19th May, 2018

Statement from Healthwatch Birmingham on The Royal Orthopaedic Hospital NHS Foundation Trust Quality Account 2017/18

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for The Royal Orthopaedic Hospital NHS Foundation Trust. We are pleased to see that the Trust has taken on board some of our comments regarding the previous Quality Account. For example, the Trust has:

- Provided details of how it shares learning from complaints and incidents across the Trust.

Patient and Public Involvement

In our response to the Trusts 2016/17 Quality Accounts, we asked to see the following in the 2017/18 Quality Accounts in relation to patient and public involvement:

- A demonstration of how patient feedback and experiences have been used to develop priorities for the 2018/19 Quality Account in the 2017/18 Quality Account;
- Changes in practice or improvement to services that have been made as a result of patient feedback and experience in the 2017/18 Quality Account.
- A demonstration of how the Trust uses patient insight and experience to understand the barriers different groups face and the impact on health outcomes. Consequently, how this data is used to implement change or improvement that addresses the needs of these groups.

It is positive to see that through the external provider 'I want Great Care', the Trust has increased individual pieces of feedback it receives. We note that the Trust received 19,840 pieces of feedback from the Friends and Family Test (FFT) for 2017/18. This is a significant increase on last year's responses which was 2,437 in February 2017. Healthwatch Birmingham would like to commend the Trust for surpassing last year's positive recommender score. We note that 96.6% (19,150) of those who left feedback were happy with the care they received and would recommend the Trust. We believe that the Trust has a rich source of data from the feedback that it has collected through FFT. We therefore welcome plans to code this feedback in the same way the Trusts codes concerns in order to compare for trend analysis.

However, we note that the Trust has not provided any examples of how it uses feedback to improve the quality of services and to understand the needs of particular groups. In our response to the 2016/17 Quality Accounts, we asked the Trust to consider using patient feedback and experience to identify, understand and address health inequality. We argued that this would help identify any gaps in service provision and the needs of different groups. We therefore welcomed the inclusion of demographic data to the FFT questionnaire and the use of this to inform equality and diversity issues across the Trust. It is not clear in the 2017/18 Quality Accounts, how the Trusts use of patient feedback and experience is embedded in the various activities the Trust carried out. The Quality Accounts presents an opportunity for the Trust to demonstrate how patients, the public and carer's feedback, insight and experience is used in decision-making. We look forward to reading in the 2018/19 Quality Accounts:

- how feedback, insight and experiences have informed changes within the Trust.
- how the Trust shares good practice from positive feedback and the impact of this on services and practice.
- how the Trust communicates with patients about how they are using their feedback to make changes. At Healthwatch Birmingham, we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback.

As we suggested in our response to the 2016/17 Quality Accounts, the Trust should consider developing a strategy that outlines how and why patients, the public and carers' are engaged in plans to improve health outcomes and reduce health inequality. A strategy will ensure that there is commitment across the Trust to using patient and public insight, experience and feedback. It will also make clear arrangements for collating feedback and experience.

Regarding staff surveys, we note that 319 members of staff responded to the NHS Annual staff survey, and staff Friends and Family Test. Fifty-six percent of these said that they are extremely or would likely recommend the Trust to family and friends as a place to work. Twenty-one percent were neither likely nor unlikely to recommend the Trust, whilst twenty-three percent were unlikely or extremely unlikely to recommend the Trust. We acknowledge that the Trust has undergone many significant changes over the past year that might have influenced these scores. For instance, the cessation of paediatric services, financial pressure, and increased focus on performance management. We welcome work that has already started in order to improve the response rate. We note that work to improve communication with staff has already began; and initiatives have started to improve patient outcomes and their experiences including 'perfecting pathways', examining the patient journey and seeking continuous improvement. It is positive that these actions will continue to be implemented in 2018/19 in addition to new actions.

We welcome, in particular, plans to develop and implement local staff engagement plans and to provide greater opportunity for staff feedback in order to enhance the value of staff voice. It is our hope that engagement with staff will include engagement in relation to patient experience. This will be important if the Trust is to succeed in embedding a culture of continuous improvement. It is important that staff understand what their role is in relation to patient experience, insights and feedback, and how this informs decision-making within their service area.

We believe that the basic approach of Healthwatch Birmingham's Quality Standard for Patient and Public Involvement (PPI) will help the Trust develop this further. The Quality Standard has a set of questions relating to staff and PPI, which ascertain whether:

- there is a clear strategic approach for PPI that staff understand across the Trust?
- staff understand what their responsibilities are in relation to PPI?
- staff have set objectives for PPI that are regularly monitored?

- staff understand how PPI informs decision-making in their service area to make improvement and address inequality? and,
- staff understand that improvements or changes made as a result of feedback should be shared with patients and the public?

A new requirement for the 2017/2018 Quality Account was to provide information on how the Trust learns from deaths. We commend the Trust for implementing a 'Learning from Death' policy against which each death is reviewed. However, Trust has not stated how it involves and engages meaningfully with bereaved families and carers. It is not clear how the Trust is listening to these families and carers, and informing them of their rights and how they can access support or advocacy. We ask that the Trust demonstrates how it follows the NHS National Guidance on Learning from Deaths regarding family and friends. The guidance states: "*Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken*"

Involving families and carers in case reviews and investigations offers a more rounded view and understanding of patient experience. We would like to read in the 2018/19 Quality Accounts, how families and patients have been involved in various stages of case reviews and investigations. In addition, how the Trust weights families and patient's views, compared with how they weight the views of clinical staff.

