NHS

Royal National Orthopaedic Hospital

NHS Trust

QUALITY ACCOUNT

2016/17

NO never events during 2016/17

Rated as one of THE TOP 100 places to work by the HSJ

Increase of **100%** in flu vaccination uptake

95% of outpatients **would** recommend the hospital to their friends and family

99.8% patients were assessed for life-threatening blood clots

Maintaining good performance in avoiding **C.difficile cases** with only **2** incidents this year

Over **134,000** outpatient ATTENDANCES

96% of in-patients **would** recommend the hospital to their friends and family

CONTENTS

1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE 5

2 INTRODUCTION 7

2.1 About the RNOH
2.2 What is Quality?
2.3 The Quality Account
2.4 Quality Highlights of 2016/17
2.5 Val-You Campaign
2.6 Pharmacy and Medicines Optimisation 2016/17

3 PROGRESS AGAINST 2016/17 PRIORITIES 25

3.1 Priority 1: Improving patients' health before surgery in order to improve post-surgical outcomes
3.2 Priority 2: Reducing illness or injury associated with surgery, in particular injury of the kidneys
3.3 Priority 3: Implementation of a programme of exemplar discharge
3.4 Priority 4: Enhancement of shared learning from incidents and complaints
3.5 Priority 5: Focus on customer care and service across the Trust to deliver a positive patient experience

4 QUALITY PRIORITIES FOR 2017/18 AND STATEMENT OF ASSURANCE FROM THE BOARD 35

4.1 Quality Priorities in 2017/18
4.1.1 Priority 1: Improving Length of Stay
4.1.2 Priority 2: A focus on gram negative infections
4.1.3 Priority 3: Reducing Request Errors
4.1.4 Priority 4: Enhancement of Shared learning from Incidents and Complaints
4.1.5 Priority 5: Development, Implementation and evaluation of 5 local safety standards in Invasive Procedure

4.2 Statements of Assurance
4.2.1 Review of services
4.2.2 Participation in clinical audits
4.2.3 Participation in clinical research
4.2.4 Use of the CQUIN payment framework
4.2.5 CQC registration and compliance
4.2.6 Data quality
4.2.7 NHS number and General Medical Practice Code Validity
4.2.8 Information Governance Toolkit attainment levels
4.2.9 Clinical coding error rate

CONTENTS

5 REVIEW OF QUALITY PERFORMANCE 69

5.1 Patient Safety Measures
5.1.1 Venous thromboembolism (VTE)
5.1.2 C Difficile infection
5.1.3 Patient safety incidents
5.1.4 Pressure ulcers
5.2 Clinical Effectiveness Measures
5.2.1 SHMI
5.2.2 PROMs
5.2.3 Emergency readmissions within 28 days
5.3 Patient Experience Measures
5.3.1 Responsiveness to personal needs
5.3.2 Friends and Family Test (Patients)
5.3.3 Friends and Family Test (Staff)
5.3.4 Complaints
5.3.5 PALS
5.4 Maintaining Continuous Quality Improvement
5.4.1 Implementation of Duty of Candour
5.4.2 Safety Improvement Plan
5.4.3 WRES results for KF21 AND KF26
5.4.4 Our CQC results

APPENDIX 1 93
Statements from NHS England Specialist Commissioning, Harrow Health watch & Harrow Health and Social Care Scrutiny Sub-Committee

APPENDIX 2 95
Statement of directors' responsibilities

APPENDIX 3 96
External audit limited assurance report

GLOSSARY 99
Terms and abbreviations

1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Delivering high quality care for all for the RNOH patients remains the key focus of the organisation. I continue to be impressed by the dedication and enthusiasm of the staff at the RNOH who always strive for the highest standards of care for our patients. I commend the determination and commitment of those staff who work tirelessly to ensure that we make improvements to our services, particularly when we recognise that things have gone wrong.

We know that the highest quality of care is delivered by motivated and happy staff. We are committed to improving the experience of our staff at RNOH to ensure that they can improve the safety and experience of our patients. In 2016/17 we have seen really significant developments with the development of our Val-You Charter which we know will help to support our staff to deliver clinical excellence for all our patients.

We are thrilled to see the progress that has been made with the redevelopment of the site since last summer. The opening of this new inpatient building will ensure that we are able to deliver high quality care in a setting that our patients and staff deserve. We plan to be able to open the building to inpatients in 2018.

Financially the RNOH, like many other NHS Trusts, are facing significant Financial challenges. However, our goal for 2017/18 is to be a world leading orthopaedic hospital with the best patient care and staff experience in the NHS.

I confirm to the best of my knowledge that the information contained in this report is accurate.

ROB HURD
CHIEF EXECUTIVE
June 2017

NEW INPATIENT WARD BLOCK

Construction of the new inpatient ward block began in August 2016 and is set to be completed and open in autumn 2018.

The brand new building will mean the RNOH are able to offer patients the very best ward facilities and allow staff to work in an environment that matches their skill and dedication. The major portion of the project will be funded from a land sales receipt when the surplus land on the West of the site is sold for residential redevelopment.

The Inpatient ward building will accommodate a 27 bed Children and Young People's Ward with embedded therapy and education functions and an external play area to replace the current paediatric ward beds.

There will also be new Adult Acute Wards comprising 64 beds over two floors, with embedded therapies to replace several of the current outdated adult wards.

Alongside the clinical spaces, the new block will include a main entrance that will provide reception and waiting space, in addition to a retail outlet, coffee shop and a children's activity center which will be fitted with a range of toys, games and interactive technological equipment for our pediatric patient's and their families, funded from a charitable donation of £5000,000

2 INTRODUCTION

2.1 The Royal National Orthopaedic Hospital

The Royal National Orthopaedic Hospital is the UK's leading specialist orthopaedic hospital. 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 sufferers.

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

Over 20% of all UK orthopaedic surgeons receive training at the RNOH, and our patients benefit from a team of highly specialised consultants, many of whom are internationally recognised for their expertise.

The RNOH has a long track record of innovative research, and our research projects are pertinent to patient needs. Research is 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 new devices and treatments for some of the most complex orthopaedic and musculoskeletal conditions.

2.2 What is Quality?

High quality care in the NHS means patients have a good overall experience of care which is clinically effective and delivered safely. An organisation committed to delivering high quality care is one which is always striving to be even better. The RNOH is 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 different ways including comparison with our peers through participation in National 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 our own best practice guidelines. This helps us understand more clearly what we do really 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 is care in which avoidable error and harm has been effectively removed. Safe care can be measured 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 focussed on improving the safety of care provided, we can expect to see high levels of incident reporting. Each incident report, whether or not it impacts a patient or staff member, provides further opportunity for quality improvement and learning within the hospital.

Ensuring that patients and their families have a good experience while at the RNOH is incredibly important to us. We continue to work to find better ways of enabling our patients to give us feedback on the ways in which we can do better. We were really pleased to be identified as the best Trust in the country for seeking views from our patients in the 2016 inpatient survey. We are committed to improving the care that we provide based on that feedback.

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 improving the quality of our care and being even better.

2.3 The Quality Account

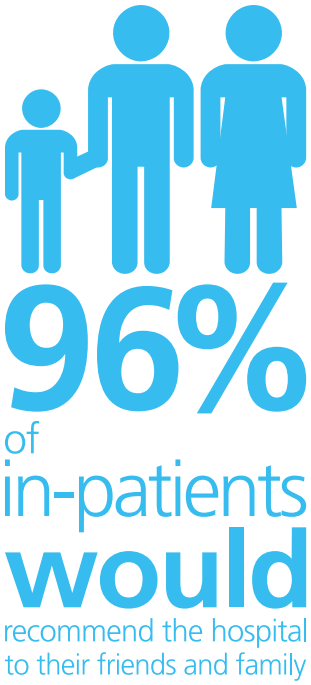
Every year the Trust is required to produce an account of the quality of the services it provides. The account is an important way for NHS services to provide information to the public about the quality of care it provides as well as demonstrating what work it is undertaking to improve services.

The 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 2017/18 as well as reviewing our progress against last year's priorities.

2.4 Quality Highlights of 2016/17

Over the past year, work has gone on around the Trust to improve the quality of our care and services. This section takes a look at some notable highlights in our quality improvement work in 2016/17:

- **Friends and Family Test Performance**
  We have maintained a really high level of approval from both our inpatients and outpatients. 96% of our patients would recommend our services to their family and friends.



- **Kate Granger Award**
  Zoe Keates, Play Specialist for Coxen Ward and Yoryd Khatri, Biomedical Team Lead were one of 9 finalists nominated for the Kate Granger award for their mini toy MRI which was designed to education and prepare young patients for their scan.

- **Introduction of the Buggy Service**
  Amongst many fantastic new interventions to improve patient experience at RNOH, 2016 saw the introduction of the 'Buggy Service', which involved 2 golf buggies moving our patients, many of whom suffer from mobility problems, across our large site.

- **First Gold 'I delivered great care' badge awarded**
  Maya Benny, a staff nurse on RNOH's Short Stay Unit was awarded the first gold 'I delivered great care' badge after receipt of 125 individual badges from patients she has cared for since the scheme began in February 2016. The badges are part of the RNOH patient Welcome Pack and are awarded by patients to members of staff who they feel have delivered great care to them during their stay.

Paul Fish, Director of Nursing, who presented Maya with her badge said:

> "Maya Benny has clearly made a massive impact on the patients which she has cared for on the short stay unit. To have received personal recognition from more than 125 patients is a great achievement and something which not only she is proud of, but something which we can all celebrate. Well done and thank you Maya."

- **First impressions project**
  A patient group led initiative focussed on the quality improvements which could be made to ensure that RNOH makes the best 'First Impression' when they attend site for the first time. This has led to some really great improvements to our estate in conjunction with the Director of Estates and his team.

- **Redevelopment started on new Inpatient Ward Block**
  Work finally began on our brand new building in August 2016 and it is set to be completed and opened by Autumn 2018.

- **Introduction of the RNOH Val-You charter**
  Following a Trust wide listening event in 2016, we have launched a new RNOH VAL-YOU charter which sets out our values and expectations of behavior and attitude for all our staff.

Volunteer Services
Funded by The RNOH Charity

Volunteer Service

The newly developed Volunteering department has grown and become embedded in the culture of the RNOH over the past year. The RNOH Charity fully fund Volunteer Services to improve the experience of patients. By working with the local community the RNOH are increasingly being seen as the preferred place to volunteer in the local community.

A new, distinctive logo was created and successfully used in a publicity and recruitment campaign across the Trust and into the local community.

We have developed excellent partnerships with Stanmore College, Harrow College, local U3A groups and local religious organisations to promote volunteering opportunities at the hospital. We aim to utilise the skills, knowledge base and personal characteristics of each individual and, due to our reach across the Trust, we can match the person to the available volunteers role to ensure both the volunteer and the area being supported are fulfilled.

Some of the feedback from our volunteers on their experience of volunteering

"Makes people feel valued and demonstrate caring, she encourages others to reach their potential by focusing on detail, empowering the team and giving them the autonomy to change things."

"The whole recruitment process was slick and professional. I was contacted quickly and the volunteering team really supported me. They are always friendly and approachable."

SW VOLUNTEER

Photography SIU

Working with the London Spinal Cord Injury Centre we have established a new photography project for tetraplegic patients. Running once a month, and led by a volunteer with a passion for photography, wheelchair users are encouraged to use their phones or i-pads focusing on picture framing and composition. New artwork is added to the displays around the department and allows our patients to develop a new skill during admission.

New Partnerships

Basilian, our on-site coffee shop, is happy to support Volunteering Services in offering a discount for all those "wearing the yellow". Many of our current volunteers have joined after seeing adverts in the coffee shop and the enthusiasm shown by Basil and his team for the work the volunteers do.

Meal Time Buddies

The results of the 2015 in patient survey suggested that there was scope for us to improve the support available to assist patients with their meals so the Volunteering Team worked with Mona Diamond ward and Duke of Gloucester ward to develop a meal time buddy programme. The meal time buddies help patients by ensuring hot meals are delivered in a timely manner, that the patients have all the condiments and cutlery they need and ensure that water, tea and coffee is available. In addition, volunteers are able to undertake shopping for newspapers and the odd bar of chocolate as well as a friendly smile and someone to talk to.

"The volunteer intuitively knew what I needed as I came round after my operation. I was hungry and very emotional. She was just "there" and organised just what I needed, when I needed it, with no fuss and such gentleness."

MEALTIME BUDDIES PATIENT NEED
Friends & Family Test - Inpatient feedback 2016

"The food needs to come around in a timely manner."

"Only let down was the cold meals when its supposed to be hot."

"There are not enough people/facilities to take care of food as lunch/dinner runs late and orders are frequently incorrect - if an order isn't there, ask patient for alternative don't just choose for them."

"We had cold toast, missing food, luke warm food and wrong food. When you are using so much physical and emotional energy, food is an important part of restoring that energy - and Seyhan was fabulous at getting this right. It was stressful at meal times when she was not here because you never knew what you were getting or how it was going to be served or when!"

"My only complaint - food sometimes a little bit cold."

"Really could have had a little [help] opening packets with food especially if you have one operable arm."

"The only thing I would improve is the food. Often you would order one thing and another thing would arrive. How the kitchen staff are meant to get out all the food in one hour with the facilities they are provided is a joke."

"There are certain times during the day when extra staff were needed. Some patients needed help with feeding. It is the little things that matter, putting food & drink in right place for example."

MEALTIME BUDDIES PATIENT FEEDBACK

Since the introduction of the project, this is some of the great feedback for the mealtime buddy service.

"I feel like I have really worked hard for the patients today."
VOLUNTEER FEEDBACK

"Kelly intuitively knew what I needed as I came round after my operation. I was hungry and very emotional. She was just "there" and organised just what I needed, when I needed it, with no fuss and such gentleness."

"Volunteers coming onto the ward in this role have provided welcome support to patients, staff and ISS Housekeeping staff. Previously, volunteers only visited the patients to chat and so it was sometimes difficult for them to approach a patient. This new role of Mealtime Buddy gives the volunteers a more defined purpose and makes it much easier to connect with patients, as their role provides such an important service."
MONA, WARD MANAGER

"You were just there when I needed you, somebody to help and bring me just what I needed."

"The patients are really appreciative of our help, I feel I am making a real difference with the help I give."
VOLUNTEER FEEDBACK

"After everything RNOH have done for me over the years, it is nice to be able to give something back!"
VOLUNTEER FEEDBACK

"For an hour you took me out of myself and I forgot where I was. Lovely to meet you."

The Volunteer Patient Buggy Service

Successfully launched in July 2016 the patient buggy service has grown in popularity Our ten cheery volunteers operate the two golf buggies Monday to Friday in all weathers. They are often the first point of contact our patients and visitors have with the hospital.

Transporting over 1000 visitors a week, over some challenging terrain, our golf buggies have become an integral part of the hospital and their contribution was recognised in the staff awards.

> “I did not expect to feel the personal satisfaction and get so much back from volunteering.”

PATIENT BUGGY SERVICE MEASURING SUCCESS
Friends & Family Test - Outpatient feedback 2016/17

This is some of the feedback from patients which highlighted the need for improvement.

"Excellent service buggy from car park"

"Been coming here for 20 years, many improvements have been made over this time. Of late the 'Buggy' taxi system."

"The assistance from car parks to people who require it, is amazing."

"Buggy service to offer lift, I thought that was good."

"Brought up on buggy trolley from Eastgate house to outpatient also used from OPD to car park. Really contented"

ART THERAPY PROGRAMME PATIENT NEED
Friends & Family Test
- Inpatient feedback 2017

What our patients say.

A patient who gave direct feedback to nursing staff on the ward explained that without Julie re-introducing him to art he would have struggled to manage his programme. He went home on the first weekend of the course and had a flare up and didn't know how to distract himself from his pain, he decided to draw something and this took his mind off the pain. He has now taken up drawing again as a form of distraction from his pain.

