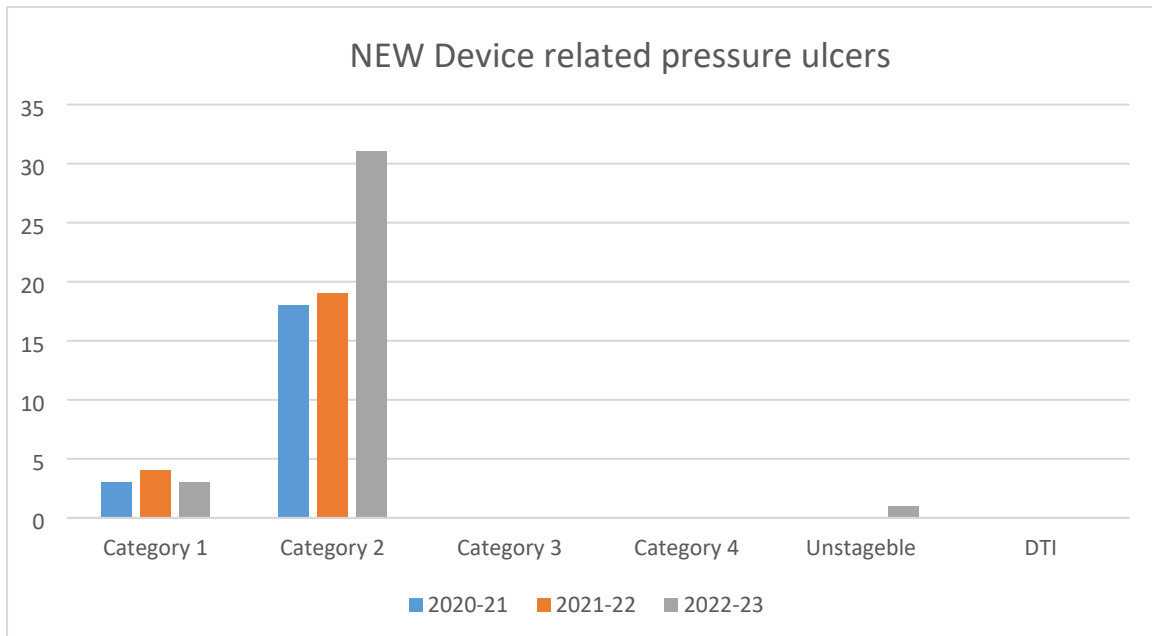
The chart below highlights the body site of the validated new non-device related pressure ulcers.

This enables focussed educational sessions within the clinical areas to reduce incidents based on the harm in these locations e.g. turning regimes to reduce sacral and buttock pressure ulcers.



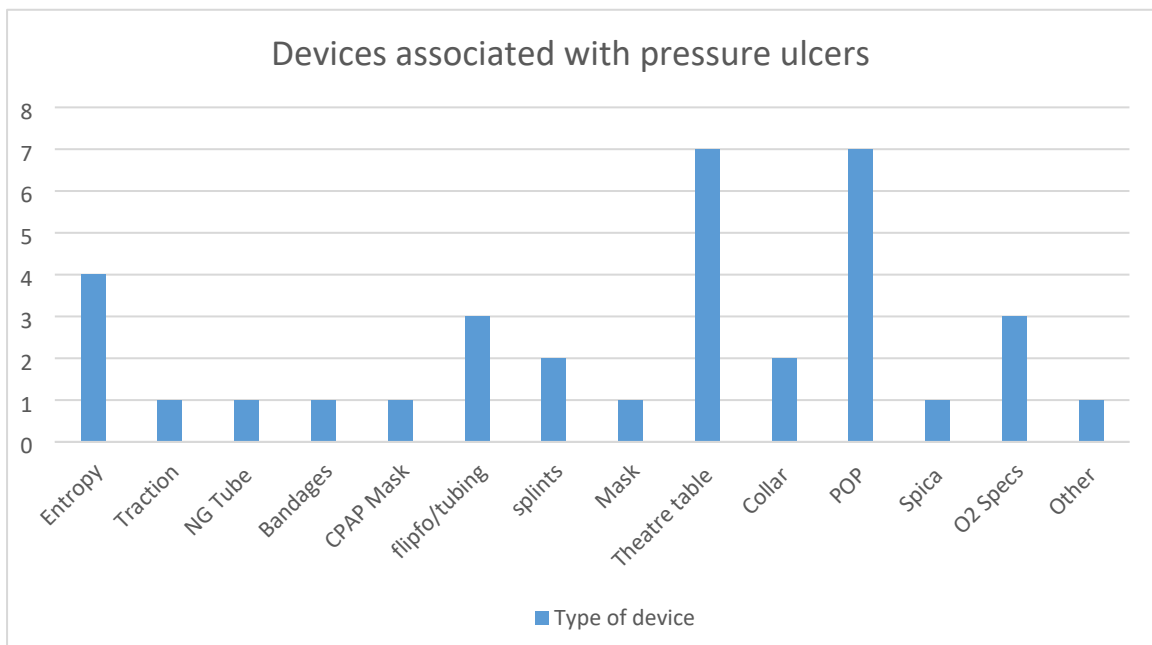
5.1.4.3 NEW non-device related Pressure ulcer body site

The number of device related pressure ulcers equates to 54.7% of the validated pressure ulcers, which is an increase from the previous year. These are identified and validated as category 1 and 2 pressure ulcers. Those pressure ulcers that are unstageable continue to undergo treatment until the tissue has evolved to establish the category.



