Secondary Care Quality Account 2016-2017

Commitment to quality

Our locations

Community Diagnostics	
1	Community Diagnostics Head Office, Salford
2	East Lancashire Community DXA Service, Accrington
3	Blackburn with Darwen Community DXA Service, Darwen
4	East Lancashire Community DXA Service, Burnley
5	Calderdale DXA Service, Boothtown
6	Greater Manchester DXA Service, Rochdale
7	Greater Machester DXA Service, Ashton under Lyme
8	Norfolk Community DXA Service, Kings Lynn
9	Norfolk Community DXA Service, Docking
10	Norfolk Community DXA Service, Swaffham
11	North East Essex DXA Service, Colchester
12	Wirral Community DXA Service, Wallasey
13	Wirral Community DXA Service, Wirral
Clinical Assessment and Treatment Services	
14	Rochdale Opthalmology Service, Heywood
15	Rochdale Opthalmology Head Office, Rochdale
16	Rochdale Opthalmology Service, Rochdale

NHS Treatment Centres	
17	Barlborough NHS Treatment Centre, Barlborough
18	North East London NHS Treatment Centre, Ilford
19	Will Adams NHS Treatment Centre, Gillingham
20	Devizes NHS Treatment Centre, Devizes
21	Emersons Greem NHS Treatment Centre, Bristol
22	Shepton Mallet NHS Treatment Centre, Shepton Mallet
23	Southampton NHS Treatment Centre & MIIU, Southampton
24	Havant NHS Diagnostic Centre, Havant
25	St Mary's NHS Treatment Centre & MIIU, Portsmouth
26	Peninsula NHS Treatment Centre, Plymouth
Satellite Clinics	
28	Barlborough Satellite Clinc, Louth
29	Barlborough Satellite Clinc, Boston
30	Barlborough Satellite Clinc, Lincoln
31	Shepton Mallet Satellie Clinic, Frome
32	Shepton Mallet Satellie Clinic, South Petherton
Macular Services	
33	North West Macular Service, Preston
34	North West Macular Service, Preston
35	North West Macular Service, Chorley

Contents

Foreword
by Jim Easton

We provide a uniquely diverse range of healthcare services for NHS patients, commissioned by, or working with, our NHS partners. Throughout our business, you will find colleagues who continuously demonstrate Care UK's values by delivering effective care that achieves the best possible outcome for each patient.

The Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2016/17 and our priorities for quality improvement during the forthcoming year. In developing our Quality Account we have identified and shared information across the organisation, with our patients, doctors, nurses, therapists and management.

Quality improvements have been underpinned by our clinical governance systems and processes, both of which are fundamental to the delivery of high quality care.

Looking to the future, I am confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence.

We remain committed to improving quality across all of our services, and aim to be in the top 10% of all NHS providers for the key quality measures of the services we provide.

This Quality Account

This Quality Account sets out our performance on a range of key measures for our patients, the wider public, commissioners and partners.

It demonstrates what we have achieved in the past year, and plan to achieve in the coming year, within our Secondary Care Division, which currently provides NHS services across:

- Elective Surgery Independent Sector Treatment Centres
- Minor Injury Units/Walk-in Centres

In line with Department of Health guidance 2010-2011, this document focuses mainly upon the following areas:

- Independent Sector Treatment Centres (ISTCs)

Care UK operates:

- Nine Treatment Centres on behalf of the NHS
- Two minor injury units
- One Ophthalmology surgery unit

In the year April 2016 to March 2017 Care UK's Treatment Centres carried out:

- 56673 day case procedures
- 8201 inpatient procedures
- 189478 outpatient consultations, including telephone consultations

Achievements 2016-2017

Over the past year, our achievements have included the first CQC rating of outstanding within the Independent elective surgery sector at our Peninsula Treatment Centre in Plymouth, and in Rochdale Ophthalmology Centre.

In addition we are delighted to report that Shepton Mallet Treatment Centre has been awarded an overall outstanding rating in all domains.

Care UK have had no cases of MRSA bacteraemia or C.difficile in our elective surgery patients since 2011, no cases have been reported of E.coli bacteraemia nor MSSA bacteraemia since national surveillance for these infections began.

Priorities 2017-2018

Our priorities for the coming year are outlined within this Quality Account and once again reflect the five key lines of enquiry set by the Care Quality Commission:

- Safe
- Effective
- Caring
- Responsive
- Well-led

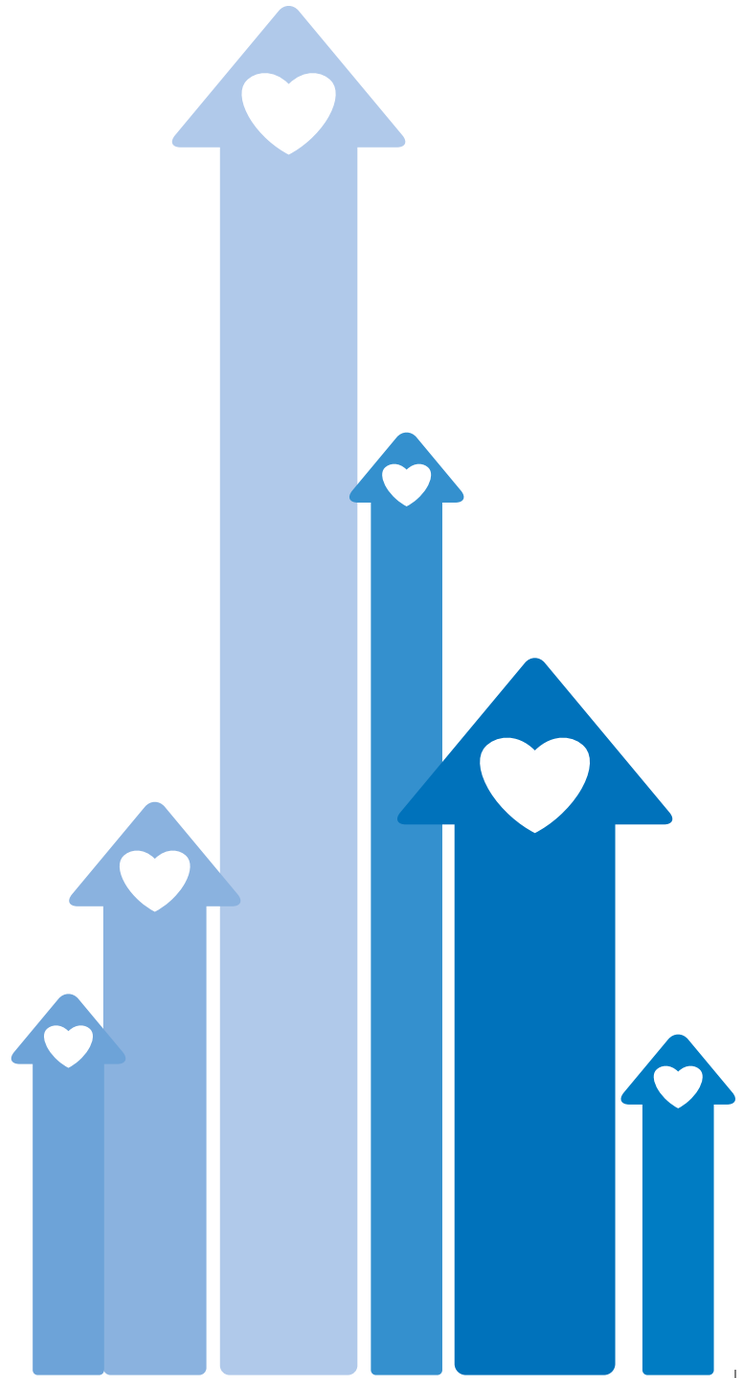
This provides a well-rounded view of the factors that influence quality, and I am confident that, as we continue to listen and respond to our patients and service users, invest in our employees and keep quality-focused in all that we do, we will provide a positive experience for those we are here to care for and help recover.

To the best of my knowledge, the information in this report is accurate.

Jim Easton
Managing Director, Health Care

Part One

Quality Priorities



What is a Quality Account?

Quality Accounts were introduced under the Health Act (2009) to strengthen healthcare providers' board-level accountability for quality, and place quality reporting on an equal footing with financial reporting.

Quality Accounts are both retrospective and forward-looking.

They look back on the previous year's information about service quality to explain where a provider is doing well and where improvement is needed.

Crucially, they also look forward, to explain what a provider has identified (through evidence and/or engagement) as the priorities for improvement over the coming year and how these priorities will be achieved and measured.

The legal duty to publish an annual Quality Account applies to all providers of NHS-funded healthcare services (whether they are NHS, independent or voluntary sector organisations). Only those providing primary care services or NHS continuing care are currently exempt under the regulations.

At Care UK we remain committed to transparency in all our reporting and follow the NHS guidance, as applicable, for our Quality Account.

This encompasses our adoption of the single common definition of quality that encompasses three equally important parts:

- Care that is clinically effective - not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is safe; and,
- Care that provides as positive an experience for patients as possible

Care UK vision and values

Our values are:

- our customers are at the heart of everything we do
- every one of us makes a difference
- together we make things better

Each of us is committed to the highest standards of quality and best practice, to meeting and exceeding our compliance to all standards across the healthcare sector.

Our vision is **'fulfilling lives'**, and each of us works to achieve this every day.

By supporting our teams to focus on three key aims we will fulfil our vision. These are to:

Focus on quality

We want to be renowned for providing high quality services. We must always seek to be the best provider of each of our services, meeting and, ideally, exceeding our service commitments. Constantly engaging with commissioners and patients to understand and meet their needs will help us to achieve this aim.

Lead change

The way healthcare is organised across the NHS is often inefficient for commissioners and frustrating for patients. As a major organisation delivering healthcare and social care, we have an unrivalled opportunity, even a responsibility, to work with commissioners to spearhead a more integrated approach.

Drive innovation

We have a key part to play in driving innovation, efficiency and effectiveness. We can do this by:

- Attracting, engaging, training and rewarding talented, compassionate and caring employees
- Investing in the development of new services aimed at providing the right care in the right place at the right time, integrated for convenience to patients
- Continuing to work closely with partners, suppliers and the many organisations and people we connect with to identify new ways of working.

Introduction

Care UK is an independent provider of healthcare services across England, on behalf of the NHS. Our NHS Treatment Centres provide inpatient, outpatient and day surgery for a range of planned surgery, endoscopy procedures, diagnostic tests and post-operative rehabilitation. Our Treatment Centre facilities are modern and purpose-built and are situated close to public transport links or in redesigned buildings close to, or within, NHS hospitals

Care UK is committed to improving the quality of our services we provide to our patients, their families and carers.

Our 2016/17 quality account is an annual report of:

- How we have performed over the last year against the priorities which we set out in last years' quality account
- Statements about quality of the NHS services provided
- Feedback of the quality account provided by our commissioners, Healthwatch and patient groups
- Our priorities setting out clearly how we are going to improve in the coming year.

As you read this report we hope that it will explain what we believe that great care looks like and what you can expect if you need use our services.

Quality priorities 2017-2018

Healthcare quality priorities.

Care UK's Secondary Care Health Care Division has identified five new quality improvement priorities for 2017-2018.

These will be monitored through our internal reporting programme, shared with commissioners as part of our joint quality reviews and achievements monitored through our internal governance structures at a local and national level.

Achievements and outcomes will be reported in next year's Quality Account.

The identification and development of our new quality priorities involved numerous stakeholders, and took into account patient feedback, complaints, incidents that occurred throughout the past year, as well as new national guidance.

In addition to focusing on the identified national quality priorities, local services will work with commissioners and patient groups to identify pertinent priorities linked to the local healthcare landscape.

Our overall aim is always to provide the best possible experience for those choosing to use Care UK's services.

Quality priority domain	Priority detail	Measure
Safe	The implementation of an electronic audit tool to measure cleaning standards and control within treatment centres.	An electronic audit tool will be developed and implemented enabling audit outcomes of cleaning standards and control to be recorded and evaluated electronically and key points of shared learning disseminated more efficiently.
Caring	Dignity champions will be implemented in each service.	All services have a dedicated dignity champion in role.
Responsive	The implementation of the National eDischarge template and population relevant fields.	All sites with edischarge template in place and relevant fields able to be populated electronically.
Effective	Improvements in the identification and dissemination of shared learning from serious incidents ensuring all valuable, safety-critical learning opportunities have been achieved across all services.	• Local action plans are developed following investigation. The action plans are implemented within defined timeframes locally and monitored accordingly • Serious Incident investigation outcomes will be disseminated broadly across all services, helping to improve shared learning and understanding of how incidents occur and importantly to reduce incidences of any future SI's from occurring.
Well-led	To improve the uptake of the winter flu vaccination and immunisation of all clinical staff across treatment centres.	Priority target - An increase of 5% of staff who are vaccinated against flu.

Safe

Priority - The implementation of an electronic audit tool to measure cleaning standards and control within treatment centres.

What are we trying to improve?
To demonstrate clean and safe services are in place with evidence of maintenance of standards across services

What will success look like?
An electronic audit tool will be developed and implemented enabling audit outcomes of cleaning standards and control to be recorded and evaluated electronically with key points of shared learning disseminated more efficiently. This will allow effective benchmarking across treatment centres via monthly monitoring and dashboards.