"I really admired the dedication of the volunteers at RNOH. The lady who greeted me and settled me in was so caring and competent. The art class was wonderful too. I have never had an interest in Art, but she made it so accessible that I now have a new hobby to aid relaxation."

"Found the art class really nice form of therapy as it really took away my focus from pain to painting which was a great relief. Please more therapies like this. Thank You."

2.5 VAL-YOU

At the RNOH, compassionate and excellent patient care has always been fundamental to our values and mission. As a Trust, we can be extremely proud of the quality of care and experience we provide and this quality account will demonstrate that on a number of measures we are truly a world-class orthopaedic hospital.

The main reason for safety and effectiveness of our patient services and treatment is the, skills and effort of our staff. It is through their devotion and dedication that the RNOH has the global reputation and quality of patient outcomes.

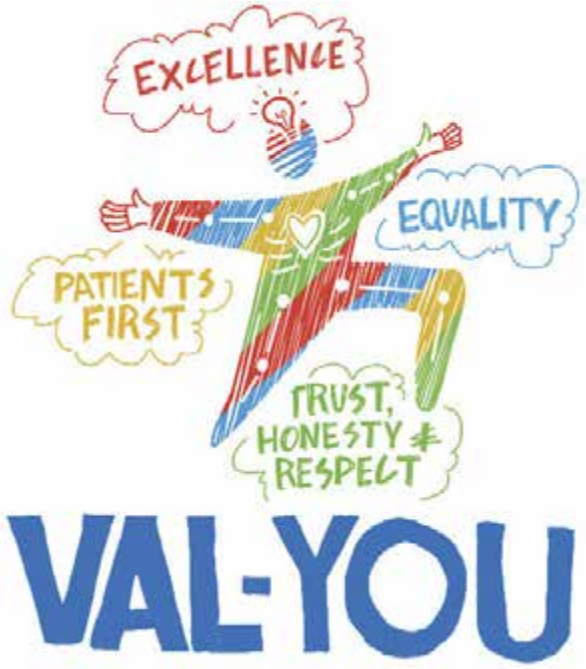
In the fourth quarter of 2016, the RNOH made a commitment to its staff to become the best place to work in the NHS. To make this goal a reality, the Trust launched 'RNOH VAL-YOU' as our concerted effort to enhance the experience our staff have at work and continue to improve the already excellent care we provide to our patients.

Essentially, we want to afford our staff with the same care and support we give to our patients every day.

Since inception, the RNOH VAL-YOU team have been busy speaking to staff about their experience at the Trust in an attempt to understand the great things about working at the Trust and the areas where we have room to improve. Using the language and stories from these discussions, staff defined the VAL-YOU 'Charter of Behaviours' to explain what our four Trust values – Patients first, Excellence, Trust, honesty and respect, and Equality – mean we want to see from each other every day. Staff also helped bring life to P.E.T.E (see below), our VAL-YOU mascot, and combined representation of our four Trust values.

The Charter of Behaviours was officially launched in February 2017 as a set of shared expectations of behaviour and attitude for staff. The challenge for the Trust is the process of embedding the charter into the language of the organisation so that everyone can appreciate when they see their colleagues living up to these principles and have constructive conversations on the occasions when we fall short of our usual high standards.

In addition to the creation of the Charter of Behaviours, the VAL-YOU campaign has been working on other ways to improve the experience of staff at the Trust. A summary of the key achievements of the programme are:



- Introduction of the 'Leadership Excellence Programme' the RNOH's first personalised leadership development programme for senior managers and clinicians
- Launch of two 'staff recognition awards' to appreciate individuals and team for demonstrating our Trust values and contributions to patient care, staff experience and teamwork
- Successful application to host a 'Darzi Fellow' to raise the capability of future clinical leaders
- Appointment of the RNOH's first 'Freedom to Speak Up Guardian' whose role is to support staff who raise concerns, questions or feedback about working at the Trust
- Concerted marketing of the ways staff can both formally and informally raise concerns, suggest improvements and offer feedback
- Running of a 'health and wellbeing day' to promote the internal and external support available to staff
- Highly successfully delivery of a 'Diversity Festival' to celebrate equality and inclusivity of staff from across the Trust
- Improved the visibility and approachability of executive leaders by revitalising 'back-to-the-floor', 'executive clinics' and 'open forums'

For more information about RNOH VAL-YOU and our work to become the best place to work in the NHS please visit the RNOH's website, internal grapevine page (for staff only) or email VALYOU@rnoh.nhs.uk

2.6 Pharmacy and Medicines Optimisation 2016/17

The RNOH Pharmacy continues to ensure high quality medicines optimisation for patients. Medicines optimisation is about ensuring that the right patients get the right choice of medicine at the right time. This helps improve patient outcomes, ensure patients take their medicines correctly, avoid taking unnecessary medicines, reduce medicines wastage and improve medicines safety.

Some of the ways in which this continues to happen is through:

Medicines safety

Medicines have the potential to cause harm to patients, and medicines optimisation aims to improve medicines safety. Also, in the unfortunate event that mistakes have been made by staff, patients are informed, and apologies for the mistakes offered. It is important to learn from these mistakes and incidents. The RNOH has a medicines safety committee which meets monthly, where medicines-related incidents are discussed, trends found, and steps taken to prevent such incidents recurring. The committee comprises of pharmacists, doctors, nurses and the RNOH patient safety team. In 2016 – 17 we helped identify trends in medicines-related incidents involving controlled drugs. We put additional training into place for doctors, nurses and pharmacy staffs, reviewed the use of some controlled drugs, and have seen a reduction in such types of incidents from occurring.

Medicines Safety Newsletter

Publication of this newsletter twice a year provides staff with updates on medicines-related issues, with a focus on local developments in order to improve medicines safety for patients.

RNOH Formulary

A list of medicines that have been approved for use at RNOH is available for patients and staff alike to access. It is web-based, and can be accessed at www.rnohformulary.nhs.uk

It is updated on a monthly basis and is the output of the quality and governance processes around introducing new medicines and reviewing existing medicines used by RNOH staff in treating our patients.

We also work closely with other hospitals and CCGs local to us in ensuring high quality medicines-related services are provided and the quality and governance forum through which we do this is known as the North Central London Joint Formulary Committee (www.ncl-jfc.org.uk)

Medicines optimisation clinics and telemedicine clinics

Pharmacy, work closely with the rheumatology department in ensuring medicines optimisation for patients seen by the rheumatologists. The medicines used by rheumatologists often require close monitoring of the patient, and have the potential to cause unpleasant side effects for patients. Once the doctor has seen the patient and recommended treatment, the pharmacist will see the patient and ensure the patient understands what side effects to look out for, how to administer the medicine, how to store it, how to obtain repeat prescriptions from the hospital amongst other aspects. The feedback from patients is extremely positive, and patients now call and speak directly to the pharmacist about any problems or concerns they have. These clinics have seen improved outcomes for patients and closer working relationships between the RNOH rheumatology department and pharmacy in ensuring safe and improved patient care.

In order to ensure patients have ongoing access to medicines and advice, and to closely monitor for adverse effects, pharmacists and pharmacy technicians also now routinely undertake telephone clinics in specific clinical areas of care e.g. in the treatment of chronic pain patients, long-term treatment of patients with bone infections. Through this work the RNOH ensures that harm to patients from medicines is avoided and reduced, and outcomes for patients continue to improve.

In the coming year(s), RNOH patients will also be able to access advice through a dedicated medicines helpline.

Pre-assessment medicines optimisation

The RNOH has employed a specialist pharmacist who works with the staff in our pre-assessment clinics, in ensuring patients are provided with the right advice relating to stopping and starting medicines in preparation for surgery (e.g. anticoagulation, diabetes medicines etc), discussing concerns or issues patients have as regards their medicines and the surgical procedure, for some patients prescribing the medicines in advance of patients and supporting patients in continuing to take their medicines as intended. The pre-assessment team actively promote and encourage patients to bring their medicines with them for their hospital admission, and use the 'green bag scheme' (www.mymedicinesmyhealth.org.uk) to help patients do so. Research demonstrates that one of the biggest 'let-downs' for patients and medicines is in the 'interface' between hospital and primary care (GPs and community pharmacies). The pharmacist in the pre-assessment clinic aims to bridge this gap by enabling proactive communication

between the hospital and primary care, thereby minimising the impact of any medicines-related 'interface' issues that may occur after our patients are discharged from hospital.

Medicines optimisation by patients' bedsides

For inpatients who are admitted into hospital, pharmacists and pharmacy technicians are available on the wards to discuss any issues and concerns patients have as regards their medicines. For those patients who are staying overnight, the pharmacy staff reconcile the information between the GP, community pharmacy and patient, in ensuring that our patients have the correct medicines prescribed, such that our nurses can administer medicines to patients. They also make use of the 'green bag scheme' in ensuring that if a patient is moved from one ward to another then the patients' medicines are also moved. This helps ensure that medicines are available for patients to take as intended, and therefore optimise recovery time after your operation.

Self-administration of medicines

Patients take their medicines often by themselves before they come into hospital. Patients take their medicines often by themselves after they go home form hospital. So why do we not permit patients to take their medicines by themselves when they are in hospital? We answered this question by evaluating a pilot of 'self-administration' of medicines on our Jubilee Rehabilitation ward. And patients and nursing staff found this to be very useful. So we have in 2016 – 17 started to roll this out to other wards where patients are able to, want to, and can self-administer their own medicines.

The 2016 inpatient survey included a new question about patients being able to self-administer medication. Our performance was average compared to our peers but we hope to see this score improve in the 2017 survey on the back of our quality improvement interventions.

Improving the patient experience

Research, patient surveys and patient feedback all tell us that the one thing patients do not like doing is to wait around in hospital after they have been declared fit for discharge. We know that some of the delays are patients waiting for medical to be ready. In order to improve the patient experience around discharge, where possible, working closely with the doctors and nurses, the pharmacy team prepare your prescriptions on the wards such that any delays are avoided and minimised. They do this by using existing space in the treatment rooms and computers on the wards to make this happen. In 2017 we started a new pilot with our volunteering service to try to reduce the time it takes for medication to be brought from the pharmacy to the ward, as a result of the positive feedback from our patient we have rolled this out to almost all wards.

In the past years our patients have told us that waiting inside the pharmacy for their prescriptions is not a pleasant experience. We worked with RNOH charity to improve our patients' experience in entitling all patients using pharmacy a complimentary drink in the hospital restaurant. The feedback from our patients is that they really appreciated the drink, in having somewhere to sit down and provided a better experience for them and we therefore continue to offer this to our patients.

In 2017 we have started a new pilot with our volunteer's service to try to reduce the amount of time it takes for medications to be brought from the pharmacy to the wards. We really hope this has a positive impact on patient's discharge experience.


“I believe being a nurse for a living has great integrity. That to me is worth more than any other career can ever be.”

3 PROGRESS AGAINST 2016/17 QUALITY PRIORITIES

3.1 Priority 1

Improving patients' health before surgery in order to improve post-surgical outcomes

We know that patients who have their health maximised before they undergo surgical intervention have better postoperative outcomes with less complications. There are a range of factors that can improve outcomes, such as ensuring adequate Iron levels, cessation of smoking, control of weight or stabilization of blood glucose level.

Last year we committed to identifying best practice in relation to pre-surgical preparation and to implement a programme of work through our pre-operative assessment unit.

Over the past 12 months under the under the guidance of the Trusts consultant Anaesthetists, the RNOH have introduced interventions within the outpatient faculty, patients who are not responsive to oral iron Therapy can be pre-optimised in a timely manner without causing unnecessary delays to their surgery. The effectiveness of the use of intravenous iron enables a reduction in the use of donor blood and improves post-surgical outcomes.

3.2 Priority 2

Reducing illness or injury associated with surgery, in particular injury of the kidneys

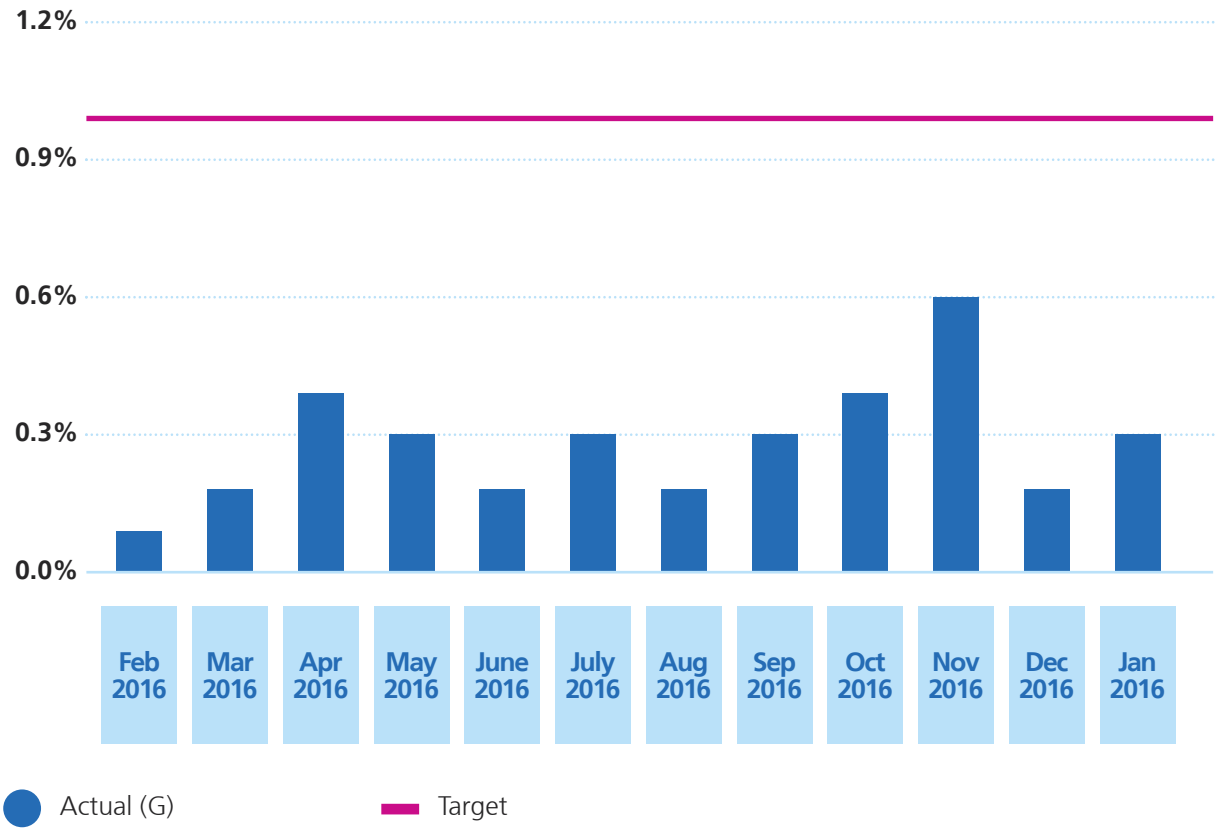
Post-operative complications can occur from time to time and where we believe there is a chance of this we will advise patients of the risk as part of the consent process. There are however opportunities to reduce the likelihood of patients developing particular complications, such as acute kidney injury (AKI). The consequences of perioperative AKI can be very serious.

Timely recognition of patients who are particularly vulnerable to acute kidney injury (AKI) allows the team to adjust their clinical journey to minimise exposure to renal insults, and to optimise the potential for renal recovery should injury occur.

We have measured our rate of acute kidney injury throughout 2016-17 through our Trust Balanced Scorecard.

Over the past 12 month, the Trust has used data Trust Balanced Scorecard to monitor the occurrence of post-operative AKI to measure the effectiveness of our intervention.