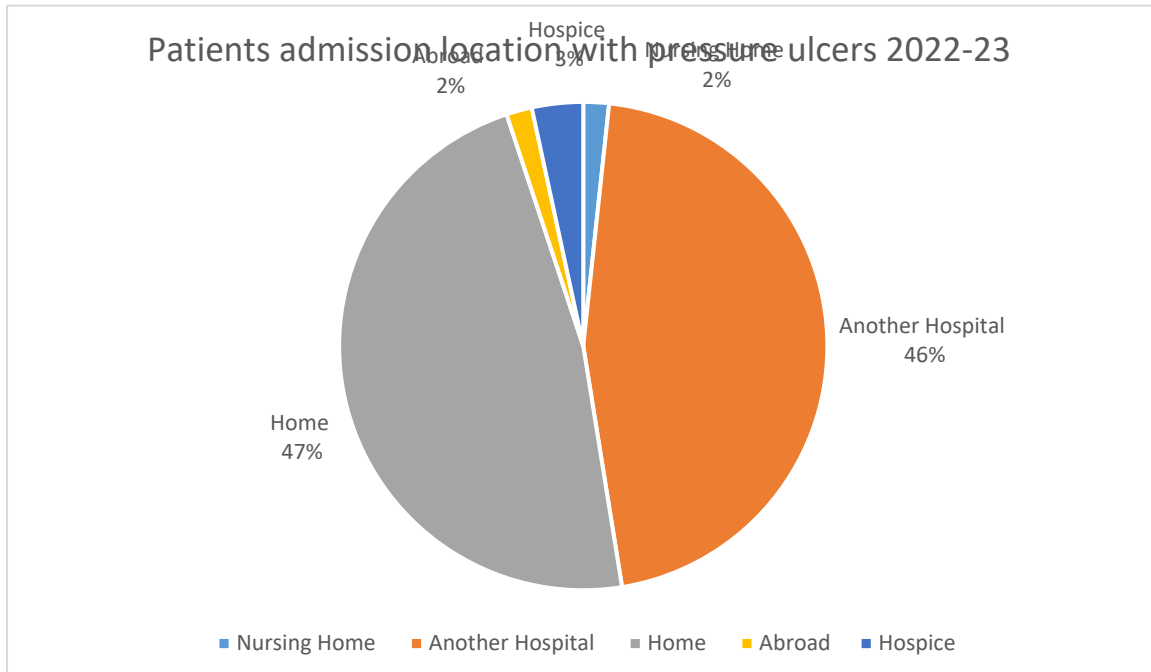
5.1.4.4 New device related pressure ulcers

The recorded devices that are associated with pressure ulcer damage continue to be investigated and action plans implemented to reduce harm.



5.1.4.5 Types of devices related to new pressure ulcers

A total number of 60 patients were admitted with pre-existing pressure ulcers ranging from Category 1 to Category 4 tissue damage predominantly from the patient's home or another Hospital Trust.



5.1.4.6 Location of Patients admitted to the Trust with Pressure Ulcers

Actions implemented:

- Implementation of the Tissue Viability Champions Program– the first cohort will graduate in August 2023.
- Ensuring the Pressure Ulcer-Harms Free group includes representation from all clinical professional bodies.
- Pressure ulcer prevention e-learning continues with 95.37% compliance
- Annual mattress audit conducted in November 2022 with an observed increase in the use of alternating pressure relieving mattresses based on the patients' pressure ulcer risk assessment level. Product training 99.56% compliant
- Theatre skin care meetings continue to identify trends and themes of pressure ulcer development or other areas of skin damage such as MARS (medical adhesive-related skin damage) and implement changes to practice to minimise incidents.
- Pressure ulcer incidents are investigated, through rapid review processes and root cause analysis where indicated, to identify learning, ward or specialty specific action plans or organisational educational needs through common themes/trends.

5.2 Clinical Effectiveness Measures

5.2.1 Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) is a national programme that enables patients undergoing elective inpatient surgical procedures to assess improvements to their health following their treatment. Participation in the programme is a requirement outlined in the NHS standard contract. The following 4 procedures are relevant to and assessed at RNOH:

- Primary Hip Replacement
- Revision Hip Replacement
- Primary Knee Replacement
- Revision Knee Replacement

Patients are issued two questionnaires (one before surgery and one six months after treatment) which ask questions about their health and quality of life and produce a health score. The difference in the score is measured and indicates the success and benefit of the surgery on their health – this is called a health gain.

There are 3 different validated measures that PROMs use to assess health gains:

1. **Oxford Hip / Knee Score:** This is a condition-specific measure that assessed the impact of the patient's condition on their daily life
2. **EQ-5D Index:** This is a general health measure that assesses 5 aspects of quality of life – mobility, self-care, daily activity, pain/discomfort and anxiety/depression
3. **EQ-VAS:** This is a general health measure that takes a snapshot of the patient's self-reported general health on the day the questionnaire is completed (this score may be influenced by other factors than the patient's condition/surgery)

Participation in the programme is voluntary and patients can withdraw their consent at any point. Results are reported by financial year (April – March) and are reported for the previous year to enable all questionnaires to be received and processed.

There has been a delay in National data reporting due to some changes in the HES data. Below are the locally available figures for data collection and submissions to NHS Digital.

Procedure	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate
Hip Replacement	389	326	84%
Knee Replacement	378	324	86%
All Procedures	767	650	85%

Table 5.2.1.1 Pre-operative questionnaires participation rate

RNOH considers that PROMs results are as described for the following reasons:

- RNOH has a process in place to ensure that relevant patients are given questionnaires to complete and that patients are encouraged to do so. It is

important to note that the Trust has no control over the completion and return of these forms.

- Questionnaires are processed independently of the Trust, by an independent accredited supplier.
- Questionnaires are produced by NHS Digital and are in standardised use across the country. Data is analysed and reported independently by NHS Digital.

5.2.2 Emergency readmissions within 28 days

During 2022/23, RNOH admitted 14,439 NHS patients (April 2022 - March 2023). Of these, 60 were emergency re-admissions within 28 days of discharge. The table below (5.2.2.1) outlines the figures for the Trust over the past four years:

Percentage of emergency readmissions within 28 days of discharge from hospital of patients:	2019/20	2020/21	2021/22	2022/23
i) 0 to 15 years (indicator from 2017/18 onwards)	0.4%	0.6%	0.2%	0.3%
ii) 16 and Over (indicator from 2017/18 onwards)	0.5%	0.8%	0.4%	0.4%

Table 5.2.2.1: Trust Level Data provided by the Information Team (Accessed April 2023)

RNOH considers that the percentage of emergency readmissions within 28 days of discharge from the hospital is as described for the following reasons:

- Every time a patient is discharged and readmitted to the hospital the episode of care is coded. The Information Team provides reports to allow operations teams to monitor and audit data quality locally and the Trust participates in the external audit which enables the Trust to benchmark its performance against other Trusts.