How will we monitor progress?
The audit scores and associated action plans will be reviewed as part of the monthly performance reviews with exceptions in services identified and monitored by the Secondary Care Quality and Governance Assurance Committee.

Caring

Priority - Identification of Dignity champions in each service.

What are we trying to improve?
To promote dignity and respect for all patients. This priority links with the dementia strategy to ensure that individual patient and carer needs are identified and managed appropriately.

What will success look like?
An annual dignity audit will be developed and completed by services which will enable the Treatment Centres to create a local action plan to address relevant areas. Each service will identify a dignity champion who will provide support to the local teams whilst linking with Dignity Champions across the organization to ensure best practice is shared.

How will we monitor progress?
The identified action plan will be monitored and managed within the monthly local quality assurance meetings. Any identified needs within services will be discussed at the quarterly Professional Leads meetings

Responsive

Priority - The implementation of the National edischarge template and population relevant fields.

What are we trying to improve?
To ensure the safe onward care of patients within healthcare services. To promote clearer communication routes with other providers to provide seamless care and support improved communication, clinical workflow and more effective transfers of care for our patients

What will success look like?
That all services will have electronic discharge summaries in place with relevant fields populated to share with healthcare agencies in line with National requirements.

How will we monitor progress?
Effective implementation of e discharge templates will be monitored via the monthly performance meetings with exceptions reported via the Quarterly Secondary Care Quality and Governance Assurance Committee meetings.

Effective

Priority - The improvement in the identification and dissemination of shared learning from serious incidents across services.

What are we trying to improve?
To provide robust evidence of the dissemination and implementation of learning across services. This will be in addition to the identification of embedded learning within operational and clinical practice.

What will success look like?
That local action plans are developed following an investigation and these action plans are implemented within defined timeframes locally and monitored accordingly. Serious Incident investigation outcomes are disseminated broadly across all services, helping to improve shared learning and understanding of how incidents occur and importantly to reduce incidences of any future serious incidents from occurring.

How will we monitor progress?
Reduction of repeated serious incidents across services.

Well-led

Priority - To improve the uptake of the winter flu vaccination and immunisation of all clinical employees across treatment centres.

What are we trying to improve?
Through increased vaccination of our frontline employees we hope to minimise the risk of vulnerable patients contracting the virus whilst in our facilities. We also hope to see a decrease in employee absence due to the influenza virus; this will in turn help improve continuity of care.

What will success look like?
Priority target - An increase of 5% of employees who are vaccinated against flu.

How will we monitor progress?
Flu champions in each service will monitor influenza immunization of employees locally. These figures will be reported monthly via monthly performance meetings.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Annabelle Rath

Part Two

Review of priorities for improvement 2016-2017

Reporting back on 2016-2017 quality priorities

In our 2016-2017 Quality Account we set out our priorities for improving the quality of our services during 2016-2017, and, have provided updates and a review of our progress for each priority below.

Quality priority domain	Priority detail	Measure
Safe	1. Establish a frailty scoring system and associated outcomes framework for patients aged over 75 years undergoing planned inpatient surgery 2. Implement the National Safety Standards for Invasive Procedures (NATSSIPs) programme 3. Improve our reporting mechanisms for medication interventions and subsequent action planning	1. All sites to complete a frailty score for patients over 75 who are undergoing elective inpatient procedures. 100% of patients with scores over 7 will have care plans in place 2. Local services to have LOCSSIPs in place in line with NATSSIPs requirements identified centrally 3. All medication interventions to be recorded at all sites and action plans discussed at Quality Governance meetings
Caring	1. To continue to improve Friends and Family Test response rates from outpatients 2. Maintain a supportive environment for those living with dementia by implementing a dementia strategy and introducing dementia champions for all services	1. To achieve a 60% response rate for 1st outpatient attendances 2. Dementia champions identified within all services to support the roll out of key priorities within the dementia strategy
Responsive	1. Continue to respond consistently to patients' complaints and feedback 2. To deliver services free from discrimination and meet the needs of the Equality Act (2010)	1. The introduction of 'You said, we did' feedback mechanisms within all services so that is visible to patients in key patient areas 2. Continuation of our staff survey to identify areas for improvement. Implement the Workforce Race Equality Standard (WRES) and EDS2
Effective	1. The implementation of electronic discharge (EDS) via our patient administration system (PAS) for improved continuity of care and to reduce unplanned follow up in primary care 2. To implement an antibiotic stewardship programme and strategy across secondary care	1. All Treatment Centres to have electronic discharge capabilities within their services 2. All services to have an antibiotic stewardship lead to support the delivery of key priorities within the strategy
Well-led	1. Prepare secondary care diagnostic imaging services for Imaging Services Accreditation Scheme (ISAS) accreditation 2. To develop and implement a training programme for clinical staff in middle management roles	1. Develop a framework to support the ISAS application (through gathering supportive evidence, process review etc.) 2. Identification and enrolment of key managers to undertake a bespoke 12 month training programme

Safe - Priority one:

Establish a frailty scoring system and associated outcomes framework for patients aged over 75 years undergoing planned inpatient surgery.

- All sites complete a frailty score for patients over 75 who are undergoing elective inpatient procedures.
- 100% of identified patients with scores over 7 have care plans in place, with all inpatient services having implemented the Edmonton frailty assessment. Shepton Mallet Treatment Centre complete an alternative assessment tool in line with local Health Care services.
- At the pre-assessment stage of the patient pathway, guidance notes have been prepared and circulated to staff to support their learning of how to use the Frailty Scoring System (FSS) for patients over 75.
- Resources for patients and staff have been developed to explain the rationale for the assessment scoring and expectations for patients.

Safe - Priority two:

Implement the National Safety Standards for Invasive Procedures (NATSSIPs) programme.

All Treatment Centres have completed a review of patient pathways developing and implementing local safety standards for invasive procedures (LocSSIPs) based on the national guidelines. These standards have been reviewed and ratified by the senior management team locally.

4 national LocSSIPs have been identified to be implemented at the relevant Treatment Centres delivering care.

- The use of YAG laser in Ophthalmology
- Dental - to include marking of teeth for removal on the sterile field. This follows shared learning identified as part of a Never Event investigation
- Prosthesis checking to ensure the correct sized prosthesis inserted This follows shared learning identified as part of a Never Event investigation
- Tourniquet removal process as identified as part of a Never Event investigation.

Local SSIPs have been written and are supported by local Standard Operating Procedures to cover all recommendations held within national document.

Audits of implementation of Local SSIPs have been completed resulting in an action plan and gap analysis with recorded actions.

Safe - Priority three:

Improve our reporting mechanisms for medication interventions and subsequent action planning.

Using Datix, we have manufactured a central platform for recording all medicine (pharmacy) related interventions.

The communication and implementation programme has aligned the action planning from these interventions to the local Clinical Governance forums.

Centrally, these interventions have been collated across Secondary Care, to allow benchmarking and limit setting for local sites against this national data.

Caring - Priority one:

To continue to improve Friends and Family Test response rates from outpatients.

We highlighted that we would strive for a response rate of 60% or higher amongst those attending booked first outpatients appointments.

The table below demonstrates the achievement across services.

There has been some improvement in certain areas although not in a consistent manner.

Changes with standard operation procedures have been incorporated with clear lines of responsibility for the distribution of questionnaires to patients and the subsequent electronic download of data.

All services have developed action plans to address the trends identified from patient experience feedback.

Outpatient	Devizes	St Mary's	Will Adams	Barlborough	Emersons	NEL	Peninsula	Shepton	Southampton	Average
April 2016	70%	61%	55%	80%	33%	52%	53%	73%	88%	62.78%
May 2016	78%	61%	55%	78%	38%	85%	44%	73%	75%	65.22%
June 2016	59%	54%	45%	34%	41%	59%	64%	43%	83%	53.56%
July 2016	51%	54%	28%	76%	31%	42%	27%	50%	75%	48.22%
August 2016	67%	55%	35%	82%	33%	40%	31%	46%	80%	52.11%
Sept 2016	72%	100%	48%	68%	27%	17%	46%	44%	31%	50.33%
October 2016	82%	36%	51%	69%	23%	34%	63%	36%	51%	49.44%
November	86%	48%	54%	74%	40%	44%	30%	49%	61%	54.00%
Dec 2016	86%	33%	55%	59%	40%	43%	19%	12%	49%	44.00%
January 2017	100%	59%	84%	82%	62%	44%	55%	17%	74%	64.11%
Average	75.10%	56.10%	51.00%	70.20%	36.80%	46.00%	43.20%	44.30%	66.70%	**54.38%**

Caring - Priority two:

Maintain a supportive environment for those living with dementia by implementing a dementia strategy and introducing dementia link nurses for all services.

Services have identified dementia champions and ensure that any patients with a diagnosis of dementia have a multi-disciplinary meeting to determine individual patient needs. An individualized care plan is prepared to ensure all aspects of care are identified.

St Mary's NHS Treatment Centre has enrolled a number of Dementia Friends, who have attended local training conducted by the Alzheimer's Society and they work in the clinical and support areas.

The clinical teams are committed and trained to identify and support the individual needs of each patient and will provide extra 1:1 support within a dementia friendly setting in the ward.

The PLACE Audit supports the environment regarding Dementia care achieving a site score of 89.09% compared to the national average of 75.28%.

A quality priority for the coming year relates to ensuring dignity champions are in place in all services, this compliments the dementia champion role to ensure that care is delivered, considering the dignity and individual needs at all times.

Responsive - Priority one:

Continue to respond consistently to patients' complaints and feedback.

'You said, we did' methodology has been in place throughout all services over the last year. The 'You Said, We Did' template is a laminated document which is completed in handwriting.

Departmental feedback is displayed within patient areas with staff developing associated action plans for services. These are monitored at a local level within the quality governance meetings and via performance meetings corporately.

Responsive - Priority two:

To deliver services free from discrimination and meet the needs of the Equality Act (2010).

We have made significant progress regarding Equality and Diversity and the implementation of the WRES over the course of the last 12 months.

Overseen by our Equality and Diversity Steering Group, chaired by a member of the Health Care Executive Team, we have initiated a divisional wide on-going educative programme to promote best practice in both employment and service provision as it relates to equality and diversity, predominantly in response to outcomes from the 2016 Care UK annual staff survey.

In addition, in accordance with EDS2, each unit within Secondary Care has a localised action plan in place which addresses specific local issues both in terms of the delivery of clinical services together with target setting relating to the WRES.

Quarterly reports on progress are provided by the Equality and Diversity Steering Group to the Health Care Governance Risk and Compliance Committee chaired by the Health Care Managing Director as well as to the Care UK Executive Board chaired by the Care UK Chief Executive.

Training compliance to date is noted below, which equates to an overal compliance of 93.6% for the year across secondary care.

Site Name	Course ID	Total Allocated	Total Completed	Part Completed	Not Yet Started	Percentage Compliance
Care UK Health - Barlborough Treatment Centre	Equality & Diversity eLearning	294	232	53	9	91.00%
Care UK Health - Devizes NHS Treatment Centre	Equality & Diversity eLearning	51	46	0	5	100.00%
Care UK Health - North East London NHS Treatment Centre	Equality & Diversity eLearning	239	213	23	3	94.56%
Care UK Health - Peninsula NHS Treatment Centre	Equality & Diversity eLearning	225	213	0	12	98.63%
Care UK Health - Shepton Mallet NHS Treatment Centre	Equality & Diversity eLearning	271	191	9	71	73.80%
Care UK Health - Southampton MIU	Equality & Diversity eLearning	33	30	0	3	100.00%
Care UK Heath - Emersons Green Treatment Centre	Equality & Diversity eLearning	402	325	6	71	85.37%
Care UK Health - Southampton NHS Treatment Centre	Equality & Diversity eLearning	289	254	7	28	95.02%
Care UK Health - St Marys NHS Treatment Centre	Equality & Diversity eLearning	183	155	0	28	98.31%
Care UK Health - Will Adams NHS Treatment Centre	Equality & Diversity eLearning	91	79	1	11	100.00%

Effective - Priority one:

The implementation of electronic discharge (EDS) via our patient administration system (PAS) for improved continuity of care and to reduce unplanned follow up in primary care.

All services have the capacity to produce an electronic discharge report although not in a standardized format currently.

In line with the National programme linked with software suppliers there is a move to standardize the templates provided within patient administration systems.

Phase 1 of the National Programme requires that headers are in place within the discharge report to a designated format.

This has been largely configured and completed in the test environment and a member of the internal applications team will be arranging to illustrate this to each site and obtain sign off before putting it into the live environment.

A quality priority for the coming year is the introduction of the standardised template with relevant fields populated electronically which builds on this priority and is line with National requirements.

Effective - Priority two:

To implement an antibiotic stewardship programme and strategy across secondary care.

Agreement has been sought to create a national statement of strategy across care UK Primary Care, Secondary Care and Health in Justice services.

This will allow clear roles, responsibilities and delivery priorities to be designed at a local level. An assurance framework with reporting capabilities is to be developed into the strategy to allow appropriate governance and assurance to be monitored centrally.

Treatment Centres have implemented local antibiotic stewardship multidisciplinary team meetings to support robust process within services.

This allows for a localized plan to be developed and implemented in line with other local Health Care agencies to provide a cohesive approach to antibiotic prescribing.

Well-led - Priority one:

Prepare secondary care diagnostic imaging services for Imaging Services Accreditation Scheme (ISAS) accreditation.