The Chart below documents that we are consistently below 0.6% of our patients suffering AKI.



Indicator based on: Internal Target
From CRAB data.

3.3 Priority 3

Implementation of a programme of exemplar discharge

We recognise that being discharged from hospital, which patients often feel is a place of safety, can be an anxious time. We also recognise that once the decision has been made to discharge a patient home it's important that this takes place quickly and efficiently. We therefore decided to undertake a programme of work that would be designed to improve our discharge processes, based on national best practice.

As part of the Trust's priority work to reduce inpatient Length of Stay (LOS) a review of the effectiveness of the wards' daily MDT Huddle has commenced. The huddles are undertaken each morning and include representation from the ward nursing team, Physiotherapy, Occupational Therapy, Social Work, the Discharge Coordination Team, Bed Management and Healthcare at Home. Senior Nursing or Therapies representation is also often present. The purpose of the Huddle is to review the status of each patient and identify the necessary actions to facilitate a safe and timely discharge. This information is used to confirm or amend the planned date of discharge which is in turn communicated to the ward staff and patient.

3.4 Priority 4

Enhancement of shared learning from incidents and complaints

We recognise that in the delivery of complex specialist healthcare, we do not always get everything right. Being open and honest about this puts us in the best position to learn from what has happened so that we can prevent the same thing happening to another patient.

This year we have worked hard to improve and increase the ways in which we share learning from incidents and complaints. This includes the production of the monthly Quality Report that contains a clear focus on lessons learned from incidents, PALS, FFT, Complaints, Clinical Audits, Health & Safety, Fire, & Moving & Handling.

This document is produced each month by the Quality Team. It includes Trust wide and specialty specific information about trends and outcomes for incidents, complaints, friends & family test feedback. It includes lessons that we've learned from significant incidents that have been investigated. This document is shared widely by the Director of Nursing and the Medical Director with staff at all levels across the organisation to provide the opportunity for all staff to learn from each other and improve the quality of care in their areas. It is available for all staff on our internal intranet pages.

Audit Morning

The Trust has a bimonthly audit morning which all Trust staff are encouraged to attend. We have introduced a standing item at that meeting for the sharing of lessons learned. This is undertaken by the Trust Audit Lead, Dr Matt Henley. A copy of the presentation is made available to all staff via Grapevine (our internal intranet) and included in the Audit Round Up, which is a new newsletter which includes a summary of all the learning from presentations at the Audit Morning. It is a helpful way of sharing learning with those unable to attend the meeting, and also provides a good reminder for those who were there.

Quality Improvement and Lessons Learned Forum

We have established a new committee called the Quality Improvement and Lessons Learned forum which will focus on examining the evidence that actions have been taken to help the organisation learn from serious incidents, complaints and claims. We know that through aggregration of the themes and lessons from these events that we can really ensure that the organisation effectively identifies the areas for focussed quality improvement.

Lessons Learned sessions for Junior Doctors

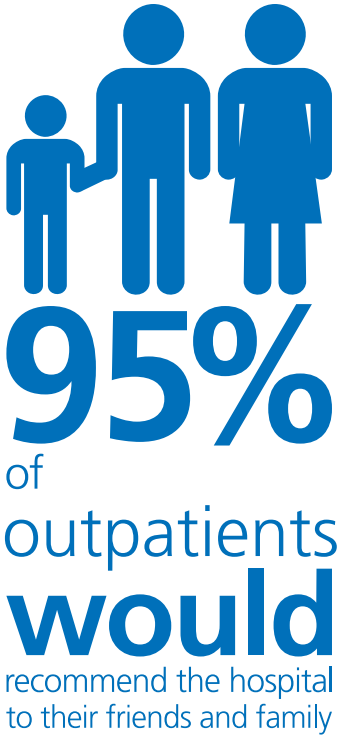
We recognise the huge contribution of our junior doctors in ensuring that the organisation delivers high quality care and how important it is that we ensure they have the opportunity to learn about how we can improve care. As a staff group who move through organisations regularly, they are a really important source of sharing good practice between NHS hospitals. This year we have introduced a monthly lessons learned section within their lunchtime training sessions.

3.5 Priority 5

Focus on customer care and service across the Trust to deliver a positive patient experience

The experience that our patients receive whilst being cared for at the RNOH is one of our most important priorities. Clinical outcomes for our patients are amongst some of the best nationally and internationally and it is our intention to ensure that our patient's experience is the best in the NHS.

We were pleased to see that the RNOH continues to have very high approval rates among our patients. In 2016/17 96.3% of our patients indicated that they would definitely recommend us to their family and friends. This is an amazing achievement, particularly given our continued high response rate of 55%. Sadly, approximately 0.8% of our patients reported that they would not recommend the RNOH. We continue to work hard to address the concerns of those who do not feel that they can recommend the care provided.



Customer Services Training

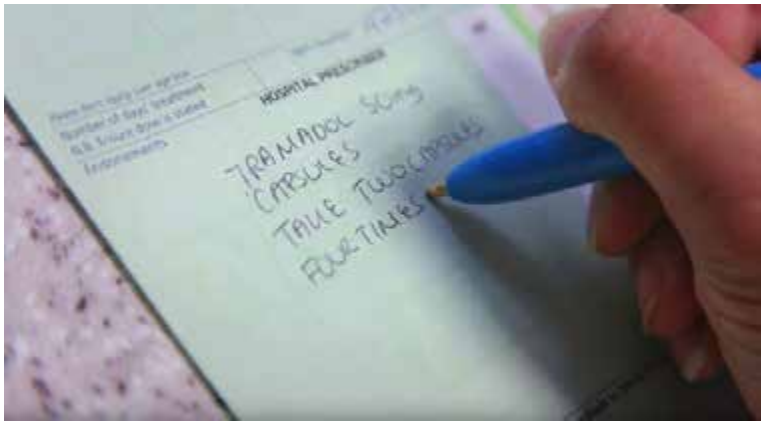
In 2016 we engaged an experienced training provider accustomed to developing and delivering customer service training in high end retail sectors to help develop a package of training for staff and contractors at the RNOH. Our first cohorts of staff were trained over 3 days in January 2017. It was really exciting to see such enthusiasm for delivering a high standard of customer services training. Our customer services experts are now preparing bespoke training based around key RNOH patient experience issues including management of phone calls, 'front of house', and dealing with conflict situations effectively.

During 2016/17 the Trust arranged external training for a Team of 11 multi-disciplinary staff, who undertook a four day interactive training programme on providing excellent customer service to our patients. The team known as the "Customer Care Champions are currently working towards developing a training package suitable for all RNOH staff to attend.

The training will be rolled out over the coming year and will focus on what good customer service is and how to ensure we consistently achieve it across the Trust.

Complaints Process

We recognised that delays in our complaints investigation process were leading to delays in the organisation learning from this type of patient feedback. Following feedback from staff that they felt the process did not sufficiently support local ownership of the investigation and quality actions arising from the findings, we changed the complaints investigation process. Under the new system we have seen the response time for complaints investigations reduce to 19 days (in January 2017) against a target of 25 working days.



Quality Report

In 2016/17 we introduced a new version of the Trust's monthly Quality Report. This includes a Trust summary of trends and themes from complaints and concerns raised via PALS. It also includes divisional and specialty level data to help local areas to discuss and share the learning from significant complaints across the Trust.

First Impressions Project

We engaged with our patient group to undertake a project called 'First Impressions Count'. This involved a group of patients visiting the site, and trying to view the environment through the eyes of a patient who was attending the hospital for the first time.

'First impressions' refers to the opinion a person forms quickly after meeting somebody new, visiting a new place, or using a new service. This impression is formed by human interaction, the environment, and the quality of service.

First impressions are a singular event: they only happen once. For patients and visitors coming to a hospital, the stress and anxiety already makes the visit challenging. It is important that they are made to feel well-cared for, looked after, and safe. Positive first impressions can make the difference between a visit that goes well and one that goes badly. 'Patient experience' is often a concept that is applied to what happens inside the wards: the standard of care, treatment, and courtesy a patient receives. But it applies to every interaction a patient or visitor has with a hospital. From initial communication and correspondence, to making the first visit, finding their way around site, interacting with staff at all levels.

The 'First Impressions' visit is the first stage in building a much broader and fuller picture of the patient experience by looking at what new visitors see and encounter when they come to our site. The teams focused on these key issues:

BEING HELPFUL AND PROFESSIONAL
Did staff approach you with an offer of help and assistance?
Were staff visible at their desks when you entered a hospital area? Did they look at you and greet you?
Did they provide you with useful and relevant information?
Did staff do all they could to answer your question / help you?

Two groups made up of patients, public, and volunteers visited a variety of areas of the hospital grounds armed with a clipboard and a camera. One group started at the West Gate entrance and made their way down to Outpatients. The other group started at Main Gate and followed the route down to the main hospital. The group took pictures to help illustrate the issues that they identified.

BEING WELCOMING
Did staff acknowledge you when you entered a hospital area? Did they smile and say hello?
If you called in did they introduce themselves fully with a polite greeting?
Did the staff you spoke to introduce themselves / or have a visible name badge?
Did the staff you spoke to give you their full attention?
ACCESS AND THE ENVIRONMENT
Were reception and waiting areas kept clean, tidy and welcoming?
Did staff appear to take pride in their place of work?
Did you feel the hospital grounds were well-maintained and gave a good impression?
Did the buildings look maintained and accessible?
Did you have any difficulties accessing the building or using facilities?
Did you find noticeboards / signs / displays engaging and informative?
Did you notice any extra touches, such as plants, decoration or facilities to improve comfort and experience?

They identified important themes and areas for improvement in relation to:

- Smoking
- Access & Facilities for the Disabled
- Customer Service
- Grounds and buildings
- Signage
- Litter and bins

Our Director of Estates, Mark Masters, has worked very closely with the patient group to develop and implement an action plan to address these issues.

We are really pleased with the success of phase 1 of first impressions and now in the planning stages of phase 2, which will see us assessing the first impressions of those patients who are attempting to contact the hospital by phone.


“Helping to ease their pain, making them more comfortable, or just being there to hold their hand and ease their minds. It’s what I love the most.”

4 QUALITY PRIORITIES FOR 2017/18 AND STATEMENT OF ASSURANCE FROM THE BOARD

4.1 Quality Priorities for 2017/18

4.1.1 Priority 1

Improving Length of Stay, A Quality Improvement Initiative

We will undertake a programme of work that will improve systems for pre-operative assessment, discharge planning, multi-disciplinary working and informatics which will reduce the length of stay for patients. This is an important quality issue which ensures that patients are safely discharged following their treatment in the trust.

How we will monitor this

We will establish a project manager to lead the work, as part of a multi-disciplinary team. Metrics will be included in the Trust Balanced Scorecard that will be assessed monthly by our Quality forums and the Trust Board to ensure that progress with reducing length of stay is being achieved.

4.1.2 Priority 2

A focus on gram negative infections, implementation of a bundle of care to reduce e-coli

Great progress has been made within the NHS in the prevention of hospital acquired infections such as MRSA and CDiff. Whilst progress with these micro-organisms has been promising there has been less progress with gram negative infections, in particular e-coli. A national infection control programme will be launched in 2017 and the RNOH will fully participate in this and will implement and evaluate an evidence based bundle of care to reduce these infections.

How we will monitor this

Infections are monitored via the Trust Balanced Scorecard and for 2017/18 we will add measures for gram negative infections. These will be monitored via Quality forums, the Trust Infection Prevention and Control Committee and via Trust Board to ensure that progress is being made. Specific progress with implementation of the bundle of care will be monitored via the Trust Infection Prevention and Control Committee.

4.1.3 Priority 3

Reducing Request Errors, A Quality Improvement Initiative

We have identified a quality concern in relation to the requesting of diagnostic imaging within the trust, which has the potential to impact the care of circa 2000 patients per annum. We will undertake a Quality Improvement Initiative, to improve the understanding of this complex issue and to identify, implement and evaluate interventions to reduce the number of request errors.

How we will monitor this

The number of request errors will be reported and monitored via the trust Clinical Quality and Governance Meeting so that progress with a reduction in errors is maintained. A multi-professional team, led jointly by the Deputy Director of Quality and the Associate Medical Director will coordinate the programme of improvement and will report on progress periodically to quality forums and the executive team.

4.1.4 Priority 4

Enhancement of shared learning from incidents and complaints

Where errors occur in NHS provider organisations it is essential that organisations thoroughly investigate and learn. Progress has been made on this quality priority in 2016/17, which we will continue to focus on in 2017/18. The focus of improvement for the coming year will be in ensuring thorough investigation through implementation of the recommendations of the newly formed Healthcare Safety Investigation Branch (HSIB) and from the recently published requirements related to the investigation of deaths in hospitals. We will update our trust incident management system and utilise the latest software version to share learning more widely and we will undertake human factors training for key groups of staff.

- We will respond to all complaints within 25 working days
- We will increase our PALs responsiveness rate to >80%
- We will increase our incident feedback to staff rate to >75%

How we will monitor this

Organisational learning culture is assessed as part of the NHS Staff Survey and we will monitor progress with these indicators through the Quality Report and the Trust Balanced Scorecard which is discussed at trust board and other quality forums, in conjunction with other internal metrics and surveys to ensure that progress with this issue is maintained.

4.1.5 Priority 5

Development, implementation and evaluation of 5 Local Safety Standards in Invasive Procedures (LocSSIP's)

Local Safety Standards for Invasive Procedures are a mechanism of ensuring consistent application of safety critical interventions for high risk procedures. NHS provider organisations are required to develop local procedures based on national best practice examples and this will form a major quality priority for the organisation in 2017/18.

How we will monitor this

Development, testing and roll out of LocSSIP's is being led by the Clinical Director of Critical Support Services, as part of a multi-professional team. A task force will be established to coordinate the development of these procedures, test their effectiveness and to recommend to the Clinical Governance and Quality Committee (CQGC) that they are adopted for use within the organisation. CQGC will act as the monitoring committee to ensure that this critical work progresses.

4.2 Statements 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.

The NHS income generated by the relevant health services as identified in this represents 82% of total Trust income in 2016/17.

4.2.1 Review of services

During 2016/17, the RNOH provided 21 NHS services. The RNOH has reviewed all the data available to them on the quality of care in all of these NHS services.

The 22 clinical services provided by the RNOH are:

- Anaesthesia
- Bone Infection Unit
- Clinical pharmacy and Medicines Optimisation
- Clinical Neurophysiology
- Foot and Ankle
- Functional Assessment and Restoration (FARs)
- Histopathology and Pathology
- Integrated Back Unit
- Joint Reconstruction
- London Sarcoma Unit
- London Spinal Cord Injury Centre
- Orthopaedic Medicine
- Orthotics and Prosthetics
- Paediatric and Adolescents
- Pain Management Services
- Peripheral Nerve Injury Unit
- Plastics
- Radiology
- Rehabilitation and Therapy
- Shoulder and Upper Limb
- Spinal Surgical Unit
- Urology

4.2.2 Participation in National Clinical Audits

In 2016/17, 3 national clinical audits and 1 national confidential enquiries covered relevant health services that the RNOH provides.

During the reporting period the RNOH participated in 100% (3) national clinical audits and 100% (1) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the RNOH was eligible to participate in during 2016/17 are listed below, alongside the number of cases submitted compared to the requirements set out by the enquiry/audit.