The Trust intends to take the following actions to reduce readmissions to improve the quality of its services:

- Working to implement a process of exemplar discharge
- Continuing to monitor those patients discharged from RNOH and readmitted to other hospitals to ensure accurate readmission rates and appropriate clinical review of any readmissions within 28 days
- Develop our clinical pathways through Quality Improvement methodology, to ensure patients receive excellent and efficient care, which includes working on our discharge pathways and ensuring patients do not stay in the hospital longer than necessary with the risk that carries.

- Implement our updated admissions and discharge policy supporting staff to manage patients' journeys better, including discharge pathways.
- We aim to work on reducing the length of stay for some clinical pathways. Reducing waste such as delays in the current system or implementing improved services such as a twilight therapies service to start therapy post-surgery at the earliest opportunity, will ensure that we free up capacity to treat more patients.
- Continue to monitor readmission rates. We know that readmissions have not increased despite the increased amount of day surgeries in the last year, converting overnight stays to day cases **and** reducing the length of stay for some other patient groups.

5.2.3 Cancer waiting times

RNOH is one of only five designated centres in the country that specialises in the care and treatment of patients who suffer from bone and soft tissue cancers. The national standard states that patients should receive the first treatment within 62 days of the urgent referral date (Target 85%). The table below (5.2.3.1) outlines the performance of the Trust against this standard.

	% of patients receiving first treatment within 62 days of urgent referral					
	2020/21		2021/22		2022/23	
	N	%	N	%	N	%
RNOH	77.5	88.2%	65	76.6%	72	82.3%

Table 5.2.3.1 62 days wait for first cancer treatment (Data Accessed May 2023)

RNOH considers the data to be as described for the following reasons:

- Data is submitted by the Trust to NHS England monthly. NHS England undertakes high-level validations of the data submitted by the Trust
- Data is formally published by NHS England monthly

5.2.4 Waiting times for diagnostic procedures

NHS Access standards for elective care state that 99% of patients undergoing diagnostic tests should have a maximum waiting time of six weeks from referral to testing. This ensures that patients can access diagnostic tests quickly and treatment can be commenced promptly. The table below (5.2.4.1) shows the results for RNOH over the last 3 financial years:

	% of patients waiting <6 weeks for diagnostic tests					
	2020/21		2021/22		2022/23	
	N	%	N	%	N	%
RNOH	17221	65%	21822	97.1%	26252	96.3%

Table 5.2.4.1 Diagnostic waiting times (Data Accessed May 2023)

N = the number of patients waiting up to 6 weeks for the year

RNOH considers this data to be as described for the following reasons:

- Data is submitted by the Trust to NHS England monthly. NHS England undertakes high-level validations of the data submitted by the Trust
- Data is formally published by NHS England monthly

5.3 Patient Experience Measures

5.3.1 Responsiveness to personal needs

Responsiveness to inpatient's personal needs is an experience measure captured by the National Adult Inpatient Survey. The Adult Inpatient Survey takes place annually and looks at the experiences of adult patients that have been an inpatient within an NHS hospital. Trusts sample eligible patients who would have been discharged from the hospital during, and including, the 6 months preceding November 2021.

The survey presents the Trust with contemporaneous data on patient experience. It is a rich source of information in itself and, when viewed alongside the data gathered from complaints and Friends and Family Tests, has the potential to ensure the organisation directs improvement efforts towards actions that will have the greatest impact on patients' experience of care and treatment.

The Trust's responsiveness to personal needs is considered across numerous survey questions and includes (but is not limited to):

- i) Were you involved as much as you wanted to be in decisions about your care and treatment?
- ii) Did you find someone on the hospital staff to talk to about worries and fears?
- iii) Were you given enough privacy when being examined or treated?
- iv) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?

The annual publication of 2022/23 data has been delayed nationally due to a review of the NHS Outcomes Framework by NHS Digital. The results below are based on 2021/22 data.

During 2021/22, the Trust continued to perform considerably above the national average in most questions and achieved a top score of the overall patient experience being much better than expected. The scores indicate that the Trust is performing extremely well, with 42 scores in the upper 20% range and many of these being the highest scores achieved when compared to other Trusts.

The Adult Inpatient Survey has been conducted annually since 2002. The CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's monitoring tools, which provide inspectors with an assessment of performance in areas of care within an NHS trust that needs to be followed up. Survey data will also be used to support CQC inspections.

The report provides benchmarked results for the 2021 Adult Inpatient Survey. It contains the same scoring and 'banding' (how RNOH performed compared to other trusts across England), and national scores.

A total of 166,318 patients were invited to participate in the survey across 134 acute and specialist NHS trusts. Completed responses were received from 62,235 patients, an adjusted response rate of 39%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in the hospital during November 2021 and were not admitted to maternity or psychiatric units.

For the year 2021/22, 1,250 RNOH patients were randomly selected and sent a nationally agreed questionnaire. A total of 602 RNOH patients responded to the survey with a response rate of 49% (the average response rate for all trusts was 39%).

RNOH has taken the following actions to improve this rate and so the quality of its services:

1. Quality improvement work to monitor and reduce the ambient sound levels on the wards
2. Continuous work in improving the shared decision-making processes and explanations of care
3. Continue to publish the monthly Quality Report that provides each division with a breakdown of patient feedback scores and comments
4. Continued use of *you said, we did* format to drive improvements in patient experience
5. Established and embedded Patient Safety Partners to support the Trust's commitment to openness and transparency between staff and patients

5.3.2 Friends and Family Test

The Friends and Family Test (FFT) continues to be an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps to identify both good and poor performance and encourages staff to make improvements where services do not meet expectations. It means staff from "board to ward" have access to up-to-date patient feedback and will be informed and empowered to take immediate action to tackle areas of weak performance and build on success. Tracking trends provides validation of where targeted improvements are most effective.