Secondary Care diagnostic imaging services have now completed a robust review of the entire scope of ISAS accreditation including a full review of the updated ISAS standard published in January 2017.

The services have engaged with the ISAS officer, met with organisations that have achieved ISAS accreditation and understand what is required to successfully attain ISAS accreditation.

Having robustly assessed these requirements, we have concluded that our organisational framework is sufficiently established to support a formal ISAS application.

Well-led - Priority two:

To develop and implement a training programme for clinical staff in middle management roles.

The Director of Nursing and Quality spearheaded the need for a leadership development programme for clinical nurses and allied healthcare professionals (AHPs) to equip them with the skills to manage effectively.

The Head of Education and Training established the Chrysalis Programme, which is run over 12-months. Its objective is to nurture both existing and future nurse and AHP leaders - providing structure to their development and focusing on safe and effective clinical practice for themselves, their team and the services they work and manage in.

The programme is a hybrid of eLearning, masterclass face to face sessions and practical workplace practice.

Chrysalis is innovative and bespoke, utilising the Care UK Management Essentials programme as its bedrock. Equipping its participants with a managerial and leadership skill set bespoke to the challenging needs of a healthcare setting.

The programme consists of three key themes:

1. Managing Myself
2. Managing My Team
3. Managing My Service

Each of these elements is focused on during a 12-month period including the following:

- 360 Insights evaluation and feedback
- eLearning modules from the Edward Jenner NHS Management and Leadership programme
- In-Practice and Reflective sessions
- Face to Face Masterclasses from the Care UK Management Essential Programme

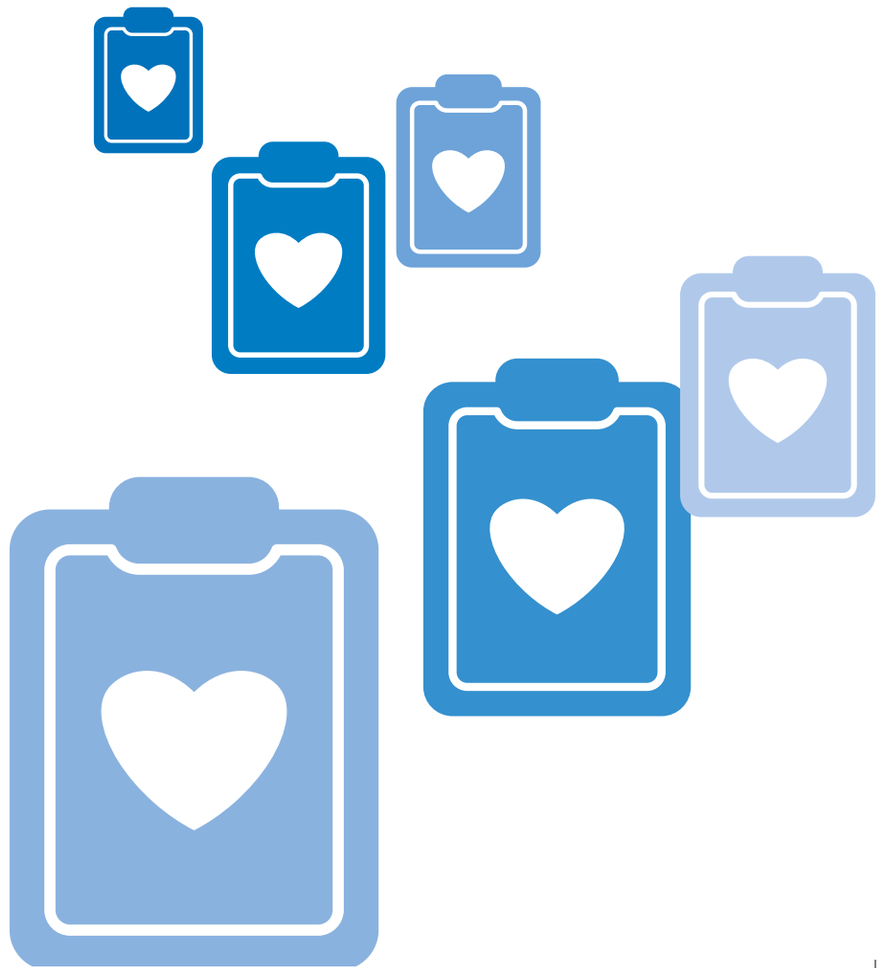
To date we have 45 employees enrolled on the programme. There are 4 active cohorts ranging from 10 - 13 participants. There is a fifth cohort panned for to run in July 2017.

The first three cohorts have all completed their 360 reviews, the insights programme and have completed the first two masterclasses. They are working through the eLearning modules with the first cohort due to complete the entire programme by the end of October 2017.

It has been agreed to review the programme after October 2017 so that it can be expanded for future cohorts to run through 2018 and onwards.

Part Three

Regulatory Statements for our services 2016-2017



Regulatory Statements for our services 2016-2017

In line with the National Health Service (Quality Account) Regulations 2011, Care UK is required to provide information on a range of quality activities.

From April 2016 - March 2017, Care UK provided or sub-contracted all of the services listed on Page two, at the locations specified.

Duty of Candour

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Care UK have robust appropriate processes for communicating with a patient and/or family/carer following a reportable patient safety incident and these are followed in conjunction with Care UK Incident Reporting Policy and Procedure.

There is clear guidance for staff which outlines Care UK's policy on its duty of candour and the processes by which openness will be supported.

This support allows Care UK to meet its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst Care UK employees care for and treat patients.

Safeguarding

The Department of Health requires all healthcare providers to safeguard all those using their services from abuse.

The Care Quality Commission (CQC) outcome statement similarly states that: *'People who use services should be protected from abuse, or the risk of abuse, and their human rights respected and upheld'*.

To ensure that we fulfil this guidance, all employees working in our NHS Treatment Centres complete annual mandatory Level 1 safeguarding training via online courses (eLearning).

All patient- facing staff also complete Level 2 safeguarding training designed to protect children and adults.

We have undertaken an annual review of Safeguarding within Secondary Care services. This will be shared with Commissioners, patient groups and local safeguarding boards.

In line with the Department of Health's guidance on Quality Accounts, the statement below summarises our approach to safeguarding within our Treatment Centres:

- Care UK meets the statutory requirement to conduct Disclosure and Barring Service (DBS) checks on all staff
- Safeguarding policies for children, vulnerable adults and allegations against staff are robust, up-to-date, and have been reviewed within the last year
- Safeguarding training, which encompasses the Mental Capacity Act, forms part of every staff member's induction and mandatory training schedule
- Named professionals are clear about their roles with regard to safeguarding and have sufficient time and support to fulfil them
- There is a named Safeguarding Lead for vulnerable people, including children, who has direct access to the Board, if required

Participation in clinical research

Care UK will support the National Institute for Health Research's (NIHR) multi-centre observational research study in 2017 on the 'return to work of patients following carpal tunnel release surgery'. Two hand surgeons from our Southampton NHS Treatment Centre will participate in the study. The research protocol and all study documents have been approved by the national NHS Research Ethics Committee. No other patients receiving NHS services provided or subcontracted by Care UK at any of our Treatment Centres from April 2016 to March 2017, were recruited to participate in research approved by a research ethics committee.

Our Treatment Centres participated in national audits and confidential enquiries appropriate to the services we deliver (see section to follow).

Care Quality Commission (CQC) registration

Care UK is required to register with the CQC and must comply with the Health and Social Care Act 2008 (regulated activities) Regulations (2010) and the CQC (Registration) Regulations 2009 (Essential standards of quality and safety 2010).

All of our services are registered with the CQC and work to ensure they remain compliant with the essential standards of quality and safety.

The CQC inspected ten of our service locations between 16th March 2015 and 16th November 2016.

Four were found to be fully compliant with standards, whilst two services (Barlborough NHS Treatment Centre and Southampton NHS Treatment Centre) were judged 'outstanding' within the caring domain.

Peninsula NHS Treatment Centre was judged 'outstanding' overall. Three reports are still awaited from CQC.

Participation in Commissioning for Quality and Innovation (CQUIN)

In April 2009, the Department of Health launched the CQUIN framework to encourage healthcare providers to continuously demonstrate improvements and innovation in the quality of the care they provide. The framework supports the vision set out in 'High Quality Care for All' (Darzi, 2008) where quality is viewed an organisational principle.

CQUIN rewards excellence by linking a proportion of the provider's income to the achievement of local quality improvement goals. A proportion of our income in 2016/17 was conditional upon us achieving pre-agreed quality improvement and innovation goals as set out in the CQUIN payment framework. We are pleased to report that we have consistently achieved these goals, demonstrating our active engagement in quality improvement with our commissioners.

Details of the agreed CQUIN goals for each of our services for both 2016/7 and the coming year can be requested from the Hospital Directors at each Treatment Centre.

(NB: as CQUIN targets are locally agreed they may vary between Treatment Centres).

Participation in clinical audits and national confidential enquiries

The reports of the two national clinical audits (National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS) were reviewed for April 2015 – March 2016 (see table below).

Patients' participation in national PROMS was lower than we would like, and Care UK will seek to improve participation rates by sharing and implementing processes that have been shown to produce a high response rate in comparable services.

Details of the national clinical audits and national confidential enquiries that Care UK participated in during April 2015 to March 2016 can be found in Appendix 2 . This also lists those we did not participate in, with a rationale i.e. we are not commissioned to provide the service being audited.

Category	Name of National Clinical Audit	% of cases submitted
Acute	National Joint Registry (NJR - 2016)	99%
Other	Elective surgery (National PROMs Programme - 2015/16)	74% - Varicose Veins 68% - Groin Hernia

Reporting against core indicators

The Department of Health requires independent healthcare providers such as Care UK to report against a core set of quality indicators, using information that is provided by the Health and Social Care Information Centre (HSCIC) to compare our results to others.

Patient Reported Outcome Measures (PROMs)

The NHS requires providers to ask patients having one of four specific procedures to complete questionnaires before and after their operation, to find out how much difference the operation has made to them. The four procedures are hip replacement, knee replacement, groin hernia surgery and varicose vein surgery.

The tables opposite show how well we have done by comparing our achievements to the national average and to the best and worst performers.

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) data - April 2016- June 2016		
Patient reported Outcome measures (PROMS) participation rates	April 2015 - March 2016	April 2016 - June 2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
Hip replacement surgery	100.0%	92.44%	100%	0%	86%
Knee replacement surgery	100.0%	100.00%	100%	0%	94%
Groin hernia surgery	76.7%	68.00%	100%	0%	56%
Varicose vein surgery	82.2%	73.75%	1000%	0%	32%
HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2015 to March 2016 (published Nov 2016) / HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2016 to June 2016 (published Nov 2016)					

100% = rate adjusted down to 100% as volume of Q1s received exceeded number of episodes submitted to SUS

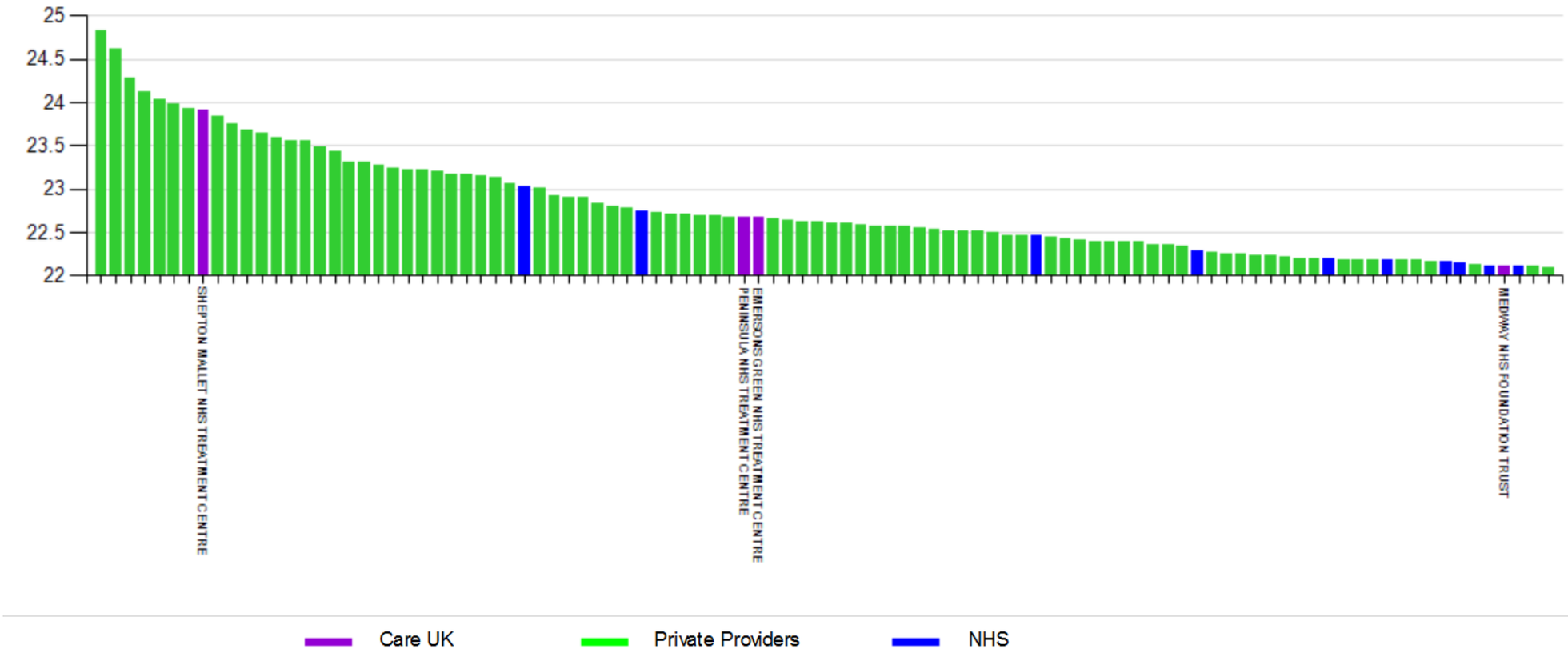
Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) data - April 2016- June 2016		
Patient reported Outcome measures (PROMS) adjusted health gain	April 2015 - March 2016	April 2016 - June 2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
Hip replacement surgery	22.22	Not available	31.00	14.00	21.00
Knee replacement surgery	16.45	Not available	42.00	1.00	17.89
Groin hernia surgery	0.78	0.21	0.66	-0.27	0.09
Varicose vein surgery	-6.89	-6.43	23.06	-62.26	-8.05
HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2015 to March 2016 (published Nov 2016) / HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2016 to June 2016 (published Nov 2016)					