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES	NUMBER OF CASES REQUIRED BY THE AUDIT	PERCENTAGE SUBMITTED
National Joint Registry: Hip, Knee and Ankle Replacements	**All Hip, Knee and Ankle Replacements (1243)**	**In progress (96.7%)**
National Comparative Audit of Blood Transfusion (Re- Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery)	**40**	**18 (100% eligible)**
National Comparative Audit of Blood Transfusion 2017 Audit of Transfusion Associated Circulatory Overload (TACO)	**No minimum cohort, Maximum of 20 patients**	**In progress**
NCEPOD NIV Emergency	**Not Applicable** (no patients who meet the NIV criteria set)	
NCEPOD Cancer deaths in children, teenagers and young people	**Not Applicable** (we don't provide SACT in RNOH)	
NCEPOD Chronic Neurodisability	**Organisational Questionnaire** – 7/8 completed, 1 In Progress **Clinical Questionnaires/Case notes** 7/9 completed with 2 in progress	
NCEPOD Young People's Mental Health	**Not Applicable** the RNOH do not have an Emergency department; we therefore do not treat patients who arrive at hospital as an Emergency with Anxiety, depression, an eating disorder or episode of self-harming.	

The Trust continues to contribute to the National Joint Registry (NJR). The compliance rate for submission of Hip and Knee replacement operations is currently being analysed. Continuous work is being undertaken to ensure compliance is in alignment with the benchmark figure of 95%.

The Trust participated in the National Comparative Audit of Blood Transfusion (2016 Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery). The minimum sample requirement was 40 patients who had blood transfusion. However we only had 18 patients in the data collection period requiring blood transfusion. Data were submitted for all 18 (100%) patients.
The Trust is currently participating in National Comparative Audit of Blood Transfusion - 2017 Audit of Transfusion Associated Circulatory Overload (TACO). There is no minimum cohort however Trusts are advised to submit data for a maximum of 20 patients.

The reports of 2 national clinical audits are being reviewed by RNOH in 2016/17 and we intend to take the following actions to improve the quality of healthcare provided:

NATIONAL CLINICAL AUDITS

National Joint Registry: Hip, Knee and Ankle Replacements

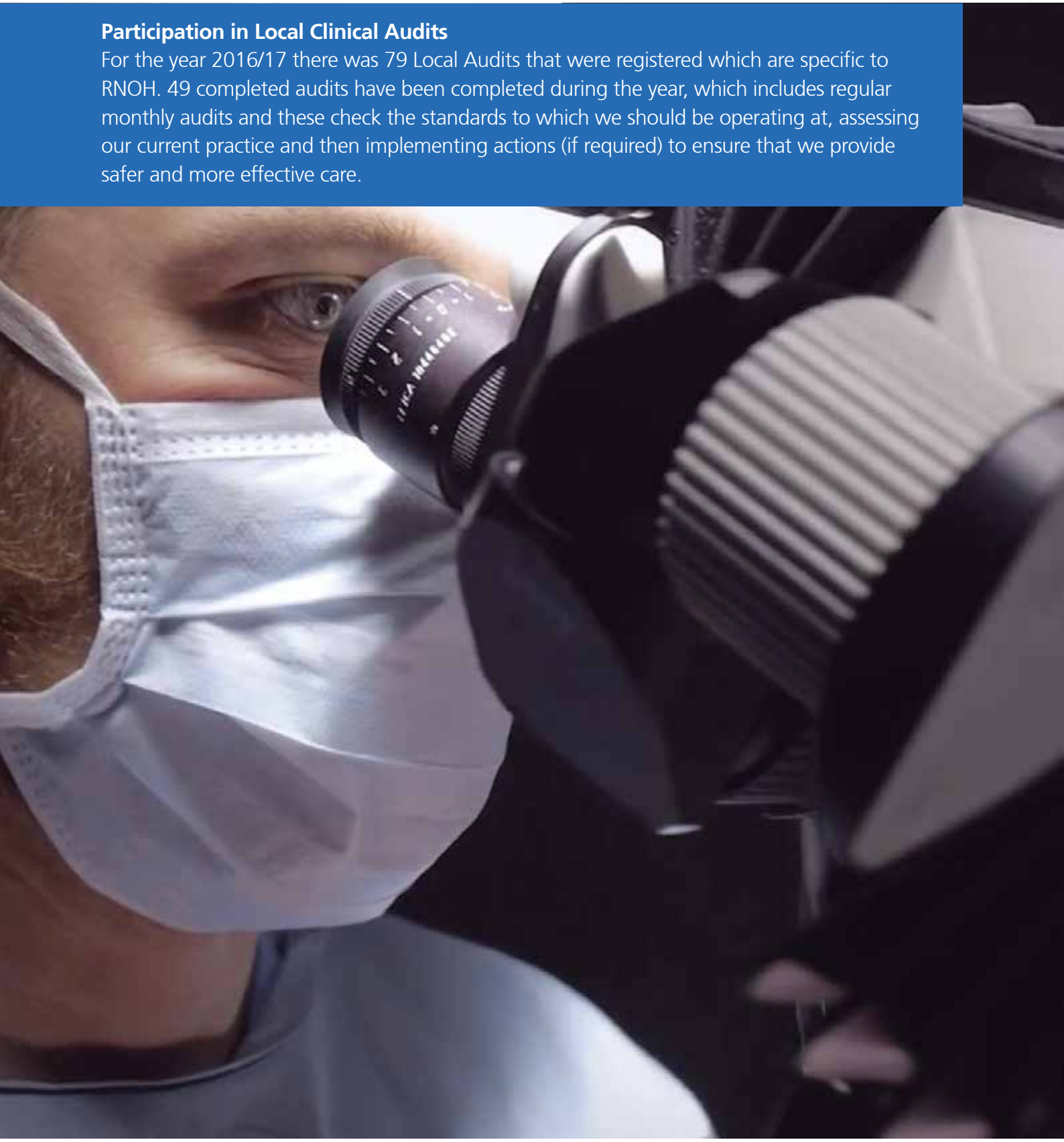
- To continue to participate in the Registry to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards; benefiting patients and clinicians
- Ensure better links between the NJR and clinicians to understand requirements for cancer patients
- Monthly reports from NJR and information (HES data) to allow monthly compliance to be reported
- Compliance figures to be produced showing figures with and without outsourced work

National Confidential Enquiry - Mental Health

- Psychiatry service is being entered on ICS
- Pharmacy are auditing 24h Medicine reconciliation
- An audit is planned around the documentation of MCA by Liaison psychiatry / Safeguarding
- Mental health training is being organised for all staff

Participation in Local Clinical Audits

For the year 2016/17 there was 79 Local Audits that were registered which are specific to RNOH. 49 completed audits have been completed during the year, which includes regular monthly audits and these check the standards to which we should be operating at, assessing our current practice and then implementing actions (if required) to ensure that we provide safer and more effective care.



LOCAL CLINICAL AUDITS

World Health Organisation (WHO) Surgical & Imaging Safety Checklist Audit
The Trust currently has a compliance percentage of 99.4% in regards to the checklist being fully completed for each patient.

The following actions were undertaken to improve compliance:
- An ongoing observational audit has been introduced to capture adherence to WHO Checklist completion policy. This will focus on the quality of checks conducted.

The NHS Safety Thermometer
For 2016/17 the highest recorded harm free percentage has been 97.14%, we have consistent low percentage of "Falls with Harm".

If any new harm is identified, actions are put into place immediately by the ward.

Arthroplasty Practitioner Clinic Patient Experience
The NHS Outcomes Framework 2016/17 puts patients at the centre of decision making with their experience of health and supporting care services central to the drive for further improvements.

The following actions were undertaken to improve compliance:
- We have worked with the current cohort of Registrars and have been seeing a steady flow of CC'd letters of referral to the AP service as well as through COFs.
- We have discussed this at our Team meetings as an on-going task when the new starters come in April 2017.
- The AP secretary has resumed sending introductory letters to patients referred in this way to the AP service.
- A further re-audit of Clinical Outpatient Letters for TKR & THR patients have been initiated.

Theatre LMP Documentation Compliance Audit
The purpose of this audit is to confirm whether staff within Imaging, Theatres and the Wards is aware of the IRMER regulations regarding pregnancy.

The following actions were undertaken to improve compliance:
- Re-training by senior staff on each ward
- Re-training by senior staff in theatre and consultants reminded
- Staff reminded of their responsibilities by managers for each area
- This saw the rate of compliance rise from 58% in December 2016 to 95% in March 2017.

LOCAL CLINICAL AUDITS

Nursing Discharge Audit

The Nursing Discharge was created to look at all aspects of a patients discharge, it was nurse led and carried out following an RCA that was undertaken in January 2015.

The following actions were undertaken to improve compliance:

- Results of the audit has been disseminated to Ward Managers and discussed at Ward meetings to implement new practice
- Addition of the "reason for admission" be included on the TTA letter to be included
- Nursing elements that were not filled in have been highlighted during Ward meetings and a re-audit will be done to check this.

Patient Satisfaction Survey

This audit focuses on the patients and carer's experience of inpatient paediatric occupational therapy and physiotherapy. We have recorded full compliance against 2 of the 3 standards.

The following actions were undertaken to improve compliance:

- The results have been disseminated to the Paediatric Therapy Team

Re-audit of Airway Equipment in Anaesthesia Clinical Cases

The aim of this audit was to check all anaesthetic areas at the RNOH for availability of airway equipment in compliance with RNOH airway equipment list and updated DAS Guidelines (2015) for which the aim was 100% compliance.

The following actions were undertaken to improve compliance:
These items have been ordered and stocked in their respective areas:

- Malleable stylets - Theatre
- McCoy blade – ICU
- Cricothyroidotomy needle - ICU

LOCAL CLINICAL AUDITS

RNOH Temperature Monitoring- Point Prevalence Clinical Audit
This audit was carried out by the Infection Control Team, it included 41 patients and was done to check compliance with temperature monitoring in surgical patient in line with NICE Quality Standard (QS49).

The following actions were undertaken to improve compliance:

- Compliance with thermal blanket usage done on 11/01/17- 19 Patients were surveyed, 12 out of 19 had the thermal blanket during transfer to Theatre making it 63% compliance rate for use of thermal Blankets. Continuous education and awareness to continue. Audit outcome reflects improved awareness i.e. reduced risk.
- Awareness of this standard is continuously raised in theatre and discussed amongst ODP and anaesthetics. Surgical site infection RCA meeting is being used for raising this awareness and also through regular annual update trainings. Recent RCA's have demonstrated increased compliance with this standard.
- Theatre lead Nurse/Anaesthetic lead have been tasked on with ensuring the WHO checklist question on temperature monitoring in theatre is changed from 'Is warming in use' to 'Is Patient Normothermia maintained pre and intra op'. This action is on the surgical site infection prevention group (SSIPG) action log for monitoring when completed.

Audit of Clinical Out-Patient Letters for Total Knee Replacement and Total Hip Replacement patients
The clinical audit was conducted because guidelines have been produced by the Arthroplasty Care Practitioner Association on the best practice in the review of these patients of the patients that are reviewed for total hip and knee replacement.

The following actions were undertaken to improve compliance:

- The results of the Audit were distributed to and discussed with the Arthroplasty Practitioner Staff.
- Members of staff were reminded of the unmet standards and the importance of completing these fields.
- A practical Teaching Session was held on the Objective Examination (Oct-2016) of the Hip and Knee.

LOCAL CLINICAL AUDITS

Audit of the Duty of Candour Procedures within RNOH

The Duty of Candour audit was conducted in 2016 to evaluate compliance with Duty of Candour regulations.

The following actions were undertaken to improve compliance:

- Duty of Candour training programme have been rolled out
- Duty of Candour "champion" training rolled out at local level across all disciples
- Duty of Candour Session at Trust Wide Audit Morning
- A Mandatory E-Learning programme to be developed to support staff in having and documenting discussions.
- Duty of candour performance metrics are included in Integrated Quality Report (IQR)
- Duty of Candour included in a Director of Nursing weekly message
- Duty of Candour Monitoring SOP development

Do children who have had scoliosis correction surgery go back to school at 6 weeks post operatively as recommended in the post-operative school letter

The Royal National Orthopaedic Hospital advises children undergoing spinal surgery to return to school at 4-6 weeks post-operatively, this audit was to check if children return to school as recommended.

The following actions were undertaken to improve compliance:

- The main reason for the for children going back longer than the recommended time was found to be due to pain and fatigue
- As 35% of patients were not returning to school as per recommendation, investigation on the impact of 2 stage surgery compared to single stage surgery on return to school and functional activities will be done.
- Results have been disseminated to the Paediatric Therapy Team
- Confirmation of re-audit in Oct 2017

LOCAL CLINICAL AUDITS

Post-operative paediatric pain scoring

This was commissioned to evaluate how well the RNOH are documenting post-operative pain scoring in children. The aim of this audit was to assess whether we are undertaking paediatric pain scoring as per our hospital protocols.

The following actions were undertaken to improve compliance:

- The results of this audit were discussed with ward staff and clinical educators to improve compliance with current guidelines.
- Additional education has been sought from the acute pain management service.

Nutrition Initiatives Audit

This audit is a snapshot assessment of: the accuracy of completion of Malnutrition Screening tools, associated Nutritional Care and Action Plans, and food record charts; the use of kitchen whiteboards; adherence to Protected Mealtimes and assistance at mealtimes; menu provision; and the provision of prescribed oral nutritional supplements, These initiatives intend to improve the nutritional care of patients in accordance with national guidelines 1,2,3,4.

The following actions were undertaken to improve compliance:

- Immediately put into action is the malnutrition screening and nutrition care plan information upon accepting a referral to address standards 2 & 3.
- Dissemination of audit results to the senior nursing managers where practical strategies will be agreed in terms of meeting the standards that were not met
- The main focus will be the education of frontline staff.

Patient Satisfaction Feedback for the Peripheral Nerve Injury Rehabilitation Programme

The main aim of conducting this audit was to determine patient's level of satisfaction with the PNI on week inpatient rehabilitation programme at the Royal National Orthopaedic Hospital.

The following actions were undertaken to improve compliance:

- Clear therapy treatment plan implemented with each patient by the team

LOCAL CLINICAL AUDITS

Audit of Adult Elective Surgical Patient Cancellations Following admission into Hospital

This audit is done to understand the reasons for patient surgery cancellation following hospital admission and to investigate if it is preventable.

The following actions were undertaken to improve compliance:

- Discussion with surgical division leads and their scheduling department
- Discussion with Preoperative Department nursing lead and education of staff.

Point of care testing Glucometer calibration audit

An audit was commissioned by the Director of Nursing to identify if SOP is duly followed by the staff responsible for checking and maintaining the blood glucose monitors.

The following actions were undertaken to improve compliance:

- External Quality Assessment (EQA) procedures are also initiated through WEQAS to ensure Quality Control of the devices.
- Audit has been discussed in the POCT Committee meeting.
- The newly appointed, POCT Manager from SWLP has been notified about the audit.
- The next audit will be conducted soon after the introduction of new Glucometers, which will replace the existing ones.

DNA Audit

A DNA is defined as a scheduled appointment that is missed without prior arrangements by the service user. Most appointments were paediatric appointments in which a patient was not brought in by their parent/carer.

The following actions were undertaken to improve compliance:

- To continue to apply these high standards
- Re-audit using the policy - include standards around the use of DNA letters.

LOCAL CLINICAL AUDITS

Patient Safety Briefing Audit

The aims of this initiative were to ensure that our standard of care will be equitable on arrival to our hospital, and the patients will have a voice in the care that they received.

The following actions were undertaken to improve compliance:

- All welcome videos are shown to patients when they are admitted to wards
- Standardisation of the welcome patient packs.

HTA Mock re-audit

This audit was conducted to check the Trust's compliance against the Human Tissue Authority (HTA) and local policy and procedures. This establishment is licensed for the procurement, testing, storage and distribution of tissues and cells under the Human Tissue (Quality and Safety for Human Application) Regulations 2007.