The fundamental principles underpinning the FFT are:

- All patients and people who use services have the right to provide anonymous feedback quickly and easily when they want to.
- The FFT is a continuous feedback stream, it is not a one-off feedback opportunity or a traditional survey.
- Parents, carers, volunteers or staff can give help to those who need it to give feedback – being careful that the feedback represents the views of the patient, not themselves.

- There may be times when it is not appropriate or possible for the provider to ask for feedback through the FFT, for example where it might cause distress. The patient or service user should still be able to give feedback if they want to.
- The feedback should be used to celebrate and build on what is working well, as well as to identify areas where improvements could be made.

Anyone using a service should be able to give feedback to the provider of that service. The NHS FFT is designed to be a quick and simple mechanism for patients and other service users to give feedback, which can then be used to identify what is working well and to improve the quality of any aspect of the patient experience. The guidance recommends additional free-text questions that are designed to elicit good quality feedback.

The FFT percentage is calculated by determining the number of people who rate the Trust as ‘Very Good’ or ‘Good’ as a proportion of the number of people who responded to the question. When combined with follow up questions, the FFT provides a way of highlighting both good and poor patient experience. This feedback is vital in transforming services and supporting patient choice as it gives all patients the opportunity to leave feedback on their care and treatment.

Usage of the data

The FFT does not provide results that can be used to directly compare providers because of the flexibility of the data collection methods and the variation in local populations. The FFT can help mark progress over time for organisations and provides patients with useful data to inform choice, alongside other information. A key benefit of the FFT lies in the follow up questions that are attached to the initial question. It provides a rich source of patient views that can be used locally to highlight and address concerns much faster than more traditional survey methods. The comments are not submitted to NHS England.

Patients/Carers can leave their responses by a variety of methods such as Paper, via SMS, QR codes and electronic tablets. An explanation of the FFT and a link to the QR code is also available on the Trust Website.

The percentage of service users who would recommend our services remains high.

RNOH results

“Overall, how was your experience of our service?”

Inpatients				
Financial Year	Responses	Response Rate	Positive (%)	Negative (%)
2022/23	2158	46%	91%	4%
2021/22	1881	38%	94.1%	2.8%
Financial Year	Responses	Response Rate	Would recommend	Would not recommend
2019/20	3,472	44.5%	96.0%	1.0%

2018/19	3,075	35.8%	95.0%	1.0%
2017/18	4,671	48.0%	95.1%	0.9%
2016/17	5,907	55.1%	96.3%	0.8%

Table 5.3.2.1: Official Inpatients Friends and Family Test (FFT) data published by NHS England (Data Accessed 12 May 2023- The financial year 2022/23 represents data from April 2022 – February 2023)

Outpatients				
Financial Year	Responses	Response Rate	Positive (%)	Negative (%)
2022/23	14540	42%	96%	2%
2021/22	12816	35.2%	94%	2.9%
Financial Year	Responses	Response Rate	Would recommend	Would not recommend
2019/20	6,031	20%	98.0%	1.0%
2018/19	9,882	17%	98.0%	1.0%
2017/18	3,180	4.1%	95.4%	1.9%
2016/17	4,470	5.9%	94.5%	2.1%

Table 5.3.2.2: Official outpatients Friends and Family Test (FFT) data published by NHS England (Data Accessed 12 May 2023- The financial year 2022/23 represents data from April 2022 – February 2023)

All divisions are provided with a monthly breakdown of FFT responses via a quality report. The Patient Experience Team work with the divisions to ensure any negative comments are managed using a ‘You Said – We Did’ format to enable learning to be cascaded throughout the organisation.

Patients continue to provide free text comments during the year, and these are analysed and reported back to wards to allow improvements to be made.

RNOH has taken the following actions to improve our patient feedback and so the quality of patient experience we deliver:

- Each division receives a monthly Quality Report that contains the performance in the Friends & Family Test for all divisional services and wards. This helps to provide quality performance monitoring and to identify any trends or issues developing over time.

Patient Feedback examples

RNOH continues to be committed to improving all communication with patients and carers. Our aim is for all patients to feel safe, involved and able to make informed choices about their treatment and care.

Rehab Ward	All the staff were friendly, and welcoming and there was always a great atmosphere throughout my stay. I made a lot of friends while there that will continue on even now I have left. The ward itself was the cleanest hospital ward I have ever stayed on.
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The Coleman Unit	The whole team on the ward gave me excellent care and made sure I was comfortable at all times. The operation was very successful. The Consultant and his team were excellent throughout the process on the day of the surgery. They have been in regular consultation with me for the past five years to identify the exact type of surgery required for my specific needs on both of my hips.
Jackson Burrows Ward	The whole experience from the very start was respectful informative, caring and more than exceptional in every way.
Duke of Gloucester	The Consultant and his first class surgical team were incredible, they kept me informed of everything that was to be worked upon, explained in detail what would happen and how I would be looked after. They were kind and comforting and I truly trust their work. This professionalism is complemented by the outstanding, attentive and kind nursing team and support staff who worked with compassion and enthusiasm throughout my stay. Every doctor, surgeon, nurse and support staff I came in contact with had a degree of professionalism and pride in their work that made me so relaxed and comfortable that I'm sure will truly aid my recovery. If this was a hotel it would get 5 stars and I would definitely stay again!! Thank you to all x
London Irish	The staff were very caring and lovely. I was looked after well by everyone. The nurses, my consultant, the anaesthetists and the porters! Everyone on DSU and the recovery ward. Faultless and brilliant care from everyone.
Private Care	The professionalism of the medical team and the environment. Everyone that I encountered was friendly and obliging. Nothing was too much trouble, they made me feel very cared for and safe.

Table 5.3.2.3: Trust Inpatient FFT Feedback Data 2022/23

Patient feedback about Outpatients service

OPD Stanmore	From the moment I arrived on site, everyone I came across was so lovely and helpful, particularly the buggy driver - I am a disabled badge holder and so appreciate the lift up the hill! and such lovely conversation too. The hospital is always clean and even in the older parts is kept up to date, the staff are incredible and it's all in all a fab hospital.
OPD Bolsover	Comfortable surroundings, appointment on time. The Consultant was kind, polite knowledgeable and efficient and answered all my questions.