Care UK considers that these data are as described for the following reasons:

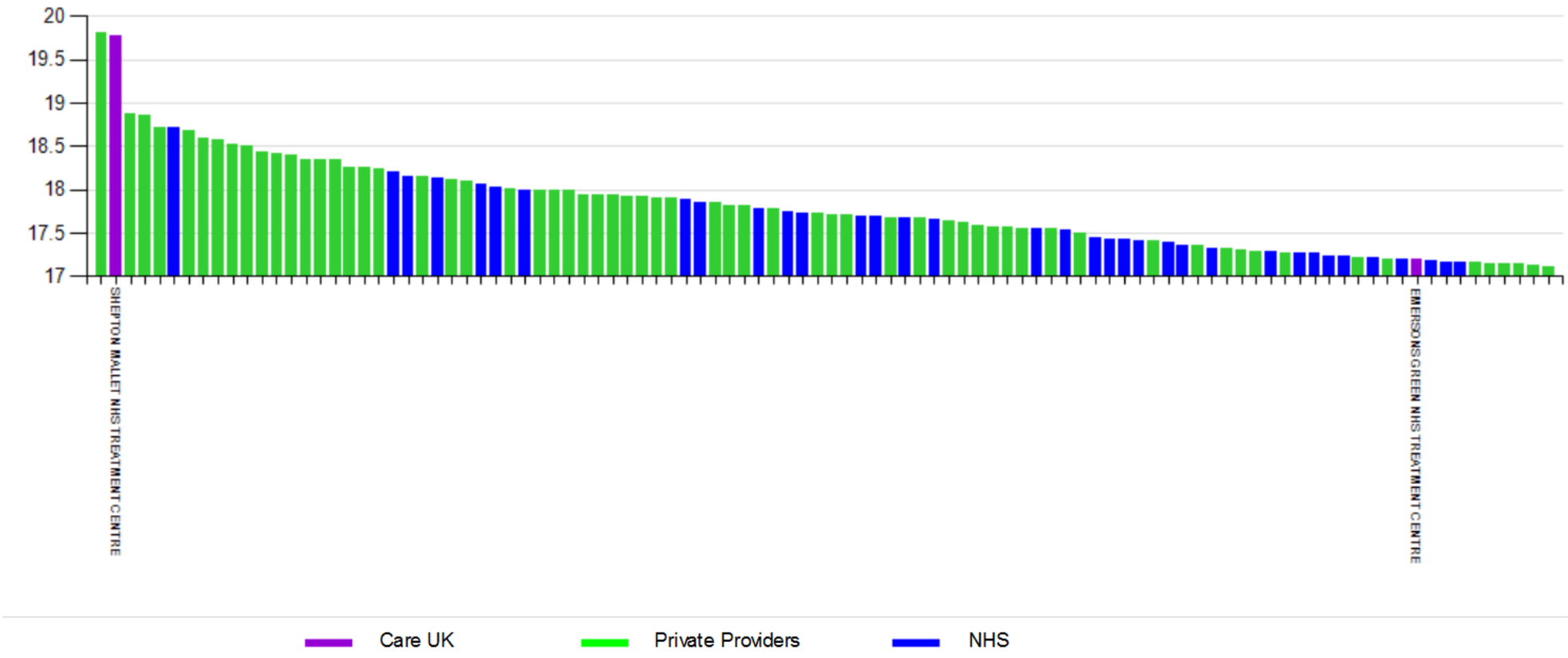
- It is taken from a national information provider.
- PROMS are an important quality indicator as they assess care quality from the patient's perspective. For this reason, Care UK is already taking the following action to improve our PROMs scores:
    - PROMs information is regularly reported to the Senior Leadership Team in a similar format to the table shown, so that areas for improvement can be swiftly identified
- Treatment Centres with PROMs scores that require improvement analyse their data with the assistance of Quality Health Ltd, who provide specialist knowledge of PROMs information. This analysis forms the basis for improvement action planning
    - The success of each improvement action plan is tracked by the Senior Leadership Team

Patient reported outcome measures (PROMS)

PROMS Adjusted average health gain - Hip Replacement Primary - Oxford Hip Score April 2015 - March 2016 (Top 100 providers)



PROMS Adjusted average health gain - Knee Replacement Primary - Oxford Knee Score April 2015 - March 2016 (Top 100 providers)



Emergency re-admission rate for patients aged 16 or over

This indicator looks at the number of patients who have been readmitted to our Treatment Centres within 30 days of surgery. Reasons for readmission can include infection, pain or other complications arising from their surgery.

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) Data Independent Sector 2011-12	
Emergency readmission to hospital within 28 days of discharge - %patients aged 16 or over readmitted within	2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
All Treatment Centres	0.24%	14.53%	7.91%	11.78%
Data Source:	Local data	HSCIC/Indicator portal data set: '3b Emergency readmissions within 30 days of discharge from hospital'	42.00	1.00

Care UK considers that these data are as described for the following reasons:

- It is taken from local data that is submitted to the department of health.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
- Emergency readmission rates are tracked monthly for each Treatment Centre and reported to the Senior Leadership Team and Board
- Each month the Senior Leadership Team examines every instance of emergency readmission that occurred and discusses the causes and what can be done to avoid similar readmissions in the future.

Risk assessment of venous thromboembolism (VTE) for people admitted to hospital

People who undergo operations may have a risk of developing a potentially harmful blood clot or venous thromboembolism (VTE).

This indicator looks at how efficiently Care UK assesses their risk of developing a VTE.

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) Data April-June 2016	
%admitted who were risk assesses for venous thromboembolism	April-June 2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
All Treatment Centres	99.55%	100.00%	64.96%	95.73%
Data Source:	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment - 201617/ NHS England website			

Care UK considers that these data are as described for the following reasons:

- It is taken from a national information provider.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:-
- VTE risk assessment rates are tracked monthly for each Treatment Centre and reported to the Senior Leadership Team and Board.
- We set ourselves a target of 100% for this indicator and compare ourselves in this area against the independent sector (average 99.0%) and the NHS every three months.
- Reasons for not achieving 100% are examined each month by the Senior Leadership Team and explained to the Board with actions to remedy.

Infection with Clostridium difficile

Indicator	Care UK Overall data				Health and Social Care Information Centre Data
Rate of Clostridium difficile (number of infections/100,000 bed days)	Apr-Mar 2015-16	Aggregate 2008-16	Apr-Mar 2014-15	Apr-Mar 2014-16	
All Treatment Centres	0	0	15.1	14.9	
Data Source:	Local data	PHE Annual epidemiological comment, 2016. Ref: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535635/AEC_final.pdf			

Care UK considers that these data iare as described for the following reasons:

- It is extracted from published verified local data that is submitted to Public Health England.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
- Care UK has a Director of Infection Prevention and Control (DIPC) who provides Board oversight and leadership on all infection prevention and control issues
- This is further strengthened with a Deputy Director of Infection Prevention and Control who provides detailed guidance to our Treatment Centres, each of which have a trained local Infection Prevention and Control lead with identified time and resource to carry out their role
- Care UK policies are implemented to: ensure effective antibiotic stewardship; facilitate the adoption of local prescribing formularies; and monitor antibiotic usage and patient outcomes.

Patient safety incidents

Patient safety incidents	2015-2016 April 2015-March 2016	2016-2017 to date April 2016-January 2017
Rate of patient safety incidents that occurred across the trust (per 100 admissions)	2016-2017 to date	4.045
Number of such patient safety incidents reported that resulted in severe harm or death	2	4
Rate of patient safety incidents resulting in severe harm or death (per 100 admissions)	0.0036	0.0084

Care UK considers that these data are as described for the following reasons:

- It is extracted from published verified local data that is taken to a national body.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
  - Each Treatment Centre has a dedicated Health and Safety lead who has appropriate Health and Safety training and protected time to carry out their role
  - An incident reporting system, DATIX, is used to report all incidents
  - All incidents that are reported must be examined, and the initial lessons learned must be noted, within 3 days of the incident taking place. Compliance against this target is examined by the Senior Leadership Team and reported monthly to the Board
  - Serious incidents are subject to root cause analysis, with results reported to the Board. Lessons learned are shared with all other relevant sites using a shared learning tool, which in 2016 was automated within Datix. The Head of Governance and Quality ensures that the lessons learned have been embedded in practice through compliance checks at a later date.
  - Care UK also checks and compares its Accident Frequency Rate (AFR) each year and reports this to the Board.

Table of CQC Inspections

Balborough Treatment Centre – inspection date 16th March 2015

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring				☆
Responsive			✓	
Well-led			✓	
Overall			✓	

The feedback received from CQC indicated that there were systems in place to identify and record patient safety incidents. Where serious incidents had occurred investigations were completed to identify learning and cascade this to staff. Not all incidents were reported to CQC as they should have been in 2014 but is now remedied.

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Southampton Treatment Centre – inspection date 18th May 2015

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring				☆
Responsive			✓	
Well-led			✓	
Overall			✓	

"Care was provided that was outstandingly kind and compassionate within the surgical ward and department"

"There were clear open and transparent processes for reporting and learning from incidents."

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			■	
Caring				■
Responsive			■	
Well-led			■	
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			not rated	
Caring			■	
Responsive			■	
Well-led			■	
Overall			Good	

St Mary's NHS Treatment Centre – inspection date 2nd October 2015

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

Breakdown by service - Urgent and emergency services

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Emersons Green NHS Treatment Centre – inspection date 30th March 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

"There was good multidisciplinary team working across all departments to ensure effective patient care"

"All staff demonstrated genuine compassion for the people in their care, which was embedded into the culture of the departments"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Peninsula NHS Treatment Centre – inspection date 13th July 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring				☆
Responsive			✓	
Well-led				☆
Overall				✓

"Leaders empowered staff to promote caring and collaborative relationships with patients"

"The multidisciplinary team made exceptional effort to accommodate the cultural needs of patients, such as single sex room, all female staff teams for the duration of patients admission, specific dietary requirements"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall				Outstanding

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall				Outstanding

Will Adams Treatment Centre – inspection date 9th August 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

"Patients were positive about their experience and received care that protected their privacy and dignity"

"There were clear, open and transparent processes for reporting and learning from incidents"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Devizes NHS Treatment Centre – inspection date 13th September 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

"There was a patient centred culture in all departments with staff showing care, kindness and compassion to all Patients"

"Patients complimented the treatment and care they received, commenting that staff were courteous and respectful"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Shepton Mallet NHS Treatment Centre – inspection date 11th Octover 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe				☆
Effective				☆
Caring				☆
Responsive				☆
Well-led				☆
Overall				✓

"High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients."

"Multidisciplinary team working was excellent throughout the surgery service."

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall				Outstanding

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall				Outstanding

North East London NHS Treatment Centre – inspection date 21st September 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe		✓		
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led		✓		
Overall		✓		

"Patients commented on how helpful and kind staff had been in providing support."

"The surgical service received consistent positive feedback from the Friends and Family test."

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall		Requires improvement		

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Rochdale Ophthalmology CATS – inspection date 15th November 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective				★
Caring				★
Responsive			✓	
Well-led			✓	
Overall				✓

"The service had a clear vision and strategy, which were understood by staff."