The following actions were undertaken to improve compliance:

- Theatre Co-ordinators to sign with date and time the receipts when received tissue from Theatre stores.
- Delegation log updated and signed by Theatre Co-ordinators.
- Theatre Co-ordinators and clinicians were reminded through email that complete the request form and inform theatre store to replace the allograft/ nerve once used.
- A review of risk assessment updated and sent to Patient Safety Lead and advisor for review.
- Review all Sops related to Human Tissue and once completed and approved by CQGC after peer review of Clinical educators, Theatre co-ordinators and director / deputy director of nursing, all theatre staff will be signed off.
- In process of reviewing all Sops related to Human Tissue and they will be interlinked to relevant SOP.
- Annual audit plan including regular/weekly audit plan will be submitted.

LOCAL CLINICAL AUDITS

WHO Safety Checklist Observational Audit

Overall high compliance was observes in majority of the areas audited, however certain areas require significant improvement.

The following actions were undertaken to improve compliance:

- Dissemination and discussion of results in the departmental theatre meeting
- Design a template to be used for team briefing
- Design a template to be used for de-brief
- Training for the procedural team around policy for completing WHO checklist.

Anticoagulation status for Radiology referrals

This audit is aimed at finding a way to minimise the delay to patient care by having a pathway to ensure the best possible treatment for patients. RNOH introduced a question on anticoagulation on each referral; electronic referrals also provide space to input further details.

The following actions were undertaken to improve compliance:

- The audit report was presented at the CQGC
- The Radiographers have been asked by email to identify altered haemostasis documented on referral when vetting
- Patients alter to be added to radiology system to flag patients at Risk
- Triage of patients by radiology nurse.

LOCAL CLINICAL AUDITS

Reduction of noise at night

Adequate sleep is an important part of health and recovery from illness or injury, poor sleep is associated with a weakened immune system and often leads to delayed healing. We understand that there are noises which are unavoidable and necessary with the day to day operation of every caring establishment. This audit was conducted to identify areas where the noise at night could be reduced and what the causes were.

The following actions were undertaken to improve compliance:

- Supplying patients with earphones in the welcome pack
- Regular maintenance of doors on all wards by Estates
- Raise awareness amongst staff about their contribution to the noise levels and the information that they are discussing outside of a private area around patient who may or may not be sleeping
- Switch off noise in the night (Pedestrian)
- Check if all equipment has a night mode (as well as buzzers)

Evaluation of technician led Nerve Conduction Study Clinics

The purpose of this study was to develop standards to which future audits could be measured against, It was decided that since carpal tunnel syndrome predominantly affects sensory function and our diagnosis relies predominantly on sensory nerve conduction criteria, our standards would be based only on the sensory portion of the testing protocol.

LOCAL CLINICAL AUDITS

Paediatric therapies notes audit 2016

Physiotherapists must be aware of the legal context within which they work, and comply with regulatory, national, professional body and local employer guidance on record keeping. This audit was done to check compliance against the standards and to highlight areas where improvements would be required.

The audit highlighted the following:

- Three of the standards out of twelve were deemed to not be appropriate to the inpatient setting
- We recorded a high compliance rate against 4 of the remaining 9 standards that were applicable
- The remaining 5 recorded medium compliance with one area requiring further improvement

The following actions were undertaken to improve compliance:

- Presentation of findings to the paediatric therapy team

Respiratory Function Test Assessment and Documentation Re-Audit

The aim of the re-audit was to assess whether the standards for monitoring respiratory function are being met by the physiotherapists for patients on LSCIC.

The following actions were undertaken to improve compliance:

- Update ICE with IT to obtain correct information
- Update paperwork to include height conversion chart and instructions on how to report results on ICE
- Update instructions and discuss with team
- Prior to discharge all paperwork are checked to ensure it has been completed
- Ensure adequate provision of Peak cough flow meters and masks available and in respiratory draw on ward.

LOCAL CLINICAL AUDITS

Improving patient compliance with self-reported outcome questionnaires
This audit was done to establish the current compliance with SPRINT and identify areas for improvement and implement an automated, email based self-reported outcome questionnaire designed by the British Spine Registry.

The following actions were undertaken to improve compliance:

- Implement British Spine Registry online/email system of patient reported questionnaires which will improve significant clinician input.

Anaesthesia Outcome Measures - Quality Improvement Audit
The aim of this audit is to review whether the anaesthetic service at the RNOH is providing anaesthesia of a high quality. The provision of high quality anaesthesia should in turn lead to high levels of patient satisfaction.

The following actions were undertaken to improve compliance:

- Maintain awareness amongst anaesthetists of the risk factors for inadvertent perioperative hypothermia, and the NICE advice on how to identify those patients at risk and treat them appropriately
- Maintain awareness amongst anaesthetists on how to identify those patients at risk of PONV, and the best ways of treating them prophylactically
- Improvements in the analgesic techniques used in patients undergoing surgery, in particular those undergoing spinal surgery or lower-limb joint replacements. Consider the use of neuraxial/regional anaesthetic techniques where appropriate
- During the next audit cycle, include information on patient fasting times. Prolonged fasting times cause distress and dehydration to patients, and may affect post-operative recovery from surgery. Minimising fasting times is preferable, but may need data to be collected prospectively
- Present the findings of the audit to the anaesthetic department on 17th of May 2017

LOCAL CLINICAL AUDITS

Audit of the Metastatic Spinal cord compression (MSCC) patients at RNOH against the GAIN guidelines (Guidelines and Audit Implementation Network).

MSCC (metastatic spinal cord compression) is defined as spinal cord or cauda equina compression by direct pressure and/ or induction of vertebral collapse or instability by metastatic spread or direct extension of malignancy that causes neurological disability.

The audit was carried out in order to ensure that all patients coming in on the MSCC pathway get the assessment and rehabilitation as outlined in the GAIN guidelines.

The following actions were undertaken to improve compliance:

- Discussions were held at the team meeting and training provided to existing as well as new members of the team by Physio or OT depending on the standard.
- A GAIN guidelines list was compiled as a guide for all physio and OTs seeing the MSCC patients.
- As a member of the specialist section for OTs working in HIV, Oncology and Palliative Care, as email was sent to request the current practice in other hospitals around the UK who see MSCC patients. We have had a great response from this and we will be collating the information to discuss what applies at RNOH.

Audit of documentation of tourniquet time in operation notes

The following actions were undertaken to improve compliance:

- Information was sent to all members of JRU to document tourniquet time and pressure on operation notes
- JRU templates are now available in theatres for arthroscopy and arthroplasty cases.
- JRU team were advised to utilise available template rather than typing one out themselves.

LOCAL CLINICAL AUDITS

Review of NPSA alerts related to medicines

This audit is done to confirm that RNOH is adhering to patient safety alerts related to medicines. The following were reviewed with individual Action Plans to support any implementation required:

- Reducing Dosing Errors with Opioid Medicines
- The adult patient's passport to safer use of insulin NPSA/2011/Alert 3
- Reducing the risk of Hyponatraemia when administering intravenous infusions to children NPSA/2007/Alert 22
- Fire Hazards with Paraffin Based Skin Products on Dressings and Clothing NPSA/2007/RRR4
- Promoting safer measurement and administration of oral liquid medicines - NPSA/2007/19
- Reducing the risk of overdose with midazolam injections in adults
- Ensuring safe practice with high dose ampoules of diamorphine and morphine.
- Compliance with NPSA alert 18 : Safe use of Warfarin at RNOH

Emergency admissions - admission to first consultant review

This audit was chosen to evaluate whether our emergency admission were seen by senior clinicians, specifically consultants, within the time frame specified by the NHS working document.

The following actions were undertaken to improve compliance:

- Awareness of standard: to be seen ≤14 hours through audit presentation
- Further education regarding documentation standards
- Presentation at Audit Meeting.

LOCAL CLINICAL AUDITS

Correct Patient, Correct Site, Correct Procedure
Overall Performance against the standard and procedures are commendable, patient identification prior to the procedure is 86% Phlebotomist and Nursing staff were 100% compliant but the Clinician only confirm the verbal identity. Group and Save sample signed and taken apart was 100% including clinician. Tube labelled at bedside Phlebotomist were 100% as they have the facility to mobilize the trolley in the ward and print the stickers, while the clinician has to come to the nursing station to print the sticker. To print the sticker prior to bleed can cause duplication and misinformation on the system in the event of unsuccessful attempts, so the overall result 77%. While the sharp disposal, a sample drawn in the correct order and PPE and devices is discarded as a single unit was overall 95%.

Agreement of the regional MDT for Spinal surgery taking place within the network The Quality Surveillance Team (QST), formerly National Peer Review Programme, leads an Integrated Quality Assurance Programme for the NHS and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF). The main aim of this audit was to identify our current practice and compare that against the standards and develop a strategy to improve the practice where applicable.

The following actions were undertaken to improve compliance:
- MDT co-ordinator to draft TOR for MDT and liaise with clinicians for sign off
- Liaising with clinicians to sign off on the guidelines to decision making
- BSR Data Administrator recruitment currently underway

Re-audit of Clinical Out-Patient Letters for AP TKR and THR patients
The Arthroplasty Practitioners review total hip and knee replacement patients in clinic and write letters to the patient and their GP outlining the consultation discussion, examinations and management plan.

The following actions were undertaken to improve compliance:
- All staff will now include this questioning in their assessment.
- All staff to include this in their assessment of 6 week and one year post-op patients.
- Going forward we will only focus on the Trendelenberg test
- All staff have been tasked with recording Neurovascular status immediately

LOCAL CLINICAL AUDITS

MDT Record Keeping Re-audit

Record Keeping is an essential part of supporting the high quality of treatment and care at the Royal National Orthopaedic Hospital. Having been established in 2011, this audit focuses on the improvement of patient's notes and looks at all the steps requiring completion to highlight good record keeping practice. As of 2015 the Trust started storing patients notes using NoteOn, the re-audit will incorporate new standards relating to the electronic document management software.

The following actions were undertaken to improve compliance:

- The final report was presented at the Clinical Quality Governance Committee Meeting (CQGC)
- Dissemination of results to individual unit teams.
- Dissemination of overall results to Medical Director, Director of Nursing, Clinical Leads, Chief Pharmacist, Head of Therapies & General Managers.
- Each area conducting an audit checking their compliance for record keeping once during the financial year, before the annual record keeping audit.
- Audit results presented at the Trust's Quality Improvement and Audit Presentation Day
- Correct admission date must be provided on the header sheet
- Establish a clear methodology for recording and populating NoteOn with 'Alerts'
- To include a question about patient's consent for sharing information in admission booklet as per NICE QS13 & NICE CG 138.

Safeguarding in Recruitment

The adoption of safe recruitment practices and procedures is vital in identifying, deterring and rejecting people unsuitable for working with children, young people and or vulnerable adults.

Key elements within this process include ensuring the job description for all posts/roles makes reference to the responsibility for safeguarding and promoting the welfare of children and vulnerable adults.

The following actions were undertaken to improve compliance:

- Safeguarding clause submitted to HR and included on all job adverts.
- Safeguarding clause for job descriptions submitted to HR for inclusion onto JD template
- Review and revision of the Recruitment and Retention Policy to ensure it is in line with Local Safeguarding Children Board (LSCB)

LOCAL CLINICAL AUDITS

Paediatric DNA Audit

The aim of this audit is to compare practice against policy; this audit looked at all the DNA's in the month of December 2016. This small spot audit indicates a lack of consistency when it comes to following the current DNA policy. The safeguarding team and / or GP were not routinely informed following a second consecutive DNA and when a vulnerable child did not attend, another appointment or decision to discharge was not made.

The following actions were undertaken to improve compliance:

- Review of policy to include clarity of:
  What to do when a child is not brought to appointment
  When to involve the safeguarding children team
  Use of DNA letter templates
- Sharing and communication of updated and reviewed policy to ensure staff awareness of what to do when a child is not brought to appointment
- Re audit of DNA process following review and update of the current policy.

Nurse Roster Audit

The purpose of this audit was to identify if the Trust is compliant with the current Nursing Rosters according to the NHS Improvement Good Practice Guide to Rostering.

The following actions were undertaken to improve compliance:

- Current Business case to increase establishment WTE
- Ward managers to ensure copy of the policy is available for staff and to discuss at ward meeting
- Continue to actively recruit
- Ongoing review of staffing by matron of the week.
- E-rostering to be implemented to support the creation of nursing rostering.

LOCAL CLINICAL AUDITS

Harrow Safeguarding Children Board Section 11

Audit Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in carrying out their work they have regard to the need to safeguard and promote the welfare of children. This was developed and passed by the London Safeguarding Children Board to provide a uniform approach to section 11 audits. Additionally, RNOH was required to submit the following information to Harrow LSCB:

- Structure chart of organisation
- Impact of any restructure on safeguarding arrangements
- Actions and outcomes from any inspections with regards to safeguarding or Government returns linked to safeguarding
- Actions and outcomes resulting from SCRs or Domestic Homicide Reviews
- Feedback from the previous section 11 meeting.

Effectiveness of MDT working for CQUIN

The Quality Surveillance Team (QST), formerly National Peer Review Programme, leads an Integrated Quality Assurance Programme for the NHS and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF).

The following actions were undertaken to improve compliance:

- Regional MDT co-ordinator to draft TOR for MDT and liaise with clinicians for sign off.

Vascular Access Management Audit

The purpose of this audit was to reduce the risk of infection by improving the use and management of vascular access devices. NICE Clinical Guidance CG139, Prevention and control of healthcare-associated infections in primary and community care (published in March 2012) contains standards for Vascular access device site care. These devices are one of the main causes of healthcare-associated infections, and bloodstream infections associated with central venous device insertion are a major cause of morbidity.

The following actions were undertaken to improve compliance:

- Trial of revised theatre documentation
- Visual Infusion Phlebitis(VIP) Score chart reviewed and approved
- New VIP score in Admission booklet scheduled for trial – April 2017
- ICC chair wrote to Theatre managers and Anaesthetic lead to ensure documentation of lines inserted in Theatre on the VIP score chart.

LOCAL CLINICAL AUDITS

Hand Hygiene

From the 1st April 2015 the Infection Control team made a change in its auditing protocol for Hand Hygiene. In line with National guidance it was decided to adopt the World Health Organisation (WHO) 5 Moments for Hand Hygiene approach. Devised by the World Health Organisation (WHO) it defines the key moments when health-care workers should perform hand hygiene.

The following actions were undertaken to improve compliance:

- Infection control implemented a trial of hand gel door handles in July/ August 2016
- IPCT continued to provide Hand Hygiene education via periodic training opportunities and word level monitoring.

Environmental Full Compliance

Environmental full compliance audit was devised to cover the environmental standards indicated in the Standard Infection Control Precautions policies.

The following actions were undertaken to improve compliance:

- IPCT working with ISS supervisor to address issue
- Discussion around top of the fridges and cupboards to be actioned by ISS supervisor
- To be included in the 2017/18 audit as a priority.

Paediatric Discharge Letter Audit

Under guidance for discharge summaries in the NHS standard contract 2016/7 between hospital and GP interface regarding discharge summaries, 'hospitals are required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours. Discharge summaries from inpatient or day case care must also use the Academy of Medical Colleges endorsed clinical headings, so GPs can find key information in the summary more easily.'

The following actions were undertaken to improve compliance:

- IT platform to enable more accurate labels of diagnosis / co-morbidities.
- Transferring data from note on to the e discharge
- Increasing training for SHOs doing discharge letters
- Involvement of the wider multidisciplinary team to do an MDT discharge letter.


“Nursing is a very fulfilling profession. It gives you a satisfaction knowing that you made a real difference towards your patients’ hospital experience.”

4.2.3 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by The Royal National Orthopaedic NHS Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 737 (January 2017) into NIHR Portfolio studies, and over 300 have been recruited into non-Portfolio studies. We continue working on plans to expand opportunities for clinical research participation to our patients, and provide access to cutting edge treatments.