Pre-operative Assessment	Wait time wasn't long at all and the advice and information received was clear and informative.
OPD Stanmore	The consultant and his team were very friendly and I was made to feel really at ease. They discussed my operation with me which I appreciated, I left the consultation feeling reassured and that I have total confidence in the team.
OPD Bolsover	The staff were all very friendly and helpful. I was very happy at the speed at which I was seen. Easy access from entrance to consulting rooms. Clean and fresh environment.
Pre-operative Assessment	A very friendly pre-assessment service, was welcomed by a very nice lady, who also offered me a drink of water, very clean.
OPD Stanmore	Nice and very courteous and friendly staff and an excellent consultant who made me relaxed and hopeful with his explanation of my problem and treatment modalities.
OPD Bolsover	Everyone has been incredibly friendly, especially the receptionist. You have made my day! I've been worrying about my appointment today for a long time, so thank you for making it better than I was expecting.
Pre-operative Assessment	At Pre-Admissions Clinic they were very friendly, helpful and efficient.
OPD Stanmore	The doctor knew my medical history and treated me as a whole, looking at all aspects of my health. All my questions were answered fully. I didn't feel rushed. Amazing and caring staff.
OPD Bolsover	Time taken to explain & check. All staff reassured me and I appreciate the time and resource committed to my care. Friendly and comfortable for all.
Pre-operative Assessment	I have never had such a friendly service and professional looking after me. Thank you all.

Table 5.3.2.4: Trust Outpatient FFT Feedback Data 2022/23

5.3.3 Staff recommendation of the Trust as a provider of care to their family and friends

The Trust considers that this data is as described for the following reasons; the data has been sourced from the official NHS Staff Survey.

Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. A total of 753 staff members completed the 2022 National Staff Survey at the Trust. The Trust had a response rate of 49%, slightly below the median response rate of the Acute Specialist Trusts (52%).

The Trust performance on this question is average against other Acute Specialist Trusts, which is an improvement from 2021 when we were slightly below average.

The Trust is proud of its Staff Survey results, which benchmark very well overall with other Acute Specialist Trusts and comparator Trusts in London. The focus of the Trust's response to the Staff Survey 2022 will include ensuring the Trust provides adequate support to develop our managers and leaders by addressing fundamental staff needs, such as access to the space and facilities they need to have a good work experience.

Indicator	RNOH 2020	RNOH 2021	RNOH 2022	National Average for Acute Specialist Trusts (2022)	Highest Score for Acute Specialist Trusts (2022)	Lowest Score for Acute Specialist Trusts (2022)
The percentage of staff employed by, or under contract to the Trust, during the reporting period, would recommend the Trust as a provider of care to their family or friends	89.6%	86.9%	86.5%	86.5%	92.5%	71.6%

Table 5.3.3.1: 2022 NHS Staff Survey (Working together to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com) - Accessed 12.05.23)

5.3.4 Complaints

Compliments, comments, complaints and feedback from patients, carers and the public are encouraged and welcomed. RNOH is committed to providing an accessible, fair and effective means of communication for those who wish to express concerns about the care, treatment or service provided by the Trust. The Trust recognises that the information derived from complaints and concerns provides an important source of data to help make improvements in hospital services. When things do not go as planned, they can act as an early warning of failings in the system and processes which need to be addressed or changed. This plays a key role in improving service quality and the patients' experience.

We report on performance, activity and on lessons learned or changes made as a result of a complaint. We have an excellent track record of acknowledging all formal complaints within two working days. Whilst there was no defined target nationally in 2022/23 the Trust aimed to respond to complaints in 25 working days. However, if the complaint was complex, the complainant was kept informed, and a mutually agreed date was set.

In 2022/23 RNOH received 187 formal complaints compared with 124 in 2021/2022. There has been an increase in the number of complaints received which averages around 16 complaints per month from 10 per month the previous year. The increase in the number of complaints has presented a challenge for the complaints team and clinical colleagues in terms of workload and timely responses. The majority of complaints related to communication, attitude of staff, access to services (cancellation and rebooking of appointments or procedures) and clinical management.

The Heads of Nursing, Operations, Divisional Clinical Directors and managers are responsible for ensuring that an investigation is undertaken and for responding to complaints made in their respective areas. All formal complaint responses are reviewed initially by the Deputy Director of Quality, then the Chief Nurse or Director of Allied Health and signed by the Chief Executive. Complaints are discussed at the Divisional monthly meetings, and the learning from complaints is included in the quarterly Complaints and PALS report to the Integrated Governance and Risk Committee and the People Committee. Non-Executive Directors.

What we achieved in 2022/23:

- Rolled out a comprehensive Complaints E-Learning course to improve staff confidence in managing and responding to feedback, comments, concerns and complaints.
- Continued to ensure patients/relatives/carers have full access to making a complaint, compliment or PALS. This includes all of the information provided on the Trust's web pages for this service and any interaction with users of the service.
- Supported the Trust in preparation for a national Complaints Standards Framework currently in development by the Parliamentary & Health Service Ombudsman.
- Continued to work on the quality of complaint responses to ensure they meet the needs of the recipient.
- Continued to work with the divisions to reduce internal response times.
- The complaints team continued to make early contact with complainants to pursue informal resolution of complaints.
- Weekly meetings were set up with the Divisions to discuss the status of the complaint.
- Updated Complaints Policy to include the process for making a complaint by a private patient.

- A review process is in place to evaluate the consistency, tone and sensitivity of the response.
- Lessons learnt by the Trust continue to be included in the response letter and any improvements made as a result are shared with the complainant.

Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2022-23, no complaints were referred to the PHSO, compared to 1 during 2021-22.

5.3.5 Patient Advice and Liaison Service (PALS)

The PALS team provide a point of contact for patients, families and carers and offer confidential help, advice, support and information. During the last year, the PALS Team has continued to ensure that individual concerns, whether these are from patients, relatives or their representatives were addressed promptly and effectively, and the appropriate actions are taken by Trust staff to resolve those concerns and improve services for the future. The PALS and Complaints team work alongside the staff in each of our divisions to ensure that patient concerns are heard and responded to.