"All patients were treated by staff compassionately and their privacy and dignity was maintained"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall				Outstanding

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

National clinical audits

Name of National clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Adult Asthma	No	No	Care UK chose not to participate in these audits
Adult Cardiac Surgery	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Asthma (paediatric and adult) care in emergency departments	No	No	Care UK chose not to participate in these audits
Bowel Cancer (NBOCAP)	No	No	Care UK does not provide cancer services from Treatment Centres
Cardiac Rhythm Management (CRM)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Case Mix Programme (CMP)	No	No	N/A
Child Health Clinical Outcome Review Programme	No	No	Care UK does not provide treatment of children from Treatment Centres
Chronic Kidney Disease in primary care	No	No	Care UK does not provide treatment of long term conditions
Congenital Heart Disease (CHD)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Diabetes (Paediatric) (NPDA)	No	No	Care UK does not provide treatment of long term conditions for children from Treatment Centres
Elective Surgery (National PROMs Programme)	Yes	Yes	None
Endocrine and Thyroid National Audit	No	No	Care UK chose not to participate in these audits
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	No	Care UK chose not to participate in this audit
Head and Neck Cancer Audit	No	No	Care UK does not provide cancer services from Treatment Centres

Name of National clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
Inflammatory Bowel Disease (IBD) programme	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
Major Trauma Audit	No	No	Care UK does not provide major trauma within its Treatment Centres
Maternal, Newborn and Infant Clinical Outcome Review Programme	No	No	Care UK does not provide Maternity or Children's services from its Treatment Centres
Medical and Surgical Clinical Outcome Review Programme	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
Mental Health Clinical Outcome Review Programme	No	No	Care UK does not provide Children's services from its Treatment Centres
National Audit of Dementia	No	No	Care UK chose not to participate in these audits
National Audit of Pulmonary Hypertension	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
National Cardiac Arrest Audit (NCAA)	Yes	No	Care UK did consider participation in the Cardiac Arrest audit but numbers of this situation occurring within our facilities were too low for inclusion
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	Care UK Treatment Centres have taken part in this audit
National Diabetes Audit – Adults	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
National Emergency Laparotomy Audit (NELA)	No	No	Care UK only provides elective surgery services from the Treatment Centres
National Heart Failure Audit	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
National Joint Registry (NJR)	Yes	Yes	Care UK provides outcomes from its Treatment Centres for this audit
National Lung Cancer Audit (NLCA)	No	No	Care UK does not provide cancer services from Treatment Centres
National Neurosurgery Audit Programme	No	No	Care UK does not provide neurological services in Treatment Centres

Name of National clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
National Ophthalmology Audit	No	No	Care UK chose not to participate in this audit
National Prostate Cancer Audit	No	No	Care UK does not provide cancer services from Treatment Centres
National Vascular Registry	No	No	Care UK does not provide treatment of cardiovascular illness from the Treatment Centres
Neonatal Intensive and Special Care (NNAP)	No	No	Care UK does not provide children's services from Treatment Centres
Nephrectomy audit	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
Oesophago-gastric Cancer (NAOGC)	No	No	Care UK does not provide cancer services from Treatment Centres
Paediatric Intensive Care (PICANet)	No	No	Care UK does not provide children's services from Treatment Centres
Paediatric Pneumonia	No	No	Care UK does not provide children's services from Treatment Centres
Percutaneous Nephrolithotomy (PCNL)	No	No	Care UK chose not to participate in this audit
Prescribing Observatory for Mental Health (POMH-UK)	Yes	No	Care UK chose not to participate in this audit
Radical Prostatectomy Audit	No	No	Care UK chose not to participate in this audit
Renal Replacement Therapy (Renal Registry)			Care UK does not manage Long Term Conditions in Treatment Centres
Rheumatoid and Early Inflammatory Arthritis			Care UK does not manage Long Term Conditions in Treatment Centres
Sentinel Stroke National Audit programme (SSNAP)			Care UK only provides elective surgery services from the Treatment Centres therefore does not manage long term conditions or acute stroke
Severe Sepsis and Septic Shock – emergency departments			Care UK does not provide emergency services
Specialist rehabilitation for patients with complex needs			Care UK does not manage Long Term Conditions in Treatment Centres
Stress Urinary Incontinence Audit			Care UK does not manage Long Term Conditions in Treatment Centres
UK Cystic Fibrosis Registry			Care UK does not manage Long Term Conditions in Treatment Centres

Local audit schedule

Audit title	Purpose of audit	Frequency	ISTC	CATS
Documentation (Clinical)	Supports best practice in patient documentation and guidance from professional bodies	Quarterly	✓	✓
Patient falls	Patient safety and compliance assessment tool	Completed when any patient falls occur	✓	
Prevention of VTE (venous thromboembolism)	Assess compliance to NICE guidance and best practice clinical protocols for assessment and the provision of prophylaxis	Monthly	✓	
Peri-operative hypothermia audit	Assess compliance to NICE guidelines – CG65	Monthly	✓	
Pain audit	Assess effectiveness of pain management protocols	Quarterly	✓	
WHO surgical site safety checklist audit	Assess compliance to WHO surgical site safety checklist	Monthly	✓	
WHO observational audit	Assess compliance against WHO checklist (Sign in, Time In & Sign out)	Monthly	✓	
NEWS (National Early Warning Score) audit	Use of NEWS audit to identify early signs of the deterioration of a patient's condition	Monthly	✓	
Fluid balance audit	To assess fluid management in patients	Quarterly	✓	
Blood transfusion audit	Compliance with blood safety and national transfusion guidance	Bi-annually	✓	
Traceability audit - endoscopy	Compliance to JAG standards and re-accreditation	Monthly	✓	✓
Endoscopy environmental audit	Compliance to JAG standards and re-accreditation	Monthly	✓	✓
Medicines Management – Controlled drugs, Stock control, Responsibilities and prescribing and administration	To monitor all aspects of medicines management across our clinical services	Annually (Self-audit) & Annually (External audit)	✓	✓
Controlled Drugs Documentation audit	A dedicated audit for Pharmacists/Meds Management Leads focusing on the documentation element of controlled drugs usage	Quarterly	✓	✓
Anaesthetic Observation audit	Assessment of compliance and quality of Anaesthetic practice	Quarterly	✓	
Ward round (MDT) audit	Assessment of ward round practices and key team member involvement	Quarterly	✓	
Quality audit	To assess services against the CQC's Essential Standards	Bi-annually	✓	✓

Audit title	Purpose of audit	Frequency	ISTC	CATS
CAS alert & NICE guidance audit	To ensure that all alerts (CAS & MHRA) are reviewed, documented and circulated and all published NICE guidance is reviewed and implemented accordingly	Bi-annually	✓	✓
Agency/Locum/Temporary staff audit	To ensure that appropriate checks and local inductions are undertaken for all agency, locum and temporary members of staff	Bi-annually	✓	✓
Information Governance & Security audit	To monitor compliance against IG Toolkit requirements and ISO 27001 accreditation	Bi-annually	✓	✓
Emergency scenario audit	To ensure that all staff are prepared and are fully aware of their responsibilities in the case of an emergency incident	Quarterly	✓	✓

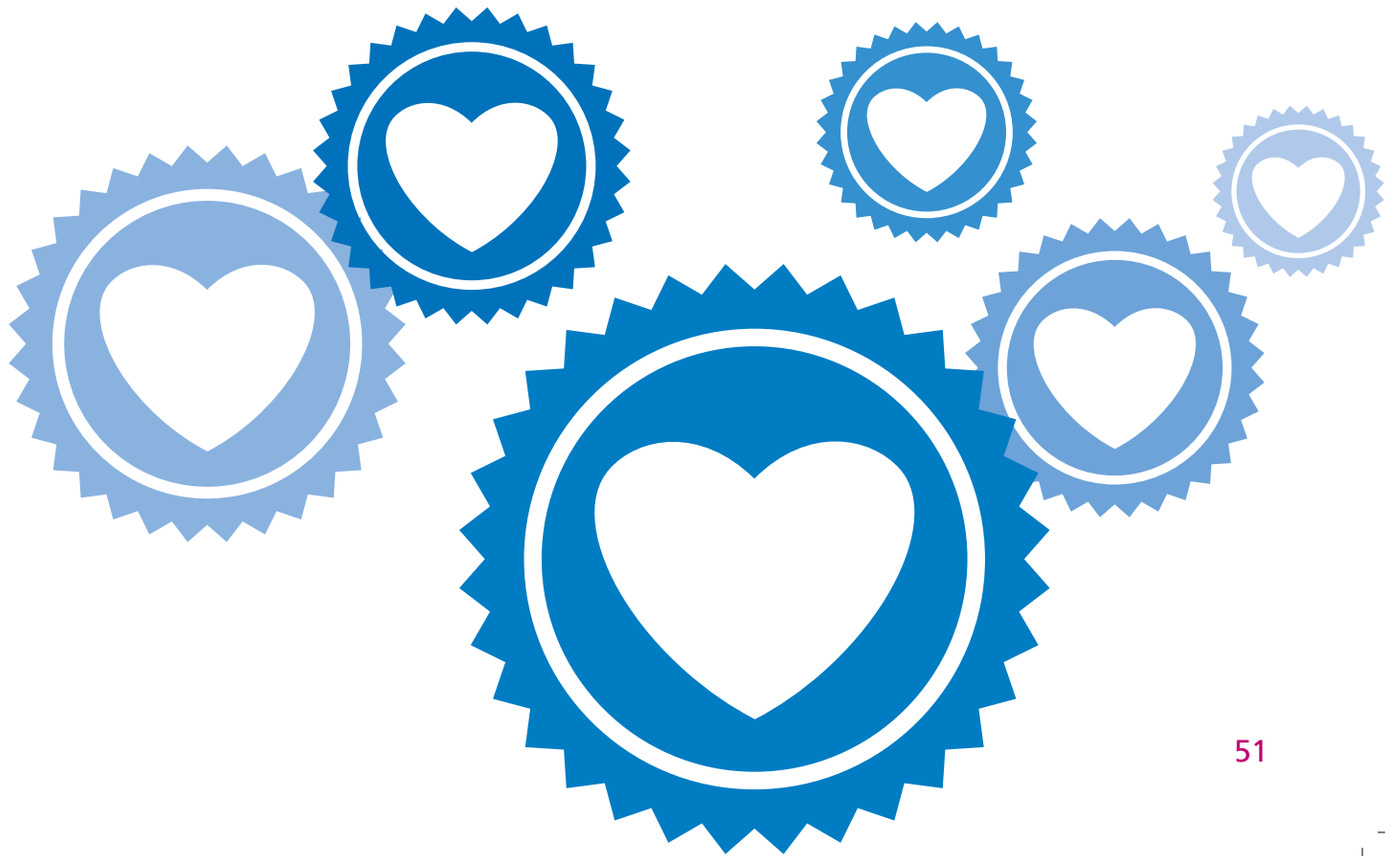
List of services and locations

Services	Facilities	Specialties
Barlborough NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Minor and major orthopaedic procedures, ophthalmology
Devizes NHS Treatment Centre	Day patients, Diagnostics,	General surgery, endoscopy, gastroenterology, gynaecology, urology, knee procedures, foot and ankle procedures, hand procedures, diagnostic imaging, ENT, ophthalmology, oral surgery
Emersons Green NHS Treatment Centre	Inpatients, Day patients, Diagnostics	General surgery, endoscopy, gastroenterology, gynaecology, urology, hip procedures, knee procedures, foot and ankle procedures, hand procedures, diagnostic imaging, ENT, ophthalmology, oral surgery
North East London NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, ENT, ophthalmology, oral surgery
Peninsula NHS Treatment Centre	Inpatients, Day patients, Diagnostics	General surgery, hip procedures, knee procedures, shoulder and elbow procedures, foot and ankle procedures, hand procedures, ophthalmology, endoscopy
Shepton Mallet NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, gynaecology, urology, diagnostic imaging, ENT, ophthalmology, pain management
Southampton NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, gynaecology, urology, diagnostic imaging, ENT, ophthalmology, oral Surgery, pain management
St Mary's NHS Treatment Centre	Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, ophthalmology, diagnostic imaging
Will Adams NHS Treatment Centre	Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, urology, ophthalmology

Diagnostic services	Facilities	Specialties
Community Diagnostics	Outpatients, Diagnostics	Musculoskeletal services
Havant Diagnostics	Diagnostics	Diagnostic imaging
Additional services	**Facilities**	**Specialties**
Rochdale Ophthalmology Clinical Assessment and Treatment Service	Day patients	Ophthalmology
Royal South Hants Minor Injuries Unit	Walk-in service	Minor injuries
St Mary's Minor Injuries Unit	Walk-in service	Minor injuries and illnesses

Part Four

How we have maintained quality



How we have maintained quality

Throughout Care UK we have policies and procedures to guide employees in their everyday work caring and managing each patient's pathway.

We continually monitor our quality through audit (local/national); governance meetings (local/national); and at monthly business reviews.

Core performance indicators are developed from this to underpin all our senior leadership team's annual performance appraisals and objective setting.