Participation in clinical research demonstrates The Royal National Orthopaedic Hospital NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. We work closely with our university partners to develop new treatments for our patients and our collaborations have produced impact on patient care locally and beyond. We're committed to producing new ideas across all staff groups to deliver research, which has a potential to change the way we treat our patients. Involving staff and patients in developing and delivering is essential for gaining the benefit associated with being a research active organisation.

The Royal National Orthopaedic Hospital NHS Trust was involved in conducting 70 clinical research studies of which 30 were initiated in 2016/17 in the neuro- musculoskeletal specialities.

The improvement in patient health outcomes in The Royal National Orthopaedic NHS Trust demonstrates that a commitment to clinical research leads to better treatments for patients. There were over 100 members of clinical staff participating in research approved by a national research ethics committee at The Royal National Orthopaedic NHS Trust. These staff participated in research covering neuro-musculoskeletal specialities, across different aspects of care provided to our patients.

Our engagement with clinical research also demonstrates The Royal National Orthopaedic NHS Trust 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 engagement with clinical research also demonstrates The Royal National Orthopaedic NHS Trust commitment to testing the latest medical treatments and techniques. Our collaborations include international projects with EU funding, and we also contribute to national projects such as the Genome 100,000, which aims to change care delivery in the UK. and work

closely with our academic partners to deliver new ground breaking research.

RNOH Research & Innovation Centre together with University College London ASPIRE CReATE team and UCL Division of surgery organises regular event public engagement events to increase awareness of our work to our patients and general public. Our 2nd Open Day event attracted over 120 visitors, and positive feedback was received from our visitors as well as staff and students.

CASE STUDY 1

Full title: TARVA (Total Ankle Replacement Versus Arthrodesis Trial): A randomised, multi-centre, non-blinded, prospective, parallel group trial of total ankle replacement (TAR) versus ankle arthrodesis in the treatment of patients with end-stage ankle osteoarthritis, comparing clinical outcomes and cost-effectiveness

Short title: TARVA

Lead: Mr Andrew Goldberg

Project:
The main aims of the TARVA study are:

1. To compare outcomes of Total Ankle Replacement (TAR) versus arthrodesis (fusion) in terms of pain-free function, physical function, quality of life, range of movement in the foot and ankle, and rates of post-procedural complications one year post-operation
2. To compare the incremental cost and cost-effectiveness of TAR versus arthrodesis

CASE STUDY 2

Full title: A pilot study to compare Virtual Reality (VR) versus VR plus haptic feedback as a possible technique to decrease upper limb phantom pain responses in amputees

Short title: AMPSIM

Lead: Dr Rui Loureiro & Dr Imad Sedki

Project:
To measure the effectiveness of an immersive Haptic system that combines a visual surrogate for the missing limb with haptic feedback (VR + Haptics) on reducing phantom limb pain, as compared with the same therapy without the haptic feedback (VR only).

4.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

Commissioning for Quality and Innovation (CQUIN) scheme is intended to deliver clinical quality improvements and drive transformational change. They are intended to reduce inequalities in access to services, the experiences of using them and the outcomes achieved.

The 2016/17 CQUIN scheme has been influenced by the ambitions of the Five Year Forward View (FYFV). CQUIN in isolation will not address these issues, but if aligned with the Sustainability and Transformation Plans (STPs) covering the whole health and social care systems, it can be a strong lever to help bring about changes: to deliver improved quality of care to patients through clinical and service transformation.

To deliver the FYFV, organisations will move to more place based commissioning geared towards transforming services to deliver better quality standards for patients, improving the working environment for staff, and delivering financial balance. The national indicators reflect these priorities. There is a focus on clinical quality improvements which that will help achieve better outcomes for patients. There is a new standard focussed on the health and wellbeing of staff, directing collective action to develop a sustainable workforce.

During 2016/17 the Trust signed up CQUINs with both Clinical Commissioning Groups (CCGs) and NHS England (Specialised Commissioning).

The Trust overall income target associated with 2016/17 CQUIN schemes was approximately £2.5 million. Details of the agreed CQUIN schemes for 2016/17 are provided in the table below. The Trust actual income to date for achievement of CQUINs is £1.7 million to date.

Monthly monitoring both within the Trust and with the commissioners has taken place to assess progress against each of the milestones.

The Trust agreed 6 CQUIN schemes with the CCG and 5 CQUIN schemes with NHS England Specialist Scheme.

For Specialised Commissioning: Out of 5 schemes the outcome was as follows: 1 was fully achieved, 2 were partially achieved, 2 are awaiting confirmation subject publication of national datasets and internal data validation.

For the CCG schemes: Out of 6 schemes the outcome was as follows: 3 were fully achieved, 2 were failed, 1 is still awaiting confirmation subject to the publication of national datasets.

During 2016/17 as a result of CQUINs programme improvements made to date include:

- Improvement in the numbers of patients who have experienced > 4 hour delay in discharge from ICU has decreased. Given the challenges of winter pressures, the continued improvement in this quality metric was particularly significant.
- Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients.
- Trust committed to increasing the use of telemedicine to help improve the experience of our patients by reducing the number of appointments which require physical attendance at the hospital. This recognises the challenges that many of our patients have in travelling to the site. In addition to disabilities and reduced mobility, our patients travel some of the largest distances in the country to access services at the RNOH, and we recognise that increased provision of telemedicine will promote greater accessibility of the services, while also achieving efficiency gains and cost reductions in service provision.
- Historically vaccine uptake has been lower at the RNOH than at neighbouring trusts, likely linked to the fact that staff are not exposed to patients suffering from influenza because we do not have an emergency department or general ITU (i.e. staff are not exposed to influenza illness and the seriousness of such illness in the same way as in general acute NHS organisations). In 2015/16 the uptake in vaccinations was 32% for clinical staff which we recognised was much lower than we had hoped.
- There has been a significant focus on Flu Vaccination within the Trust in 2016/17. We know that high levels of vaccination amongst the workforce helps protect staff and patients from catching and spreading flu. Work to improve the vaccine uptake was led by Prof. Paul Fish, Director of Nursing & Quality, and was coordinated through our Pandemic Flu group. This ensured effective collaboration between our Infection Control Team, Microbiology Team, Pharmacy Team, Nursing & Medical Colleagues, Press Team and Quality Team.

  Vaccinations started on the 10th October 2016. Fixed drop in sessions were provided, as well as roving vaccinators to wards and outpatient departments to increase the accessibility to the vaccine for clinical staff. We targeted key clinical meetings including MDT meetings, Trust wide Audit Morning, Staff achievement awards night. We also capitalised on national infection control week to increase awareness and promote uptake of the vaccination.

  We were really very pleased to be the most

improved Trust in London for the uptake of Flu Vaccinations this year. We increased the uptake from 31% of staff to 60.8%. However, despite this fantastic improvement, we did not meet the 62% target for partial payment of the CQUIN. We are confident we can achieve our target in 2017/18 and improve the flu protection for our patients and staff even further.

CQUIN Scheme 2017/18/19

For the first time the Trust are opting for a two year CQUIN scheme which will provide greater certainty and stability on the CQUIN goals leaving more time for health communities to focus on implementing the initiatives.

The CQUIN scheme is intended to deliver clinical quality improvements and drive

CCG CQUINS:

- National – NHS Staff Health & Well Being - MSK & Stress
- National – NHS Staff Health & Well Being - Healthy Food and Drinks Options
- National – NHS Staff Health & Well Being Uptake of Flu
- National – Reducing Impact of Serious Infections
- National – Advice and Guidance
- National – E-referrals
- National – Preventing ill health by risky behaviours – alcohol screening
- National – Preventing ill health by risk behaviours – alcohol brief advice or referral

NHS England CQUINS

- Spinal Surgery Network
- Clinical Benchmarking – Service Re-design
- Telemedicine

4.2.5 CQC registration and compliance

All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain high quality care in order to retain their registration. RNOH is required to register with the CQC and its current registration status is 'without conditions'.

4.2.6 Data Quality

RNOH will be taking the following actions to improve data quality RNOH will be taking the following actions to improve data quality. The oversight of data quality and its assurance will be performed by the Information Quality and Governance Steering Subcommittee. The Sub-Committee will identify and ensure that information Asset Owners have processes and validation arrangements in place to enable them to report assurance on data quality. The Information Governance Team will liaise between the Asset Owners and the Sub-committee.

4.2.7 NHS number and General Medical Practice Code Validity

RNOH submitted records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.1% for admitted patient care

99.2% for outpatient care

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

100% for admitted patient care

99.9% for outpatient care

(Source: SUS data quality dashboard. April 2016 – December 2016 inclusive)

4.2.8 Information Governance Toolkit attainment levels

Information Governance (IG) assesses the way organisations 'process' or handle information. It covers personal information (i.e. that relates to patients/service users and employees) and corporate information (e.g. financial records). IG provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- The Data Protection Act 1998
- The common law duty of confidentiality
- The Confidentiality NHS Code of Practice
- The NHS Care Record Guarantee for England
- The Social Care Record Guarantee for England
- The International Information Security standard: ISO/IEC 27002: 2005
- The Information Security NHS Code of Practice
- The Records Management NHS Code of Practice
- The Freedom of Information Act 2000

RNOH Information Governance Assessment Report overall score for 2016/17 was 71%, and was graded 'Satisfactory'. This was an improvement from the 2015/16 submission.

4.2.9 Clinical coding error rate

A formal clinical coding quality audit was completed to NHS Digital and Information Governance standards in January 2017. The audit report demonstrates that the RNOH has maintained its high standard of coding quality and has achieved similar accuracy scores compared to the previous year.

Table: coding accuracy percentages using formal coding audit process

YEAR	PRIMARY DIAGNOSIS ACCURACY	SECONDARY DIAGNOSIS ACCURACY	PRIMARY PROCEDURE ACCURACY	SECONDARY PROCEDURE ACCURACY
16/17	95.0%	97.9%	99.0%	95.0%
15/16	96.5%	98.1%	95.0%	98.2%

Data Source: RNOH-IG Clinical Coding Audit 2016-17

The income variance for the audited sample was very low (variance = 0.2% for a sample total value of £772,000). This was an improvement on the previous year where the income variance value was 0.36%. The income variance figures are very low for clinical coding audit findings and show a high level of coding and income accuracy.


“By having a positive and open attitude I feel my patients and their relatives are supported by caring staff in a friendly atmosphere.”

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 the Health and Social Care Information Centre (HSCIC) where available. The RNOH has added a number of 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) - CORE INDICATOR

The RNOH considers that this data is as described for the following reasons: the Trust has a multidisciplinary VTE group that 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
- Implement and review mechanisms for VTE related clinical audits
- Complete root cause analysis investigations of 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
- Set up training and education for staff including medical doctors, pharmacists, and ward staff on VTE prevention, recognition, and treatment.

YEAR	2014/15	2015/16	2016/17
% patients admitted who were risk assessed for VTE	**99.6**	**99.7**	**99.8***

Source: NHS England published data except *provisional internal data

5.1.2 Clostridium difficile infection rate - CORE INDICATOR

The Royal National Orthopaedic Hospital NHS Trust considers that the rate per 100,000 bed days of cases of C.difficile infection is as described for the following reasons: the Trust complies with the Department of Health guidance for mandatory reporting and management of positive cases of C. difficile infections acquired in the Trust. The data is submitted to Public Health England and it is benchmarked nationally against other Trusts. The RNOH board subjects outs C.difficile data to external audit for assurance purposes.

In 2016/17 financial year the Trust had 2 cases of C difficile infections against a target of 2. The Trust recorded a further 2 cases of C difficile carrier status in its inpatient group within the year. The infection control team on behalf of the Trust continues to embed the following actions targeted at reducing its rate of C.difficile infection in order to improve the quality of its services and patient experience by:

- Maintaining and monitoring standards of cleanliness in the hospital and patient's surroundings.
- Continuous staff education on C.difficile infection; its causes/pathway, identification, appropriate sampling, prompt treatment, isolation precautions, handwashing and other preventive measures
- Maintaining and monitoring compliance with good infection control practice across the Trust including good hand hygiene practice and cleaning of clinical equipment as a priority.
- Networking with other hospitals, sharing and implementing best practice in relation to management of C. difficile infection .
- Ensuring robust Root cause analyses of patients who develop C difficile in hospital, to identify areas for improvement in patient care.

- Maintenance of the Outpatient Parenteral Antimicrobial Therapy (OPAT) service, patient monitoring via the bone infection clinic and assurance through Antibiotic stewardship group and infection control committee.
- Strengthening Antibiotic stewardship within the Trust via consistent review of antibiotic prescribing, assessment and management of patient with or at risk of C.difficile infection in line with best practice.

The table below provides comparison of the number of C. difficile infections in the Trust last 4 years versus allocated target by NHS England. The target score is a yearly rolling figure calculated by NHS England and is based on performance indicators of the previous year.

YEAR	2013/14	2014/15	2015/16	2016/17
C.diff infections	9	3	2	2
Target	3	13	2	2

Note: Confirmed data – Public Heath England – HCAI Data Collection System 2016/17

5.1.3 Patient Safety Incident Reporting - CORE INDICATOR

The 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.

INDICATOR	2013/14		2014/15		2015/16		2016
	APR 13 – SEP 13	OCT 13 – MAR 14	APR 14 – SEP 14	OCT 14 – MAR 15	APR 15 – SEP 15	OCT 15 – MAR 16	APR 16 – SEP 16
Number of patient safety incidents reported[1]	440	478	501	361	347	334	343
Rate of patient safety incidents reported, per 100 admissions (as of 14/15 per 1000 bed days)[2]	5.55	6.03	22.15	16.33	15.9	16.05	16.3
% incidents that resulted in severe harm (or death)	2.3%	3.6%	3.8%	3.9%	0.6%	0.3%	0%
% incidents that resulted in death	0.2%	0.2%	0.4%	0.3%	0%	0%	0.3%
Lowest Performing Trust					16.34	16.05	16.3
Highest Performing Trust					150.63	141.94	150.6

Data Source: (Source: NRLS Organisation data for Acute Specialist Hospitals)

The Royal National Orthopaedic Hospital recognises that although serious incidents in health and social care are relatively uncommon, from time to time things can and do go wrong in the delivery pf complex healthcare. When adverse incidents do occur the Trust has a responsibility to investigate & ensure that there are systematic measures in place for safeguarding people, property, Trust resources and reputation. This includes responsibility to learn from these incidents in order to minimise the risk of these happening again.