During 2022/23, the PALS team dealt with 2,493 PALS enquires compared with 2,068 in 2021/22, which is an increase of 20%. There are many potential reasons for the increase in PALS contacts, for example, being unable to easily contact departments at the Trust, telephones not being answered, concerns about increasing waiting times, cancellation of operations/appointments and an increase in general enquiries.

Complaints and PALS reports, on a quarterly basis, are presented to the People Committee and are reviewed by the Executive Team and Non-Executive Directors.

5.4 Maintaining Continuous Quality Improvement

5.4.1 Improving Seven Day Hospital Services

The Seven Day Services Programme was introduced in the NHS to improve outcomes for patients who are admitted to hospital as emergencies at weekends. The programme aims to '*ensure patients admitted as an emergency receive high-quality consistent care, whatever day they enter hospital*'³.

In 2013, ten clinical standards were developed by the Seven Day Services Forum, in collaboration with the Academy of Medical Royal Colleges (AoMRC). These standards define what seven-day services should achieve, no matter when or where patients are admitted, to end the variation in outcomes. Four of the ten clinical standards were identified as priority clinical standards, based upon the potential to positively affect patient outcomes – these are as follows:

- **Standard 2: Time to first consultant review**

³ Source: NHS England (2017). <https://improvement.nhs.uk/resources/seven-day-services/>

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant, as soon as possible, but at the latest within 14 hours from the time of admission to the hospital.

RNOH has very few incoming emergency transfers but does accept emergency admissions for:

- Spinal trauma
- Spinal Infection
- Metastatic Spinal cord compression
- Admissions from the outpatient clinic
- Urgent inter-hospital transfers

All emergency admissions are accepted/transferred to RNOH under the care of a named consultant. The admitting consultant and ITU - site/outreach team, carry out a thorough risk assessment.

RNOH has a 24/7 consultant on call for ITU (both adults and children) with the provision for a patient to be seen by a consultant within 14 hours. Critically unwell inpatients are triaged for emergency admission to on-site HDU/ITU or transferred to another ITU or specialist centre if clinically indicated.

- **Standard 5: Access to diagnostic tests**

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

RNOH currently offers 24/7 access to the following consultant directed MSK diagnostic imaging services: Ultrasound, CT, MRI and urgent interventional procedures under imaging guidance. This arrangement is supported by a 24/7 radiographer cover. A Consultant Radiologist is on call 24/7 and accessible through the switchboard.

Urgent Non MSK scans/ opinions are currently reported via outsourcing to external companies. Microbiology and Echocardiography are provided via the Royal Free Hospital and are a 24/7 service.

- **Standard 6: Access to consultant-directed interventions**

Hospital inpatients must have timely 24-hour / seven days a week access to key consultant-directed interventions that meet the relevant speciality guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

RNOH is a tertiary, primarily elective, orthopaedic centre. We have on-site provision for the emergency services required regularly. RNOH maintains several formal service level agreements with outside providers for services where we require a regular on-site component or where the provision of services differs from the provider's usual referral pathway.

We continue to review our outside provider contractual arrangements and have a dedicated working group that proactively reviews our supplementary clinical services to continuously improve the governance framework around the services we formally contract. The Supplementary Clinical Services Governance Group also works to improve access to outside medical services for all staff by defining preferred providers and routes of escalation for commonly required services.

- **Standard 8: Ongoing review by a consultant twice daily if high dependency patients, daily for others**

All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients who are directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

All patients with high dependency needs at RNOH are managed in an appropriate setting or are transferred to HDU/ITU when clinically appropriate. All patients in HDU/ITU are seen on twice-daily consultant ward rounds, which take place on weekdays and weekends.

Patients are discharged from critical care only when it is considered appropriate by the ITU consultant, which requires that the patient no longer needs daily consultant review by an ITU consultant. If there are any concerns, then they will be reviewed by a critical care outreach nurse who has direct access to both the ITU SpR and Consultant if they need to escalate the level of care or seniority of review.

There is an outreach system from HDU to review any potential at-risk patients across the hospital. This is led by the medical and nursing team daily and at weekends.

RNOH has a 24/7 Consultant on call for ITU (both Adults and Children) with the provision to attend the patient within 14 hours of their admission to ITU/CHDU.

Weekday and weekend ratio data for mortality, length of stay, and readmissions confirm good performance for non-elective cases admitted on weekends.

In response to these clinical standards, the RNOH has designed a pathway in collaboration with medical, nursing, AHP and operational staff. Every six months the Trust participates in a self-assessment of performance, organised

by NHS England. The results of the self-assessments completed during 2022/23 are outlined in the table below (5.4.1.1):

Self-Assessment Results

The self-assessment for 2022/23 identified that the Trust met all 4 standards for both weekdays and weekends.

	Weekdays				Weekends			
	Standard 2 (>90%)	Standard 5 (>90%)	Standard 6 (>90%)	Standard 8 (>90%)	Standard 2 (>90%)	Standard 5 (>90%)	Standard 6 (>90%)	Standard 8 (>90%)
Spring/Summer 2022 Self-Assessment	Met	Met	Met	Met	Met	Met	Met	Met

Table 5.4.1.1 Seven Day Services Spring 2023 Data

RNOH considers this data as described for the following reasons:

- The Trust follows the national guidance & methodology for completing the self-assessment and completed a standardised national template to assess our performance against the four standards
- The self-assessment is assured by the Trust Board
- Data is submitted to and reported by NHS England

5.4.2 Medical Rota gaps

The Foundation Equivalence/ Foundation year 3 are recruited locally with high fill rates and close working with NHS Professionals as a Foundation Equivalence Programme (FEP) site. There are rarely rota gaps and these are managed via bank backfill if needed. There has been a continued year on year reduction in agency use and spending since the introduction of the FEP in 2020.