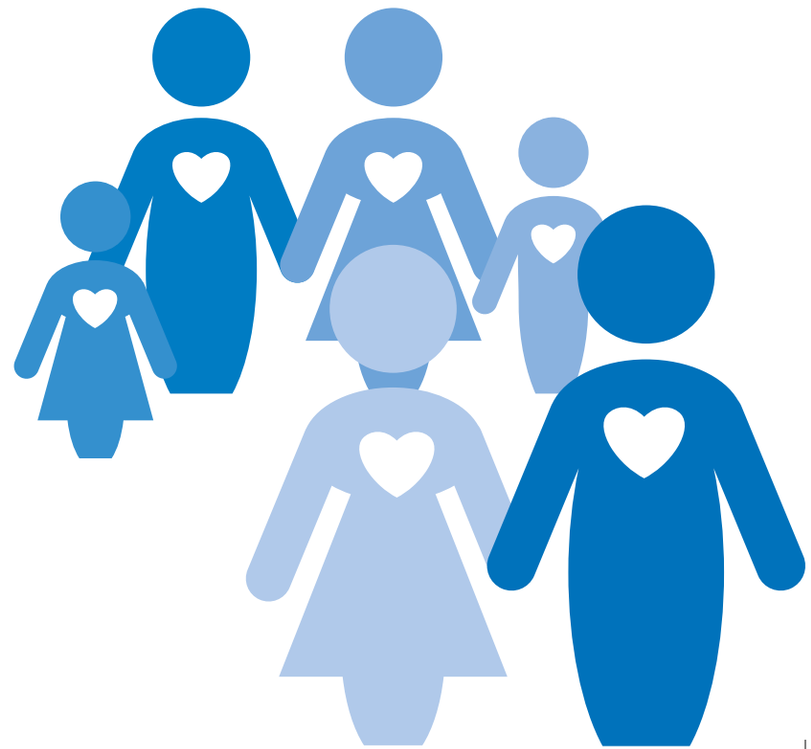
We share the lessons from where things have not gone well, both at a local level through monthly Quality Governance meetings, and at a national level through quarterly Quality and Governance Assurance Committee Meetings, chaired by the Director of Nursing and Quality. 'Shared learning' and 'shared good practice' is a fixed agenda item at our quarterly Professional Leads Meeting.

We focus on maintaining high quality patient care and endeavour to embed consistently safe, high quality standards, and an understanding of what 'good' looks like, across all our secondary care services.

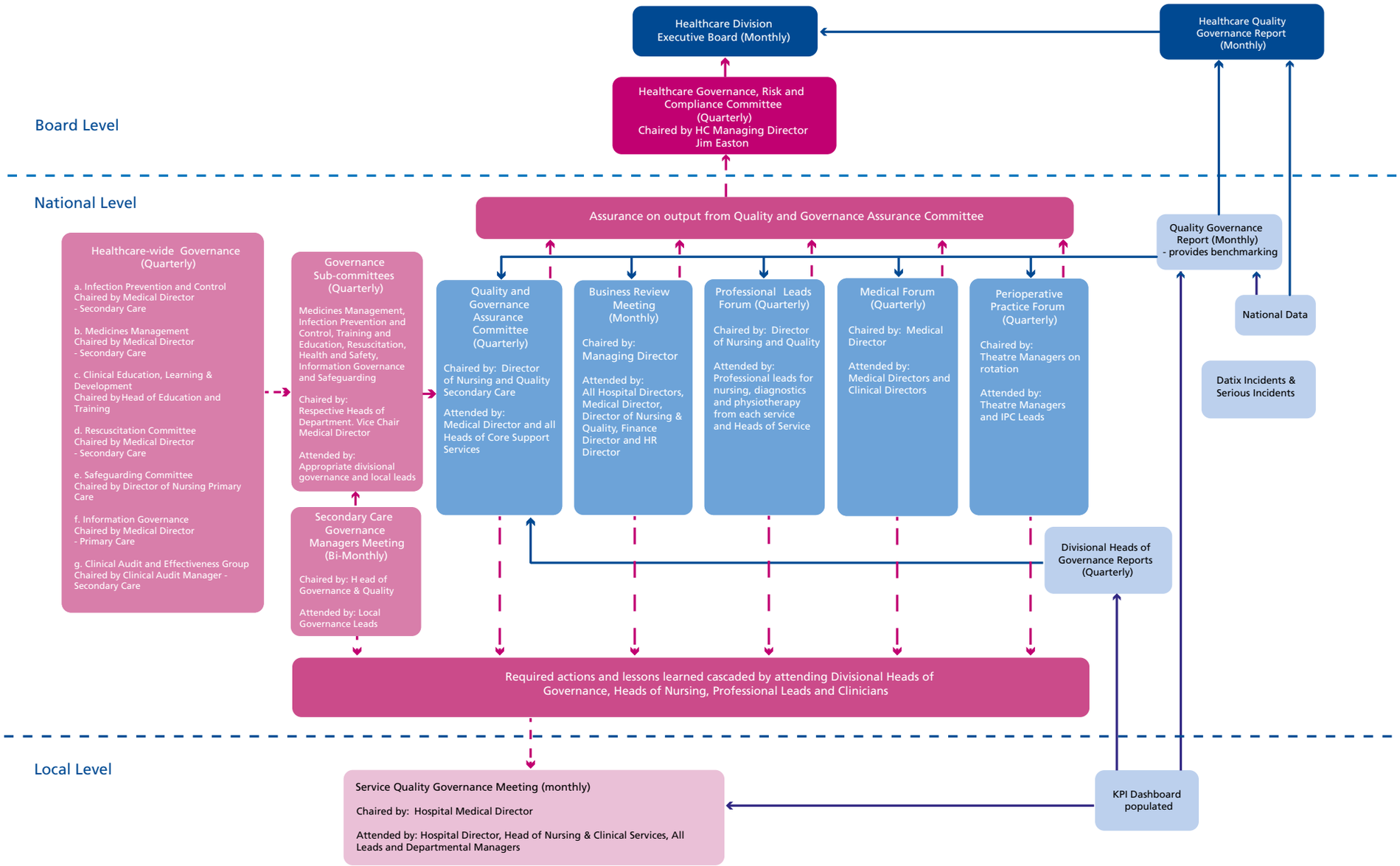
Exception reports are received and reviewed from all key service areas, with particular attention being paid to patients' safety.

We have adopted a number of approaches to ensure the services we provide are the best they can be, including accreditation with national bodies - achieving, for example, Joint Advisory Group (JAG) accreditation across all of our endoscopy services.

Our aim is to continuously improve the care that we offer and achieve excellent experiences for all patients choosing our services, as described throughout this Quality Account.



Below is a representation of the reporting and management structures within secondary care:



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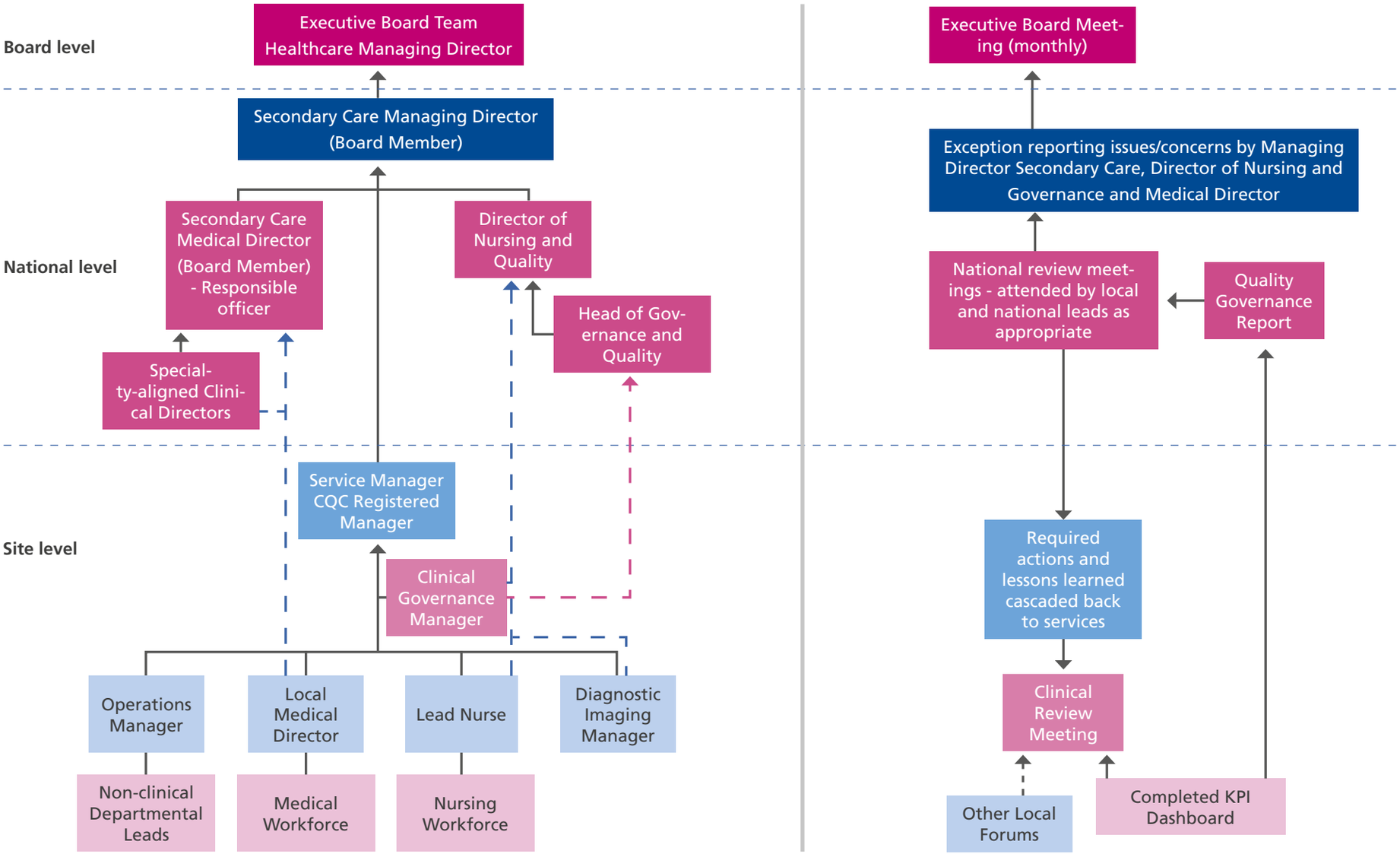


Diagnostic services

Care UK provides a range of diagnostic imaging services within its NHS Treatment Centres and Clinical Assessment and Treatment Services (CATS), including: plain film X-ray; non- obstetric ultrasound (NOUS); magnetic resonance imaging (MRI); computerized tomography (CT); and dual-energy X-ray absorptiometry (DXA).

These services are delivered using state of the art imaging systems at both fixed and mobile locations.

Flexible opening hours, which include weekends and evenings, offer patients greater accessibility and convenience. Our team of dedicated imaging staff, comprising consultant radiologists, radiographers and sonographers, are all highly experienced healthcare professionals, registered with their respective professional bodies.

Referrals to our diagnostic imaging services come from a range of healthcare professionals; doctors, nurses and allied health professionals - and the results of completed imaging examinations are available to them within 48 hours of the patient's examination.

Care UK's robust quality governance framework for diagnostic imaging includes elements, such as: clinical audit; use of latest evidence based policies, protocols and NICE guidance; competency assessment of staff; and our Quality Assurance (QA) programme.

This framework ensures that services delivered by our operational teams are safe and clinically effective. Service- based teams are ably supported by an experienced divisional team which includes: a Clinical Director & Advisor for Radiology; a highly experienced Consultant Radiologist; and a Diagnostic Imaging Lead who oversee all diagnostic imaging services within Care UK's Health Care Division.

Our QA programme comprises an enhanced quality improvement and audit tool that we use to review and evaluate the quality of three key components of the clinical pathway for imaging examinations, namely: referral; imaging; and reporting.

We review a minimum of 5% of completed imaging cases, scoring each of the three key components on a scale from one to five (one being the lowest and five highest).

This provides valuable feedback for referrers, clinicians undertaking examinations and the reporting clinicians.

In summary, our QA programme helps us to:

- Ensure quality is continuously assessed at all key points of the imaging pathway (referrals/images/reports)
- Identify whether the correct management of the patient is achieved following diagnostic examination
- Identify any areas that might require improvement in the imaging pathway
- Offer assurances to our commissioners, patients and to our own organisation regarding the quality of the imaging services we provide and the reports that we send to our patients and referring clinicians.

During the reporting period (April 2016-March 2017) our QA programme has helped us review a significant number of cases as part of our quality improvement initiative. This has provided assurance about the quality of the services that we deliver to patients. It has also provided valuable feedback and opportunities for shared learning, both internally across Care UK and also externally with our key stakeholders.

For example, we have been able to give important feedback to our referring clinicians about the appropriateness

of imaging referrals, and whether the images they have requested are the 'gold standard' for answering the clinical question posed. It has also enabled us to review the quality of images produced by our radiographers and sonographers, and the content and accuracy of imaging reports provided by consultant radiologists and sonographers.

The QA programme allows us to monitor the trends and outcomes of imaging examinations, and to quickly identify any discrepancies or errors in reporting practice, ensuring that the clinical outcomes for patients are always the primary focus of this valuable quality improvement tool.

Outcomes from the QA programme continue to be excellent:

- 99% of referrals reviewed and accepted by Care UK were scored as appropriate against national imaging referral guidelines (iRefer) developed by the Royal College of Radiologists. There were only minor comments on how the quality of information provided by our referrers could be improved (about the importance of providing relevant patient history and previous imaging undertaken for the patient)
- 99% of cases reviewed during this period show the quality of images produced by our radiographers and sonographers to be excellent. This clearly demonstrates that our clinical teams are delivering high quality diagnostic images/examinations that enable accurate and prompt diagnosis to be achieved for our patients
- 99% of reports reviewed were also deemed to be accurate, clear and precise - offering a targeted response to the clinical question being asked by the referring clinician.

We are also developing an internal peer review system for our Sonographer workforce that will enable clinicians to 'quality assure' each other's clinical practice, observing colleagues when undertaking a range of ultrasound examinations, providing professional feedback to drive continuous quality improvement within our ultrasound services.

Where the QA programme reveals any discrepancies or errors from examinations undertaken within Care UK, a robust process including a full investigation, case review and the sharing of any lessons learned, is always undertaken.