Learning from complaints and patient safety incidents

In our response to the Trust's 2016/17 Quality Accounts, we welcomed plans to address the increase in the number of complaints. We particularly welcomed the inclusion of 'embedding learning identified from complaints' as a priority for 2017/18. We are pleased to see that there has been a reduction in the number of complaints the Trust received in 2017/18. We note that the Trust received 148 formal complaints representing a 13% decrease on 2016/17. Two of the three top issues for complaints remain similar to 2016/17, namely communication and clinical treatment. A third issue is the values and behaviour of staff members across all specialties and staff groups.

On the other hand, the PALS department handled 5094 individual contacts, an increase on 2016/17, which was 4,136 contacts. We acknowledge that the increase could have been as a result of increased visibility of PALS number on letters to patients. Resulting in the Trust receiving calls about enquiries rather than complaints, compliments or concerns. We are concerned that almost half of PALS contact is concerning appointment queries, followed by clinical and administrative queries. We welcome the Trust's plans to code PALS concerns in the same way as complaints to enable easier identification of trends. We believe that the Trust should not only identify trends but identify and understand patients reasons for contacting PALS (i.e. around appointments); and develop appropriate solutions.

We note the actions the Trust is taking to address issues around complaints and PALS contact. We look forward to reading in the 2018/19 Quality Accounts, about the impact of these.

Regarding patient safety incidents, we note that incidents reported to the National Reporting and Learning System (NRLS) has increased from 1530 in 2016/17 to 2019 in 2017/18. The rate of patient safety incident per 1000 bed days has also increased from 19.43 to 45.38 with five of these incidents having led to severe harm or death. The Trust had five recorded deaths, three of which went through the Trust's new Learning from deaths process. We note that learning from the review of these incidents has been widely shared across the Trust. We welcome the Trust's plans to improve the standard of incident reporting and engage staff in feedback and sharing lessons from incidents. We look forward to reading about the impact of this in the 2018/19 Quality Accounts.

In our response to the 2016/17 Quality Accounts, we asked the Trust to demonstrate how it learns from complaints and incidents and the impact on services and practice. It is positive to see that the Trust has as one of its priorities for 2018/19 to 'ensure that learning identified from serious incidents and complaints are embedded in practice'. We welcome the goals under this priority:

- Continue to embed the 'action tracker' against recommendations made following a serious incident report.
- Focus on embedding learning into the wider organisation and address staff survey results in relation to poor quality feedback staff receive from the incidents they report.

We welcome the many methods the Trust uses to share learning, for instance through the monthly quality report that focuses on learning from incidents, litigation, coroner cases, serious incidents, PALS, FFT scores and complaints; monthly and weekly operational division meetings which focus on examining evidence of actions taken following learning; and monthly analyses of incidents/complaints. In the 2018/19 Quality Accounts, we would like to read more about the impact of the following actions on sharing learning:

- Programming action plans on the electronic reporting system to remind staff of actions automatically;
- Review of annual staff and patient survey for information relating to patient safety and incidents;
- Develop ward and department level quality reports with a clear focus on lesson learnt; and

Trust Performance against standards

We are concerned that the Trust has failed to meet standards in a number of areas that have the potential to lead to variability in the quality of care leading to poor health outcomes. We note that there has been significant improvement in the number of avoidable pressure ulcers; learning from deaths and reduction in PALS complaints by 20%. However, the Trust has failed or partially achieved in the following areas:

- Reduce the number of incidences of consent on day
- Medical ward rounds to be supported by the wider Multi-Disciplinary Team
- Ensure that learning identified from serious incidents and complaints are embedded in practice
- Ensure that all clinical and corporate policies are in date and have an appropriate audit plan
- Reduction in waiting times in clinics
- Reduction in cancellation on the day of surgery
- Reducing the number of times patient's outpatient clinic appointments are rescheduled

We note the actions that have been taken to address these, such as training for staff on consent processes, introduction of clinic templates to reduce waiting times within clinics, and implementing a 72-hour call to patients before surgery to improve cancellations. We welcome that these continue to be priorities for 2018/19 and we look forward to reading about the impact of the various actions on services and practice.

Regarding inspections, we note that the Trust was inspected by the CQC in early 2018. It is positive that improvements identified as part of this inspection will be the key focus for 2018/19. It is positive to see that the Trust has improved its overall rating to good from 'requires improvement'. We note that outpatients is still rated as 'requires improvement' for the well-led domain. The CQC states that one reason for this was failure by the Trust to share learning from incidents across the Trust.

We note the actions being taken to address the findings of the CQC and we look forward to reading about improvement on these in the 2018/19 Quality Account, in addition to the missed targets above.

The Trusts Priorities for 2018/19

Healthwatch Birmingham has taken note of the Trust's priorities for 2018/19. We particularly welcome plans around staff engagement, learning from incidents and quality improvement generally. We hope that in implementing these priorities, the Trust will involve and listen to patient's experiences to help improve patient care.

As per our role, Healthwatch Birmingham is running various projects to support providers in Birmingham to meet their statutory role of consulting/engaging with patients and the public. Consequently, ensuring that Trusts are using public and patient feedback to inform changes to services, improve the quality of services and understand inequality in access to services and health outcomes. We have worked with some Trusts to review their patient and public involvement process (PPI), identify areas of good PPI practice and recommend how PPI practice can be made more effective. We would welcome the opportunity to explore how we can support the Trust to improve in the year ahead.

Andy Cave
CEO