Middle grade doctors allocated via HEE are as follows:

Speciality	WTEs	Grades
Anaesthetics	12	ST5–ST8
Core Surgical Trainees	4	CT1-CT2
Histopathology	1	ST3-8
Paediatrics	2	ST3-8
Rehab Medicine	3	ST3-8
Rheumatology	1	ST5
Trauma & Orthopaedics	22	ST3-8

Table 5.4.2.1 Middle grade doctors allocated via HEE

The resourcing team checks the Health Education England grids 12 weeks in advance of the rotation date and sends an email to the departments to state who is coming to them (New/Extensions) and the gaps. The departments then have options to recruit to the gaps (sometimes there are already doctors on fixed term contracts that could be extended for example). The recruitment timeline for UK recruited

doctors is less than 2 months and if outside of the UK then the recruitment could take a maximum of 3 months. Visa issues can unfortunately extend this considerably on occasion. There is also the option to have Locum/Bank doctors fill the gaps. The resourcing team shares the new joiner details and manages the recruitment with the departments for any gaps 12 weeks in advance and the medical education team organises the induction nearer the time of rotation.

Over the last year, the following posts have been unfilled:

	GAPS	SPECIALTY	GRADE
Aug-22	3	Anaesthetics	ST3+
	1	Rehabilitation Medicine	ST3+
Sep-22	2	Paediatrics	ST3+
Oct-2022**	1 to 2	Trauma and Orthopaedic Surgery	CT1-2
	3 to 4	Trauma and Orthopaedic Surgery	ST3+
Nov-22	3	Anaesthetics	ST3+
Dec-22			
Jan-23			
Feb-23	2	Anaesthetics	ST3+
	1	Histopathology	ST3+
Mar-23	2	Paediatrics	ST3+
Apr-23	1	Trauma and Orthopaedic Surgery	CT1-2
	4	Trauma and Orthopaedic Surgery	ST3+
May-23	3	Anaesthetics	ST3+
Jun-23			
Jul-23			

Table 5.4.2.1 Unfilled posts to year

	No rotations
**	Approx number

It should be noted that these apparent gaps are filled by local recruitment albeit at short notice which may need to additional bank spend.

The Guardian of Safe Working Hours reports on work schedule reviews with particular regard to any adverse impact on educational opportunities or excessive workload. These reports are presented directly to the Trust Board quarterly. The 2022-23 reports show one quarter in one rota in the Spinal Cord Injury service where a gap resulted in excess workload and longer hours worked for an individual doctor. This was raised and the Guardian of Safe Working agreed to additional time in lieu. The Trust has not been subject to any fines and there have been no further examples of rota gaps usually managed in the service with either local recruitment when timelines allow or locum/ bank use.

There are continued issues with recurrent gaps in allocation e.g. anaesthetics which are covered by additional shifts and local recruitment to Fellow posts which are highly sought after.

The Medical Directorate and Postgraduate Education Department review rotas annually as recurrently unfilled slots may need escalation to HEE or consideration of conversion to local fill. Following a discussion with HEE and the School of Surgery, one recurrently unfilled core trainee post was converted to a local specialist doctor post in 2021-22 since when it has had a 100% fill rate. No other posts have been given up or converted and no other issues have been escalated by the Guardian to the Board.

5.4.3 Implementation of Duty of Candour

When clinical incidents occur, they can have a real and deep impact on people's lives. Regardless of the level of harm incurred, patients and families have a right to receive a meaningful apology and explanations for what happened as soon as possible.

The professional duty of candour is a moral and legal responsibility to be open and honest with patients and families when something that goes wrong with their treatment or care causes or has the potential to cause, harm or distress. This includes saying sorry and taking action to put things right where possible. It is always the right thing to do and is not an admission of liability.

The statutory Duty of Candour is laid out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which puts an overarching legal duty on health and social care providers to be open and transparent with people using services, and their families, about their treatment or care. It is overseen by the Care Quality Commission or CQC.

As well as the overarching duty, regulation 20 also sets out some specific actions that providers must take when a notifiable safety incident occurs.

A 'Notifiable safety incident' is a specific term defined within the duty of candour regulation and should not be confused with other types of safety incidents or notifications. A "notifiable safety incident" must meet all of the following specific criteria:

- It must have been unintended or unexpected
- It must have occurred during the provision of activity the CQC regulates
- In the reasonable opinion of a health care professional, the notifiable safety incident could, or already appears to have, resulted in death, or severe or moderate harm to the person receiving care. This includes prolonged psychological harm

Under the Duty of Candour requirements clinical professionals should:

- speak to a patient, or those close to them, as soon as possible after they realise something has gone wrong with their care that appears to have caused or has the potential to cause moderate/significant harm

- apologise to the patient – explain what happened, what can be done if they have suffered harm and what will be done to prevent someone else from being harmed in the future
- provide an account of the incident which, to the best of the provider’s knowledge, is true of all the facts the body knows about the incident as of the date of the notification
- advise the relevant person what further enquiries the provider believes are appropriate
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries
- Keep a written record of all communication with the relevant person

At RNOH, there are robust policies and procedures in place to ensure staff understand their responsibilities. Senior managers are educated on the fundamentals of compliance with the duty of candour. Managers are expected to demonstrate that they have a safe culture where staff feel able to speak up and are supported to carry out the duty of candour as appropriate. The Duty of Candour is captured and monitored via the incident reporting system Ulysses. When triggered, the system prompts the responsible division to ensure the Duty of Candour letter is uploaded to the system as soon as practicably possible. Compliance with a verbal duty of candour is achieved only once documented on Ulysses. The Patient Safety Team through a monthly audit of the incidents management system monitors compliance. Non-compliance is flagged up via the monthly Quality Report, Incident Management Report and the Balanced Scorecard.

RNOH clinicians are exemplary at having Duty of Candour discussions with patients who have suffered levels of harm. The Patient Safety team follows up with clinical teams to ensure the Duty of Candour requirements are fulfilled.

The Trust continues to work at improving the timeliness of written Duty of Candour letters to patients and their families, where appropriate. There is ongoing education and training by the Patient Safety Team to support staff and instil confidence amongst all staff groups around the appropriate steps required in undertaking the mandatory duty of candour processes in line with the local and national policies.

5.4.4 Details of ways in which staff can speak up

Freedom to Speak Up Guardians

RNOH is committed to supporting a robust speaking up culture within the Trust, which is viewed as a key component of patient safety. Since 2017 the Trust has developed the Freedom to Speak Up Guardian Service, which now consists of a Freedom to Speak Up Guardian (FTSUG) and six Champions who are supported by a Non-Executive Director. The Freedom to Speak Up Guardian will continue to strengthen relationships with senior leaders and the Board, to raise awareness and champion the role within the Trust.