Any significant errors are also formally reviewed as part of a focused Discrepancy Meeting, which includes the review of cases completed by both sonographers and consultant radiologists.

Our QA programme also allows us to track any trends in reporting errors and to identify where additional training or education may be indicated.

Our discrepancy/error rates for the reporting of imaging examinations remain at a very low rate. Although, this rate is hard to benchmark as QA programmes are not widely implemented across NHS Radiology Departments and thresholds for error are not clearly defined by the professional body (Royal College of Radiologists). We are wholly assured that the quality of our reporting is well above any suggested thresholds within the published evidence on this topic, and that we continue to provide a gold standard imaging service to our patients.

Patient led assessment of the care environment (PLACE)

Care UK are delighted that the care environments within all of our facilities scored above 85% for every PLACE category in 2016.

Cleanliness

The patient-led assessors gave us an overall score of 99% for the cleanliness of our secondary care sites.

We are immensely proud of this score, which was complemented by an overall score of 97% for the condition, appearance and maintenance of the buildings from which we provide care: these scores reflect our ambition to ever improve on the quality of our services demonstrating an improvement on 2015 scores.

In 2017 we expect to maintain these high quality ratings across all of our NHS Treatment Centres.

Dementia friendly

This was the second year that the suitability of environments for people with symptoms of dementia was assessed – in

accordance with criteria laid down by the Health and Social Care Information Centre (HSCIC). Whilst a positive 85% was scored across our secondary care premises overall last year, we have improved on this with a score of 87% in 2016. We are continuing the work to update environmental clues such as colour schemes, signage and flooring across our Treatment Centres.

Care UK PLACE Results 2016

Cleanliness

99.55%

Food

90.36%

Ward food

91.74%

Privacy, dignity and wellbeing

88.47%

Dementia

86.73%

Condition, appearance and maintenance

97.18%

Employee engagement

The annual Care UK staff survey, "Over to you!" mirrors the NHS Employee Survey in terms of questions relating to equality and diversity

Each year we carry out a staff survey, 'Over to You!' This survey not only informs us about what staff think, but also helps us measure the effectiveness of our employee engagement strategy.

Each unit, department, and team must formulate action plans based on survey results, and report on their progress. Each action plan has sections detailing: 'issues to celebrate'; 'areas where we need to make improvements'; and other factors that appear to merit further investigation.

The key measure generated by the survey is an engagement index, expressed as a percentage. Divisional targets are set year on year to increase our engagement index score – with outcomes stripped down as far as service line, unit, and teams within units, to support improvement action planning.

The survey is undertaken at the beginning of summer every year and in 2016 our engagement index improved for the third consecutive year to 66% (up from 63% in the prior year). Survey content is comparable to, and in certain sections mirrors, the NHS National Staff Survey content.

Related, and overwhelmingly, the survey indicated that our people know what is expected of them at work, feel proud of the work they do, view patient care as our top organizational priority, and know what to do if they wish to raise a formal concern at work regarding the provision of health care services.

Results compare well to the NHS staff survey outcomes and in particular with regard to employee health and well-being, providing the tools and materials required to do the job, and line management.

Whilst the outcomes to our equality and diversity questions (sourced directly from the Workforce Race Equality Standards) were broadly comparable to outcomes in the NHS survey, we have nevertheless initiated a divisional wide education campaign instigated by the Health Care Equality and Diversity Steering Group as a direct response to the survey.

This commenced in October last year and be rolled out on an on-going incremental basis to the end of September 2017 and is ensuring that equality and diversity has an organizational profile and is mainstreamed into our everyday working lives.

Over to you! 2016

Infection, prevention and control

Care UK is committed to ever- improving standards of safe practice and environmental hygiene in order to prevent and control infection. This not only enhances service users' safety, it also means that they benefit from visibly clean, high quality service environments.

Organisational management

Following the recommendations of the Health and Social Care Act 2008 (2010; 2015), Care UK maintains a robust, hierarchical structure of infection prevention and control (IPC) guidance and supervision, provided by our IPC Committee, which is chaired by the Executive Director of IPC.

Our IPC strategy is delivered through a range of operational processes that consistently assess, measure and audit infection risks and use outcome information to plan and deliver actions designed to reduce avoidable infections, in line with the national agenda. Each service has a named IPC lead, and the Deputy Director of IPC brings this network of practitioners together on a quarterly basis for clinical supervision, shared learning and peer support.

Systems of assurance

Our internal IPC assurance systems include a monthly audit schedule specifically designed to monitor relevant areas of risk within each service stream. This year the audit schedule has been revised with the aim of aligning the audit scoring to better reflect risk. This means we are actively seeking to identify exceptions to our high standards of environment and practice and we target these to ensure improvements are planned for and actioned within a timely manner. Incidences of surgical site and healthcare associated infections are reported and collated monthly. This information and contributory factors are reviewed locally and are assessed by the Deputy Director. Lessons are shared via our governance framework, which incorporates quality governance, professional forums, the IPC committee and the Health Care Board.

Performance 2016 - 2017

Healthcare Associated Infections (HCAIs): Care UK had no reported cases of Clostridium difficile infection and no incidences of methicillin resistant or sensitive Staphylococcusaureus bacteraemia attributable to their care during 2016.

This is our sixth consecutive year of zero HCAIs.

Health care associated infections (HCAI) 2011-2015

MRSA bacteraemias

0 infections

MSSA bacteraemias

0 infections

E.coli bacteraemias

0 infections

Clostridium difficile incidence

0 infections

Surgical site Infection (SSI) rates (hip and knee replacement)

Surgical site infections:

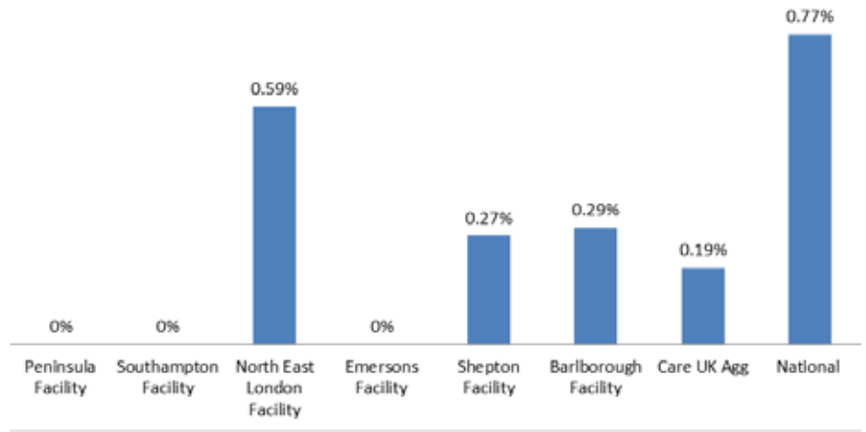
Care UK's secondary care services implement continuous surveillance of our hip and knee replacement outcomes via the Public Health England (PHE) National Surgical Site Infection Surveillance Scheme (NSSISS). We report every incidence.

Each Care UK secondary care hospital/ Treatment Centre undertaking hip and knee surgery contributes to the national database of post discharge outcomes under the Public Health England National Surgical Site Infection Surveillance Scheme (NSSISS).

Care UK report incidences of surgical site infections on a monthly basis; this exceeds the national minimum requirement of quarterly reporting.

This enhanced visibility of the post discharge outcomes of our patients undergoing hip and knee replacement promotes transparency and confidence in the true values of our reported rates of infection.

Confirmed surgical site infections of knee replacements by Care UK treatment centre, Care UK aggregate compared to the national PHE 5 year incidence (Oct 2015 - Sept 2016)



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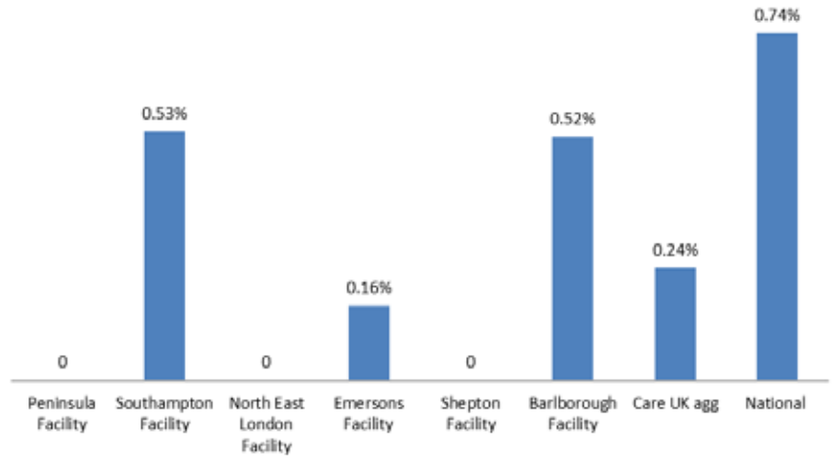


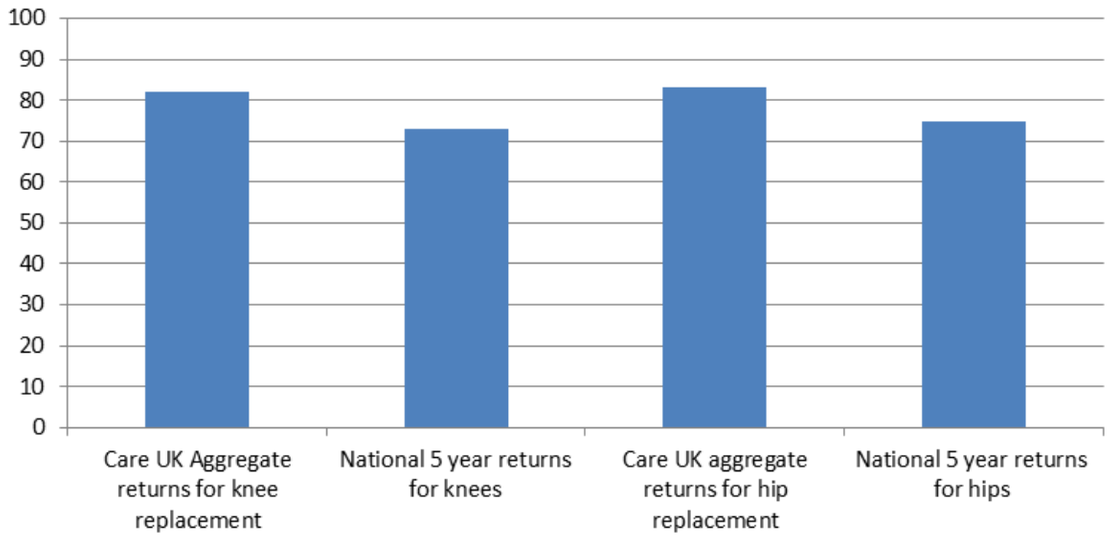
Surgical site infection rates (hips and knees replacements)

Further, Care UK actively seeks information about the experience of our patients following discharge after major joint surgery. We routinely collect data on more of our post operative joint patients than is the achievable for our NHS colleagues.

In line with national Public Health England guidance, Care UK monitors the return of patient completed questionnaires. Some of the treatment centres such as North East London bring their patients back to the clinic for the removal of clips and stitches; this provides the perfect opportunity to find out about the post operative experience of patients resulting in 100% return of the post discharge questionnaires.

Other treatment centres rely on patients posting the forms back after the 30th day since their surgery. If these forms indicate there has been a possible infection, Care UK infection prevention and control leads contact the patient and the GP to confirm whether an infection was present.

Care UK post discharge returns aggregated following knee replacement and hip replacements (Oct 2015- Sept 2016)



Ref: Public Health England Surveillance Service. 2017 Summary Report: Rates, Trends, Risk Factors and Additional Data.

Secondary care hand hygiene audit results by unit

Hand hygiene is a very important element of our comprehensive infection prevention and control (IPC) strategy, policies and procedures – all of which are designed

to minimise the risk of infection arising amongst our patients.

An annual training and audit schedule covers standard infection prevention and control precautions, including hand hygiene, use of personal protective equipment (PPE), decontamination and environmental cleanliness.

Our IPC leads and link practitioners conduct quarterly audits of the hand hygiene practice of staff within each service area. The hand hygiene audit tool and method of scoring has been redesigned this year to focus on each aspect of safe practice: this promotes excellence and reduces risk by focusing clinical staff on the detail of their practices to ensure consistent compliance. This results in lower month end audit scores but better action planning and directed training in response to the improved visibility of infection prevention and control practices.

Information governance data quality

We take our responsibilities very seriously to protect and maintain the confidentiality of patient information.

The Caldicott Guardian, who is responsible for the security of patient information, leads this work and is committed to the highest standards.

We have encouraged an open and transparent reporting culture and as a result have had a total of 131 internal information incidents within the year and we have had 3 SIRI Level 2 reportable incidents which the ICO has closed with no actions taken against us. We have continued to implement innovative and robust controls for managing the risks of breaches in all our operational areas as well enhanced our staff awareness through double checking of patients information with the patient before giving them the discharge letter and take home medicines, only printing patient information as you need it and redefined basic administration processes so there is a focus on completing one task before starting another one and reducing the risks of error.

We have a range of policies to guide employees and we train all staff at their induction and then on an annual basis in managing information and confidentiality. This is an externally assessed through our ISO 27001:2013 accreditation which we received our 3 year recertification in October 2016; a demonstration of our commitment to high standards in the management of information and security.