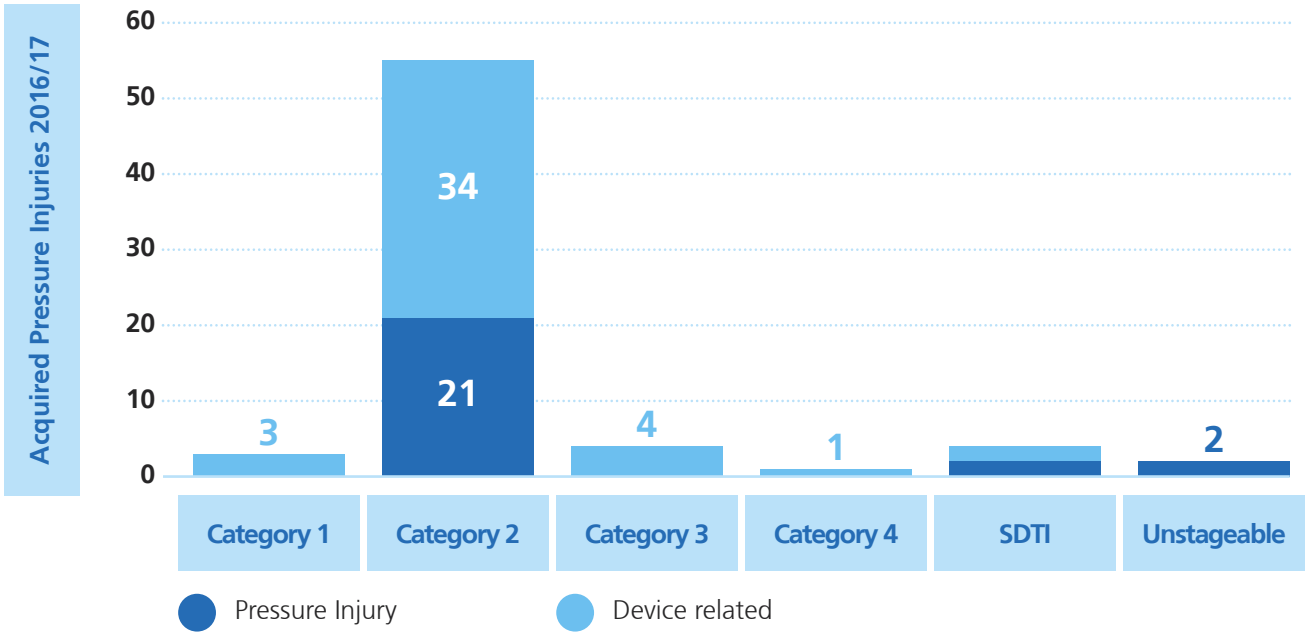
A new combined incident and serious incident policy was approved in 2015/16. This policy is supported by the Complaints Policy and Being Open and Duty of Candour Policy which helps the organisation to understand why things went wrong, how we can prevent or minimise similar incidents and how we can share that learning across the organisation and externally. Serious incidents are investigated by a nominated multidisciplinary panel using the root cause methodology Monthly reports are submitted to the Clinical Quality Governance Committee as part of the Quality report.

5.1.4 Pressure Ulcers

The Royal National Orthopaedic Hospital NHS Trust has adopted a zero tolerance to hospital acquired pressure injuries following recognition of validated pressure injury trends.

Pressure injury data is collated and reported with transparency, recognising the importance of developing strategies to tackle the direct nature of development through action learning.

This financial year (2016/2017), the trust has validated and reported 70 acquired pressure injuries.



Pressure injuries validated as category 2 or more including suspected deep tissue injuries (SDTI) and unstageable pressure injuries are escalated to a Pressure Injury Rapid review investigation. This process enables the identification of key aspects leading to learning action plans and observations of trends across the organisation. Avoidable and unavoidable analysis is considered along with aspects of SCALE (Skin Changes at Life End).

Areas identified are outlined below which have demonstrated a reduction in further pressure injuries following intervention.

PROBLEM	ACTION	PROCESS	OUTCOME
Medical device related Pressure Injuries from lateral theatre supports	Review of lateral support equipment in theatres used for positioning.	Contact with the company representatives Review of alternative products available Education of product positioning and padding.	Observed reduction in acquired pressure injuries.
Medical device related pressure injuries from anti embolism stockings	Identify if harm was caused by product vs user application.	Audit of stocking application process with company and clinical educator. Demonstrated inconsistent application of product and education sessions commenced.	Stockings re audited with marked improvement and reporting reduced following introduction of training.
Plaster cast pressure injuries on high risk patients i.e. vascular / learning disabilities	Recognition of high risk comorbidities leading to higher frequency of cast changes.	Review of plater theatre processes. Review of patient/carer education of early detection.	Observed reduction in acquired pressure injuries.

Other processes which have been introduced to raise the importance of pressure injury prevention within the Trust:

- Message of the week: a statement of highlighted aspect of care which will impact practice e.g. Use of risk assessment tools & clinical judgement
- STOP Pressure ulcer Day/ week – engagement in supporting the international event throughout the hospital for staff, patients and carers
- React to red campaign
- Review and evaluation of innovative equipment i.e. for the early detection of pressure ulcer development
- Continued mandatory training of pressure injury prevention

The Trust recognises that further work is required to reduce pressure injury incidents and the following plans outlined in the SMART chart project our goals for 2017/18.

The implementation of these plans will be coordinated and conducted by the Tissue Viability team within the Royal National Orthopaedic Hospital NHS Trust using evidence based practice guidelines to underpin all interventions.

5.2 Clinical Effectiveness Measures

5.2.1 Summary hospital-level mortality indicator (SHMI) - CORE INDICATOR

The measure for Summary Hospital-level Mortality Indicator (SHMI) is not applicable to the Trust.

5.2.2 Patient Reported Outcome Measures - CORE INDICATOR

RNOH considers that the Patient Reported Outcomes Measures (PROMS) 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.

PROMs are designed to allow patients to assess improvements to their health following surgical treatment. Patients answer questions about their quality of life before surgery and again after surgery. The two scores are compared and the difference is regarded as a health gain (or loss). These results provide an indication of the success and benefit of their surgery on their health. The responses are analysed independently and benchmarked against other trusts.

PROMS use three different measures to assess improvements to health following surgery. Although each measure is slightly different, a positive number means the patient has experienced an improvement to their health. The greater the number, the greater the patient reported improvement to their health.

Four procedures currently subject to PROMs are carried out at the RNOH and the table below provides RNOH performance against the three measures: EQ-5D, EQ-VAS, and the Oxford Hip and Knee Scores. EQ-5D asks questions about mobility, ability to self-care, ability to carry out usual activities, pain and discomfort, and anxiety and depression. EQ VAS asks patients to rate their overall health on a scale (VAS = visual analogue scale). The Oxford Score is a short questionnaire designed to assess function and pain.

PROMS – CASEMIX ADJUSTED HEALTHGAINS	NATIONAL AVERAGE 2015/16	RNOH 2013/14	RNOH 2014/15	RNOH 2015/16
Hip Replacement - PRIMARY				
EQ-5D	0.438	0.410	0.412	0.463
EQ VAS	12.405	8.014	10.68	11.204
Oxford Hip Score	21.617	19.784	21.035	22.205
Hip Replacement - REVISION				
EQ-5D	0.285	0.198	0.280	0.244
EQ VAS	6.418	5.870	6.472	4.192
Oxford Hip Score	13.206	8.703	12.990	9.726
Knee Replacement - PRIMARY				
EQ-5D	0.32	0.288	0.273	0.302
EQ VAS	6.226	3.593	4.921	4.714
Oxford Hip Score	16.368	14.438	14.91	15.141
Knee Replacement - REVISION				
EQ-5D	0.258	0.185	0.231	X
EQ VAS	2.031	-3.054	-5.04	X
Oxford Hip Score	11.935	6.867	10.223	X

Source: NHS Digital latest published data (Accessed February 2017)
X = low sample size, results not available.

Some data is not yet available due to the 6 month delay in sending out post-operative questionnaires and their return, and because the published data only covers part of the reporting year.

5.2.3 Emergency readmissions within 28 days - CORE INDICATOR

The Royal National Orthopaedic Hospital NHS Trust considers that the percentage of emergency readmissions within 28 days of discharge from hospital is as described for the following reasons: every time a patient is discharged and readmitted to hospital the episode of care is coded. The Information Team continually monitors and audits data quality locally and the Trust participates in external audit which enables the Trust to benchmark its performance against other Trust.

The Royal National Orthopaedic Hospital NHS Trust admitted 17494 (April 2016-March 2017) NHS patients in 2016/17. Of these 83 were emergency readmissions within 28 days of discharge.

The Royal National Orthopaedic Hospital NHS Trust intends to take the following actions to reduce readmissions to improve the quality of its services by working to implement a process of exemplar discharge, while continuing to monitor those patients discharged from the Royal National Orthopaedic NHS Trust and readmitted to other hospitals to ensure accurate readmission rates and appropriate clinical review of any readmissions within 28 days.

PERCENTAGE OF EMERGENCY READMISSIONS WITHIN 28 DAYS OF DISCHARGE FROM HOSPITAL OF PATIENTS:	2013/14	2014/15	2015/16	2016/17
0 to 14 year olds	0.20%	0.04%	0.04%	0.04%
15 or over	0.04%	0.50%	0.52%	0.43%

Source: Trust Data

5.3 Patient Experience Measures

5.3.1 Responsiveness to patient needs - CORE INDICATOR

The Royal National Orthopaedic Hospital NHS Trust considers that the means core of responsiveness to inpatient personal needs is as described for the following reasons:

- Each year the Trust participates in the National Inpatient Survey. A random sample of patients is sent a nationally agreed questionnaire and the results are independently analysed before being published by the CQC.
- This indicator shows the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs. (Score out of 100)
- The five questions are:
  - Were you as involved as you wanted to be in decisions about your care and treatment?
  - Did you find someone on the hospital staff to talk to about worries and fears?
  - Were you given enough privacy when discussing your condition or treatment?
  - Did a member of staff tell you about medication side effects to watch for when you went home?
  - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- For 2015/16, the Royal National Orthopaedic Hospital was rated 9th out of 150 trusts for responsiveness to patient needs.

	RNOH 2013-14	RNOH 2014-15	RNOH 2015-16	HIGHEST PERFORMING TRUST 2015/16	LOWEST PERFORMING TRUST 2015/16	NATIONAL AVERAGE 2015/16
Responsiveness to personal needs	77.8	78.7	74.4	86.2	58.9	69.6

Source: NHS Digital (2016/17 data not published)

The Royal National Orthopaedic Hospital NHS Trust has taken the following actions to improve this rate and so the quality of its services:

- Recognised that although it is performing above national average and in the top 10 Trusts nationally, work to improve patient experience needs to continue.
- Introduced new monthly Quality Report that provides each ward and service a breakdown of patient feedback scores and comments.
- Included on the Trust's Balanced Scorecard indicators specific to patient experience and patient needs. These include measures of length of stay, patient experience of the discharge process, staffing levels, and patient perception of staffing levels.
- The Trust continues to look to improve its engagement and involvement of patients in the development of its services, ensuring that patient voices are heard and acted on.

5.3.2 Friends and Family Test - CORE INDICATOR

Patient Friends and Family Test

The Friends and Family Test (FFT) is a single question which asks patients whether they would recommend the NHS service they have used to friends and family who need similar treatment or care. At the RNOH, the FFT question is asked in all inpatient wards, outpatients, and in therapies.

For inpatients, the FFT question is part of a longer real-time patient survey in which we ask patients to tell us about their experience of our care, services, and hospital environment.

In 2016/17, the RNOH was one of the top trusts nationally for inpatient response rate (see NHSE published FFT data). For the year, the Trust had a 55% response rate for the year, over double the national average for response rate.

Patients also left many thousands of free text comments during the year, and these are analysed and reported to back to wards to allow improvements to be made

	RESPONSES	RESPONSE RATE	WOULD RECOMMEND	WOULD NOT RECOMMEND
Inpatients				
	5907	55.1%	96.3%	0.8%
2015/16	5536	46.6%	96.0%	1.1%
	4422	52.4%	96.0%	1.0%
Outpatients				
	4470	5.9%	94.5%	2.1%
2015/16	3442	4.7%	93.8%	2.0%

Source: Internal Trust Data

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

Inpatient wards regularly receive patient feedback reports that provide staff with all of the good comments patients have made about the ward. These reports are discussed at team meetings and also displayed on the ward for patients and visitors to see. This reinforces not only the Trust's high standards of care but also allows staff to see that patients recognise and value their efforts.

When we don't get it right and we fail to deliver the experience of care our patients expect, it is important that we listen to patients to learn what we could have done to improve their experience. Senior nurses and ward managers receive a regular report on all of the less positive feedback. These reports establish common themes, and senior nurses and managers can use this feedback to formulate a plan of action to ensure issues are addressed. 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.

Our patient experience strategy

We have made significant progress across all our services to enhance patient experience. However, there is more we can do to strengthen our approach to listening and responding to patient feedback.

Our vision for patient experience is one that requires all staff to provide compassionate care, so that when people access our services – as a patient or a carer – they can be confident that the care they receive will be kind, sensitive and compassionate.

We have high expectations around the improvements required in patient experience, both in terms of receiving real time feedback and on achieving measurable improvements in our results in the national surveys. We are committed to improving and enhancing patient experience and expect to see significant improvements in the experiences of patients receiving care.

Patient Feedback & Suggestions

RNOH continue to be committed to improving all communication with patients and carers, and we are well on the way to reaching our aim that all patients should feel safe, involved and able to make informed choices about their treatment and care.

Patient feedback & suggestions inpatients

"Friendly staff working hard-still smiling. Volunteers helping out. Running very late but perhaps inevitable."
OUTPATIENTS

"I really admired the dedication of the volunteers at RNOH. The lady who greeted me and settled me in was so caring and competent. The art class was wonderful to. I have never had an interest in Art, but she made it so accessible that I now have a new hobby to aid relaxation."
REHAB WARD

"The welcome packs are lovely idea, and I love the idea of the reward badges thank you for all your care and attention."
THE COLEMAN UNIT

"Excellent care on the ward, only spoiled by a patient watching films without headphones late into the night."
DUKE OF GLOUCESTER

"Nothing can be done to improve or enhance my week in Ward 4. Every single person I came across has been polite, professional and good natured, Nurses, cleaners and kitchen staff. There aren't enough words to convey how overwhelmed I am with the service here. Whoever is in charge of training/hiring should be commended as it cannot be by chance that 50 staff (approx) are all so perfect in every way."
WARD 4

"The staff was all very friendly and helpful. Treatment is very good. I would also add, the assistance from car parks to people who require it, is amazing. It was made a pleasant stay. Thank you."
THE COLEMAN UNIT

Patient feedback about Outpatients service

"The service has been first class."
OPD BOLSOVER

"The service has been first class."
OPD STANMORE

"You have provided a very high level of service in all areas when I attended my recent Outpatient appointments."
RNOH OPD

"The service provided is professional. However, waiting timings can be very long."
OPD STANMORE

"Good customer care. Very warm and welcoming"
OPD BOLSOVER

"My experience of the RNOH has always been second to none. I would not want to go to any other hospital for treatment."
OPD BOLSOVER

"Inspiring confidence and all staff are helpful and pleasant to deal with."
OPD STANMORE

"Efficient friendly helpful staff. Pleasant surroundings."
THE COLEMAN UNIT

5.3.3 Staff recommendation of the Trust as a provider of care to their family or friends - CORE INDICATOR

The RNOH considers that this data is as described for the following reasons: annual national staff survey is carried by an independent organisation.

	RNOH 2014/15	RNOH 2015/16	RNOH 2016/17	NATIONAL AVERAGE FOR SPECIALIST ACUTE TRUSTS 2016/17	HIGHEST SPECIALIST ACUTE TRUST PERFORMANCE TRUST 2016/17	LOWEST SPECIALIST ACUTE TRUST PERFORMANCE TRUST 2016/17
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.	87%*	89%	88%	90%	95%	76%

Source: Picker NHS Staff Survey 2016

753 people took part in the 2016 National staff survey at RNOH this year. This is a response rate of 55%, which is above average for acute specialist Trusts in England and compares with a response rate of 52% in 2015. We can therefore be assured that the feedback is representative of the views of our staff. Overall our scores and feedback have improved, often significantly, in a wide range of areas. We have also not declined on any key finding from last year's survey. We have improved in our overall staff engagement score and narrowed the gap between white and BME staff on key indicators required for the Workforce Race Equality Standard. We have remained static in some key areas but this is in the context of a worsening national picture i.e. the majority of our comparator Trusts have declined in this areas. We are developing local action plans to deliver further improvements.

5.3.4 Complaints

Lessons learnt from investigating complaints, as well as resolving issues and concerns through our PALS service play a key role in improving service quality and patient experience. This year we report on performance, activity and on the many policy and service changes we have implemented to ensure all our patients and service users have access to prompt local resolution and an effective complaints process if they wish to make a complaint.

In 2016/17 the RNOH received 121 formal complaints compared with 88 in the previous year. There was a significant spike in number of complaints at the start of the year, however this has now reduced to approximately 7-8 complaints per month from August 2016.