The Guardian aims to make positive changes within the Trust through the provision of a confidential safe space for staff to talk through and raise concerns relating to

patient safety, staff experience and /or bullying and harassment. The FTSUG is also responsible for:

- raising awareness about and actively encouraging the development of speaking up culture
- meeting regularly with senior leaders; in particular, the Board Speaking Up representative, CEO and appropriate Non-Executive Directors, to share trends and ensure issues are responded to
- building relationships with key stakeholders
- promoting understanding and participating in speaking up pathways
- provide at least 6 monthly reports to the Board
- provide quarterly activity data to the National Guardian Office.

The main purpose of the FTSUG is to enable a culture of openness whilst protecting the individual raising a concern. Where possible, and if safe to do so, the FTSUG will maintain confidentiality to give the individual anonymity.

Other ways in which staff can speak up

At RNOH there are policies and procedures in place to ensure that staff feel safe and can voice their concerns. Staff are also supported and encouraged to raise concerns by:

- Speaking to their line manager or another senior manager
- Raising an incident form
- Speaking to members of the People Directorate
- Speaking to a Union representative

At RNOH we try to ensure that we always close the feedback loop when staff raise concerns, whether that is through formal processes, such as our Incident Reporting system, or through informal channels, such as the Freedom to Speak Up Guardian. It is clear within our Speaking Up Policy that staff should not suffer detriment as a result of speaking up, this runs counter to our aim to build transparency and a focus on patient safety. The Guardian is obligated to raise concerns to the Trust Board about any detriment suffered by a staff member for raising concerns.

Appendix 1: Statements of Assurance from Key External Stakeholders

A. Statement from NHS England Specialised Commissioning – London Region

To follow

B. Statement of assurance from Harrow Healthwatch

To follow

C. Statement of assurance from Harrow Overview and Scrutiny Committee (OSC)

To follow

Appendix 2: Statement of Directors' Responsibilities in Respect of the Quality Accounts

Glossary and abbreviated terms

AHP	Allied Healthcare Professionals
AMR	Antimicrobial Resistance
APS	Acute Pain Service
BESS	British Elbow and Shoulder Society
CAUTI	Catheter Urinary Tract Infection
CCG	Clinical Commissioning Group
CD	Controlled Drugs
C.diff	Clostridium difficile
CEO	Chief Executive Officer
CHDU	Children's High Dependency Unit
CMP	Case Mix Programme
CNS	Clinical Nurse Specialist
CoPAT	Complex Oral Outpatient Antimicrobial Therapy
COSHH	Control of Substances Hazardous to Health
COVID-19	Coronavirus Disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSP	Chartered Society of Physiotherapy
CT	Computerised Tomography
DOB	Date of Birth
DLT	Divisional Leadership Teams
DNA	Did not attend
DPST	Data Protection Security Toolkit
DTC	Drugs and Therapeutic Committee
ECOG	Eastern Cooperative Oncology Group
EMIS	Egton Medical Information Systems
ePMA	Electronic Prescribing and Medicines Administration
EPRR	Emergency Preparedness Resilience and Response
EQ-5D Index	Standardised patient reported outcome measure in knee and hip operations
EQ-VAS	Standardised patient reported outcome measure in knee and hip operations
EU	European Union
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian
GDPR	General Data Protection Regulation
GP	General Practitioner
HFE	Human Factors and Ergonomics
HMMC	Hertfordshire Medicines Management Committee
HMS	Homecare Medicines Service
HOHA	Hospital Onset Healthcare Associated
HTA	Human Tissue Act
HQIP	Healthcare Quality Improvement Partnership
ICNARC	Intensive Care National Audit and Research Centre
ICU	Intensive Care Unit
IG	Information Governance
IGRC	Integrated Governance and Risk Committee
IP	Independent prescribing
IPC	Infection Prevention and Control
IRG	Incident Review Group
ISS	Facilities support services company

IT	Information Technology
IV	Intravenous
LfE	Learning from Excellence
MAGEC Rod	Magnetic Expansion Control Rod (Surgical Scoliosis Treatment)
MHRA	Medicines and Healthcare Products Regulatory Agency
MRI	Magnetic Resonance Imaging
MDT	Multidisciplinary Team
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCL	North Central London
NCL JFC	North Central London Joint Formulary Committee
NEIAA	National Early Inflammatory Arthritis Audit
NHS	National Health Service
NHSE	NHS England
NHSEI	NHS England and Improvement
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NPSA	National Patient Safety Agency
NRLS	National Reporting & Learning System
OPAT	Outpatient Parenteral Antibiotic Therapy Service
OPD	Outpatient Department
OSC	Overview & Scrutiny Committee
OT	Occupational Therapy/Therapist
OVIVA	Oral vs. IV Antibiotic
PALS	Patient Advice Liaison Service
PAT	Pets as Therapy
PCA	Pain Controlled Analgesia
PDS	Personal Demographics Service
PIR	Post Infection Review
PNI	Peripheral Nerve Injury
POA	Pre-Operative Assessment
PROMs	Patient Reported Outcome Measures
PSI	Patient Specific Instruments
PT	Physiotherapist/Physiotherapy
PQIP	Perioperative Quality Improvement Programme
PU	Pressure Ulcer
QI	Quality Improvement
RAG	Red Amber Green
RBF	Rate based enteral feeding
RCA	Root Cause Analysis
RCN	Royal College of Nursing
REC	Research Ethics Committee
RNOH	Royal National Orthopaedic Hospital NHS Trust
RPS	Royal Pharmaceutical Society
SAFE Patient Care	Stanmore Accreditation for Excellence in Patient Care
SD	Satellite Dispensed
SEU	Shoulder & Elbow Unit
SHOT	Serious Hazards of Transfusion
SI	Serious Incident
SOP	Standard Operating Procedure
SSI	Surgical Site Infection
SUS	Secondary Uses Service

THR Total Hip Replacement
TSB The Stanmore Building
TTA To take away medicines
UK United Kingdom
VTE Venous Thromboembolism
WHO World Health Organization