The Trust continues to encourage patients to highlight their concerns to us.

5.3.5 PALS

During the last year, our Patient Advice and Liaison Service (PALS) Team has continued to provide a confidential advice and local resolution service. The team ensures that individual concerns - whether from patients, relatives or their representative - are 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 team and the central complaints team work alongside the governance staff in each of our divisions to ensure that patient concerns are heard and responded to.

During 2016/17, the PALS team dealt with 1,854 contacts. it is slightly lower than 2015/16 of 1,881 PALS contact.

5.4 Maintaining continuous quality improvement

The RNOH is committed to improving the quality of its services. This section details some of the quality improvement work currently underway at the Trust, including work addressing particular issues and concerns. Additionally, NHS England has requested each trust's 2016/17 Quality Accounts contain information on:

- Implementation of Duty of Candour
- Patient safety improvement plan (information is provided above as part of our review of last year's quality priorities)
- NHS staff survey results for key finding indicators KF21 and KF26
- CQC ratings grid

These are detailed below, with the exception of the patient safety improvement plan as this information is provided above as part of our review of last year's quality priorities.

5.4.1 Implementation of Duty of Candour

As of the 1st of November 2014, it is required that all providers registered with the CQC, both healthcare and adult social care providers, needs to be open and transparent with those who use their services about their care and treatment, including when it goes wrong.

The introduction of a statutory duty of candour is recognised as a significant step towards implementing a key recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry (commonly referred to as the Francis Inquiry).

The Royal National Orthopaedic Trust is committed to delivering care and services that are safe, effective, caring, responsive and well-led. However occasions arise where a patient suffers an unexpected negative outcome or experiences harm. Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. Being open is a set of principles that healthcare staff should use when communicating with patients their families and carers following an incident in which the patient was harmed.

This year we have carried out an audit examining our performance in relation to duty of candour. The audit found that:

- In 77% of cases we could find evidence of a discussion with the patient or their family about what had gone wrong.
- There was evidence of an apology in 50% of cases reviewed.
- There was evidence of the outcome of an investigation being shared with the patient in 25% of cases

We recognise that there is still room for improvement in the way that we document discussions with patients when we exercise the duty of candour, and in ensuring that the patient is fully updated on the outcome of investigations. To support this we have rolled out fortnightly Duty of Candour drop in training sessions for all staff. We are also implementing the following actions:

- Duty of Candour "champion" training to be rolled out at local level across all disciples
- Duty of Candour Session at Trust Wide Audit Morning
- A Mandatory E-Learning programme to be developed to support staff in having and documenting discussions.
- Duty of candour performance metrics to be included in IQR
- Duty of Candour to be included in a Director of Nursing weekly message
- Duty of Candour Monitoring SOP development.

5.4.2 WRES Results - NHS Staff survey results for key indicators KF21 & KF26

A historical comparison of the NHS Staff Survey results for key finding (KF) 26 reveals a slight increase in the percentage of staff who feel they have experienced harassment, bullying or abuse from other staff in the last 12 months. The 1% rise in these results is the same for both white and BME groups, which shows there is no ethnic difference, but does not allay the concerning trend of increasing levels of interpersonal conflict amongst staff.

A similar historical comparison of KF21 – the percentage of staff who believes the organisation provides equal opportunities for career progression of promotion – shows a marked improvement in the measure for BME staff, while the results from white staff have remained static. The increase in BME staff who believes the Trust provides equal opportunities increased from 71% in 2015 to 75% in 2016, a very positive (and statistically significant) result. The overall Trust results for KF21 are now broadly comparative to the Acute Specialist Trust average.

The Trust has dedicated significant time and effort to the equality, diversity and inclusivity agenda over the past 12 months through a number of activities and initiatives. The Equality Achievement Network (EAN) – an open forum for staff who are interested in improving the RNOH for everyone – has continued meeting regularly to discuss areas of concern for some staff groups. The EAN

	YOUR TRUST IN 2016	AVERAGE (MEDIAN) FOR ACUTE SPECIALIST TRUSTS	YOUR TRUST IN 2015
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months			
White	27%	24%	26%
BME	30%	28%	29%
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion			
White	88%	89%	88%
BME	75%	75%	71%

also delivered the Trust's first ever 'Diversity Festival', which involved a full day of activities designed to celebrate staff diversity in all its forms. A second Diversity Festival is already being planned due to the fantastic reception the first running of the event received from our staff.

In addition, the Trust has invested in new ways for staff to raise concerns and 'speak up' about things that may be bothering them at work. Central to these efforts are a dedicated page of the staff intranet for raising concerns and the appointment of the RNOH's first Freedom to Speak Up Guardian.

The continuation of the 'Listening into Action' delivery group and the introduction of the 'Fair Recruitment' guidelines are other examples of the work the Trust is undertaking to ensure all staff have a voice in the decision making of the organisation and reduce discrimination

OVERALL RATING FOR THIS HOSPITAL	REQUIRES IMPROVEMENT
Medical care	Outstanding
Surgery	Good
Critical care	Good
Services for children and young people	Requires improvement
Outpatients	Requires improvement

5.4.3 CQC Action Plan

The Care Quality Commission (CQC) monitors, inspects and regulates health and social care services in England to ensure they meet fundamental standards of quality and safety. Performance ratings and findings from the CQC on the quality and safety of services are published regularly. The CQC ask a number of key questions to inform their view on the quality and safety of services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain high quality care in order to retain their registration. RNOH is required to register with the CQC and its current registration status is 'without conditions'.

RNOH was inspected by the CQC in May 2014, with subsequent inspection report published in August 2014. RNOH was one of the first specialist Trusts to be inspected under CQC's new inspection approach.

Overall, the Trust was rated as 'Requires improvement'. The ratings for each of the Trust's service areas are shown above.

In response to the CQC inspection report, the Trust had in place an action plan to address the conclusions reported by the CQC. RNOH has made good progress in implementing the actions to address these issues.

A programme of mock inspections and quality assurance visits took place during 2016 and 2017. Additionally, some services have undertaken peer reviews and benchmarking to assess and contextualise the quality and performance of their service.

Trust has begun the implementation of a trust-wide quality improvement programme. There are three main elements to this programme: self-assessment, staff engagement, and quality improvement action planning.

A number of activities have been planned to engage staff in quality improvement. A monthly quality improvement drop in session has been established to allow staff at all levels to come and find out about quality in their department or ward and what they can do to make improvements. A CQC working group is currently visiting each ward and service to provide latest quality monitoring information, discuss the likelihood of an imminent inspection, and support and encourage staff to identify what they can do to improve quality. This has been combined with self-assessment booklets to allow staff to assess their own knowledge and practices in line with the CQC quality domains framework.

A rolling action plan / areas of focus register has been created to run alongside the Trust's risk register. This action plan is multi-level, containing areas of focus from executive to ward levels. Issues identified through a variety of intelligence sources are logged on the action plan alongside the appropriate CQC domain and KLOE. This plan will go to divisional performance meetings and other committees and forums to ensure all actionable issues are addressed.

Mock inspectors at the RNOH were carried out on the 23rd February, 1st March, and 2nd March. In total, nearly 40 members of staff were involved in the inspections from all grades, clinical and non-clinical.

The general outcome of the CQC inspection was highlighted as positive.

- Patients were very positive about the care that they have received, and a number of patients compared the RNOH favourable to that of their local hospital
- Cleaning was found to be good across the wards
- The inspection teams observed good patient care across the Trust
- Good governance processes in places (Alan Bray, Paediatrics)
- Staff felt well-supported by their management, and felt able to raise concerns
- Improvements to Duke of Gloucester and Margaret Harte facilities was appreciated by patients
- The inspection teams noted good coordination between team on Ward 4 and LSCIC in particular
- Wards displayed thank you cards on the noticeboards.

APPENDIX 1

Statements from NHS England Specialist Commissioners, Harrow Healthwatch & Harrow Health and Social Care Scrutiny Sub-Committee

The Quality Account has been developed by the Trust with input, involvement, and consultation from a range of stakeholders.

This has included:

- Consultation on the Trust website, seeking views of proposed quality priorities
- Presentation of quality priorities with the RNOH Patient Group
- Discussion of our quality priorities with commissioners through the Clinical Quality Review Group
- Internal discussions of the Quality Account at the Clinical Quality and Governance Committee
- Presentation of draft and final Quality Account to Healthwatch Harrow
- Presentation of the Quality Account to Harrow Health and Social Care Scrutiny

Specialised Commissioning
Skipton House
1st Floor
80 London Road
London SE1 6LH

NHS England's response to Royal National Orthopaedic Hospital NHS Trust Quality Accounts 2016/17

NHS England would like to thank the Royal National Orthopaedic Hospital NHS Trust for the opportunity to review and provide a statement response to their 2016/17 Quality Accounts. From reviewing the Trust's Quality Accounts, we can confirm that as far as it can be ascertained it complies with the national requirements for such a report. We are satisfied with its clarity and accuracy (as far as it is based on the information available to NHS England).

Firstly, we congratulate the Trust on its achievements over the past year. We note the detailed narrative of the key quality priorities and challenges the Trust has faced over the past 12 months. We commend the Trust for its commitment and initiatives to deliver clinical excellence for patients with initiatives such as the introduction of the pharmacist and pharmacy technician led telephone clinics, and ongoing programmes of work to reduce pressure ulcers. We particularly note the staff engagement initiatives such as the '*RNOH VAL-YOU Charter*' and '*I deliver great care*'. We are pleased to see the plans in place to further build on these achievements and the evident commitment of the Trust and the staff to high quality care for all patients.

Whilst we have acknowledged areas of achievements, we would have welcomed clarity on how the Trust will achieve improvements with its incident reporting rates, and performance against the Referral to Treatment (RTT) standard. A more detailed overview of the external reviews and visits with findings triangulated against other intelligence would have been beneficial, as well as additional details in terms of serious incidents including numbers reported and types/themes arising in 2016/17.

We support the priorities that have been identified for 2017/18 – particularly the programme of work to help identify and manage patients who are at risk of acute kidney injury and hope the Trust will link into the wider work on this important topic within the Sustainability and Transformation Partnership. We look forward to working closely with the Trust over the coming year to further improve the quality of local health services.

NHS England
London Region

Ms Vinice Thomas
Director of Nursing and Quality
Specialised Commissioning
On behalf of NHS England – London Region

18 June 2017

Parvin Ahmed-Hasib
CQC Preparation | Quality Assurance
Emergency Preparedness, Resilience, and Response
Patient Involvement Lead
Royal National Orthopaedic Hospital NHS Trust
Brockley Hill
Stanmore
Middlesex
HA7 4LP

Dear Parvin,

Re: RNOH Quality Accounts 2016/17

Thank you for inviting Enterprise Wellness, the accountable body for the Healthwatch Harrow service, to make a formal response to RNOH's Quality Account for 2016/17.

One of our statutory functions, in acting as a critical friend, requires us to comment on the quality of provision and outcomes for the patients and communities that healthcare providers serve. In this regard, we observe that RNOH's commitment to ensuring that they are accountable to patients and the public about the quality of service they provide, remains at the forefront of its delivery.

We have played an active part in recent years in working with RNOH on its quality assurance activities and note that there is year on year progress, ranging from the redevelopment of the site, to be opened in 2018, and to the development of its Val-You Charter to support staff to deliver clinical excellence for all our patients,

We welcome the introduction of a monthly Quality Report, focusing on addressing complaints and lessons learnt, for example, on patient safety, as this is a proactive way in ensuring that issues are dealt with in an effective manner.

We note that patient experience from a 55% response rate, at 96-3%, is high, and is to be commended. We also note that there is a range of priorities for 2017/18, and look forward to participating, perhaps by attending one of the Patient Impact and Lessons Learnt Forums.

As the UK's leading specialist orthopaedic hospital and national centre of excellence, we are pleased to observe the general and specific progress recorded in the Quality Account, as well as the patient and customer focused ethos embedded in by the Trust, management and staff.

Yours sincerely

Ash Verma
Chair
Enterprise Wellness Ltd.
(Accountable body for Healthwatch Harrow)

Cllr Michael Borio
Queensbury Ward
michael.borio@harrow.gov.uk

Paul Fish
Director of Nursing, Quality & Patient Experience
The Royal National Orthopaedic Hospital NHS Trust
Brockley Hill
Stanmore
HA7 4LP

Dear Professor Fish,

I can confirm that the draft report on the Royal National Orthopaedic Hospital Draft Quality Accounts was considered by the Health and Social Care Scrutiny Sub Committee at its meeting of 14 March 2017; and reviewed by the sub committee to its satisfaction.

Yours sincerely,

Cllr Michael Borio
Queensbury Ward

APPENDIX 2

Statement of directors' responsibilities in Respect of the Quality Accounts

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of the annual Quality Account (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended by the National Health Service (Quality Account) Amendment Regulations 2011).

The Quality Account presents a balanced picture of the Trust's performance over the period covered:

- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with Department of Health guidance
- The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Professor Anthony Goldstone CBE
Chairman

Rob Hurd
Chief Executive Officer

APPENDIX 3

External Audit Limited Assurance Report

Independent Auditor's Limited Assurance Report to the Directors of Royal National Orthopaedic Hospital NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Royal National Orthopaedic Hospital NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for Venous thromboembolism (VTE) as reported in section 5.1 of the Quality Account.
- Rate of Clostridium difficile infections as reported in section 5.1 of the Quality Account.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of directors and auditors

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to 28 June 2017;
- papers relating to quality reported to the Board over the period April 2016 to 28 June 2017;
- feedback from Commissioners dated 22 June 2017;
- feedback from Local Healthwatch organisations dated 18 June 2017;
- feedback from Overview and Scrutiny Committee dated 22 June 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey dated 31 May 2017;
- the latest local patient survey dated January 2017;
- the latest national staff survey dated 7 May 2017;
- the latest local staff survey dated October 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 31 May 2017
- the annual governance statement dated 31 May 2017.

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

This report, including the conclusion, is made solely to the Board of Directors of Royal National Orthopaedic Hospital NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Royal National Orthopaedic Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Royal National Orthopaedic Hospital NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

28 June 2017

GLOSSARY

AHP .....Allied Healthcare Professionals
C. difficile .....Clostridium difficile
CCG .....Clinical Commissioning Group
CQC .....Care Quality Commission
CQRG .....Clinical Quality Review Group
CQUIN .....Commissioning for Quality and Innovation
DoLS .....Deprivation of Liberties Safeguarding
EQ5D A standardised measure of patient reported health outcome for hip and knee operations
FARs .....Functional Assessment and Restoration
FFT .....Friends and Family Test
GIRFT .....Getting it Right First Time programme
HAPU .....Hospital Acquired Pressure Ulcers
HES .....Hospital Episode Statistics
IG .....Information Governance
IOMS .....Institute of Orthopaedic and Musculoskeletal Science
KPI .....Key performance indicators
LCRN .....Local Clinical Research Network
MCA .....Mental Capacity Act
MRSA .....Methicillin-resistant Staphylococcus aureus
NEWS .....National Early Warning System
NHSI .....NHS Improvement
NICE .....National Institute for Health and Clinical Excellence
NIHR .....National Institute for Health Research
NJR .....National Joint Registry
PALS .....Patient Advice Liaison Service
POD .....Patient Outcomes Data
PROMs .....Patient Reported Outcome Measures
RCA .....Root Cause Analysis
RNOH .....Royal National Orthopaedic Hospital NHS Trust
SHMI .....Summary Hospital-level Mortality Indicator
SNCT .....Safer Nursing Care Tool
TDA .....NHS Trust Development Authority
UCL .....University College London
UTI .....Urinary Tract Infections
VTE .....Venous Thromboembolism
WHO .....World Health Organization