Any serious breaches are reported to the board, commissioners and information commissioner. Information governance is included in the annual audit schedule. Monitoring and managing data quality is key to providing a quality service. Our strategy is reviewed and refreshed each year to take into account new clinical and quality performance initiatives.

As in previous years we use the data quality dashboards published on a monthly basis by the NHS Digital to monitor the ongoing data quality of the full range of commissioning dataset items for admitted patients and outpatients. Our board receives a quarterly data quality statement detailing any issues and the actions taken to correct them.

137
Internal information incidents

3
SIRI Level 2 reportable incidents

Information governance toolkit attainment

We have achieved the quality standard of Level 3 100% on the IG toolkit, which is underpinned by our ISO 27001:2013-information security management system and accreditation.

Clinical coding

During 2016-17 we submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES). These are included in the latest published data:

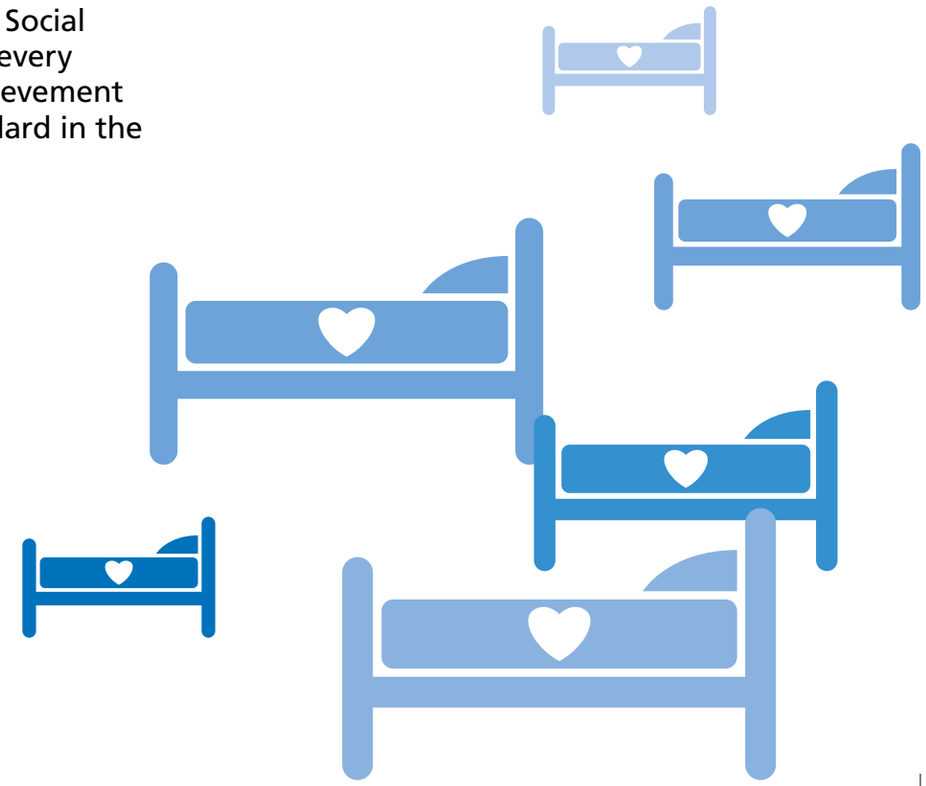
- Within Care UK there is a programme of clinical coding audits focused on data quality, in accordance with Information
- Governance Toolkit 13-505 and conducted in line with the Clinical Classification Service's clinical coding methodology: version 9. The 2016-2017 audit results demonstrated that all Care UK Treatment Centres were achieving the satisfactory percentage accuracy for either Level 2 or the higher Level 3, as recommended
- Care UK clinical coders receive ongoing training in line with the Information Governance Toolkit 14-510 attainment Level 2

Same sex accommodation

In line with Department of Health guidance on mixed sex accommodation, it is standard practice in Care UK facilities to provide separate accommodation for men and women throughout the process of admission, treatment and discharge. Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity.

Care UK can confirm that there have been no breaches of the Department of Health guidance during the past year and this has been reported to the Health and Social Care Information Centre (HSCIC) every month. We are proud of this achievement and intend to maintain this standard in the future.

"Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity"



Local clinical audit

In total, 845 clinical audits of Care UK services were completed locally, between April 2016 and February 2017. Of these, 87% achieved 'compliance' status, 10% 'partial- compliance' and 3% 'non-compliance'.

Each audit forms part of Care UK's published Clinical Audit Schedule. This is reviewed and updated annually by our Clinical Audit and Effectiveness Group, which sets specific clinical audits for each service stream within our Health Care Division.

The group prioritises audits that are mandatory and ensures that all scheduled audits are meaningful and will provide a positive contribution to quality improvement and clinical excellence.

We use a range of audit tools, and provide resource and expertise, to facilitate high quality clinical audit practices. Those involved in local clinical audit practices are also encouraged to complete Care UK's CPD accredited clinical audit training session (mandatory for at least one member of staff per service), which has been highly successful in driving a culture of clinical audit by highlighting the positives that can be achieved in terms of quality improvement.

Core audits in the Clinical Audit Schedule (undertaken within all areas) include: medicines management; documentation; CAS alert and NICE guidance; information governance and security; quality audit and emergency scenarios.

These are supplemented by focused, service stream-specific audits. For our NHS Treatment Centres, these include audits of: venous thromboembolism (VTE) risk assessment; peri-operative hypothermia; implementation of National Early Warning Score (NEWS) assessments; WHO Surgical Safety Checklist usage; and observational audits - falls and fluid balance.

Service stream-specific audits within our diagnostic imaging services, include: reject analysis; clinical practice and documentation; and, dose reference level (Radiation dose audit).

Our musculoskeletal (MSK) services also conduct local clinically focused audits to evaluate clinical practice outcomes, including: acupuncture; joint injection and patient triage.

The results, compliance status and details of any actions arising from clinical audits are submitted monthly to the Health Care Division's Clinical Audit Manager.

Results are then logged with partial and non-compliant audits reported to Care UK's Health Care Board as part of the monthly reporting cycle and governance processes.

Services are responsible for conducting clinical audits and progressing any actions arising. All actions are assigned to specific individuals for completion within defined timescales. Re-audit is completed where indicated, in order to close the audit loop.

Our operational services are clearly focused on conducting high quality clinical audit and ensuring that outcomes support teams to either demonstrate their delivery of high quality, latest evidence-based clinical practice or highlight areas for quality improvement.

The following examples provide clear evidence of how clinical audit practice across Care UK has generated demonstrable improvements in the quality, safety and clinical effectiveness of our services - with shared learning mechanisms used to maximise the benefits across whole service streams.

Will Adams NHS Treatment Centre has improved their compliance against NICE guidelines CG65 (Peri-Operative Hypothermia) from 90% (partially compliant) in August 2016 to 100% (Compliance) by November 2016. This was achieved through the introduction of pre-heated blankets and a fluid warming cabinet.

The Peninsula NHS Treatment Centre has improved their compliance with WHO Observation Audit criteria from 86% (non-compliant) in June 2016 to 98% (compliant) in January 2017.

The improvements are the result of concerted efforts to ensure the highest standards of surgical safety in the centre.

Care UK's ward rounds are complex clinical activities that provide an opportunity for the multidisciplinary team to review a patient's condition together and develop a coordinated plan of care while engaging with the patient and/or carers.

They offer opportunities for sharing information and joint learning. Emersons Green NHS Treatment Centres went from 81% (non-compliant) to 97% when they re-audited. Working closely with clinicians to improve the way information was captured and by ensuring updates were documented electronically in real-time they managed to achieve a much improved score.

In summary, our Clinical Audit Schedule ensures that practices are consistently assessed and benchmarked across a range of guidelines and standards issued by NHS and professional bodies.

Shared learning forms an integral part of the clinical audit cycle and specifically underpins our approach to using clinical audit as an effective quality improvement tool.

In this context, clinical audit outcomes, the key lessons learned and the specific changes and improvements that have been made, are formally discussed and shared amongst colleagues both locally and across Care UK, to ensure we maintain high quality standards for all our patients.

National Joint Registry (NJR)

All of the NHS Treatment Centres operated by Care UK that undertake hip and knee replacement surgery have submitted data to the National Joint Registry since their opening.

The NJR has, since 2002, monitored joint replacement surgery in terms of both its clinical effectiveness and the effectiveness of the surgical implants used.

Nationally, more than 1.6 million procedures are reported annually (11th Annual NJR Report September 2014).

Care UK's current selection of hip and knee replacement implants takes into account: the top performing outcomes demonstrated by the NJR; Orthopaedic Data Evaluation Panel (ODEP) ratings; and, the most commonly utilised implants in England and Wales.

Implants have been selected for their: proven long term performance; low revision rates; the accessibility of manufacturers' support and inventory; ease of application - which is integral to the successful outcomes for the patient.

Our protocols for choosing the right implants take into account individual patient needs, activities, age and bone stock in order to provide them with the best possible outcome and a quick return to normal life and function.

These protocols are regularly reviewed to take account of the latest high impact scientific evidence and the NJR data on revision rates.

Enhanced Recovery Programme

Care UK was an early adopter of the Department of Health's Enhanced Recovery Programme for hip and knee replacement surgery. Patients' recovery is enhanced through careful pre-operative assessment, the use of modern techniques for anaesthesia and post-operative pain relief, and support for early mobilisation.

As a result, patients have shorter hospital stays and better outcomes. The current average lengths of stay at our NHS Treatment Centres are: 2.6 days for hip replacement and 2.3 days for knee replacement.

Hospital	No. of procedures 2016/2017	No. of consultants 2016/2017	NJR consent rate	Average patient age at operation 2016/2017	Outliers – mortality rate	Outliers – hip revision rate	Outliers –knee revision rate
Barlborough NHS Treatment Centre	1,870	9	99.69%	66			
Emersons Green NHS Treatment Centre	1,235	7	98.06%				
North East London NHS Treatment Centre	744	5	100%	67			Yes
Peninsula NHS Treatment Centre	731	8	100%				
Shepton Mallet NHS Treatment Centre	614	4	99.84%			Yes	
Southampton NHS Treatment Centre	427	4	96.06%	56			Yes

Please note:

Compliance, consent and linkability are:

Red if lower than 80%

Amber if equal to or greater than 80% and lower than 95%

Green if 95% or more

Management of near miss and incident reports

It is a mandatory requirement for all providers of healthcare services to have a procedure for reporting incidents. Care UK's procedure is based on National Patient Safety Agency (NPSA) published work, and related policies are regularly revised to reflect latest best practice in this area.

We promote the open reporting of all incidents and accidents, including no harm/ prevented harm and near miss incidents.

If incidents do occur, we take immediate steps to minimise risk factors and prevent recurrence.

Our aim is to maintain a working culture that creates and maintains a safe, low risk environment for our patients and all those visiting or working within Care UK premises.

We also work with local commissioners, partners and external organisations to ensure any learning we derive from incidents is shared and overall risk is reduced. For example, all of our Treatment Centres have a nominated senior staff member who participates in the Local Information Network (LIN) to monitor and review any incidents involving controlled drugs.

Prevention of Never Events

Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'. Reviews of the circumstances surrounding never events typically expose process failures that could be addressed through modern Human Factor (HF) training. To this end, Care UK has engaged a specialist company of HF trainers to work alongside our own training department to help embed HF awareness throughout the organisation. Formal training is given to clinicians and support staff on an ongoing basis to further reduce the possibility of never events occurring in the future.

Care UK commissioned an external review carried out by a medico-legal training company, to assess the adequacy of our post hoc analysis of never events, should they occur, and our process for learning from events.

Following recommendations from this review our Incident Reporting and Investigation Policy were reviewed, along with our Root Cause Analysis tools and methodology.

There were 3 never events reported in 2016-17 across secondary care services. 2 incidents related to wrong tooth extractions, and there was a wrong-side femoral nerve block given.

Site	Category
Southampton NHS Treatment Centre	Wrong tooth extraction
Devizes Treatment Centre	Wrong tooth extraction
North East London NHS Treatment Centre	Wrong-side femoral nerve block

Root Cause Analysis

Once an incident has been investigated, we identify root causes, make recommendations and communicate those recommendations across the organisation to ensure any necessary changes are put into action. We then monitor the implementation of changes to practices, pathways and management, across all sites. Where indicated, we also review our policies and procedures to reflect these changes.

Risks identified through the reporting and investigation of incidents are also recorded in our Datix system alongside any action plans. These are frequently reviewed as part of our proactive approach to reducing the likelihood of future incidents occurring.

Patient deaths within 30 days

Patient deaths within 30 days of discharge were reported over this period although none were the result of treatment or incidents occurring while patients were under the care of Care UK.

Learning from Incidents

At a local level, shared learning from incidents and complaints is a standard agenda item at Quality Governance meetings - with additional, individual feedback being given to any staff members who were involved.

At a national level, we not only monitor the action plans resulting from incident investigations but ensure lessons learned are shared across all services. Our Professional Leads meetings, which are attended by all of our Heads of Nursing and Clinical Services, are a particularly useful forum for this.

In order to further improve the way we learn from serious incidents a new automated shared learning tool was developed in 2016, which facilitates the more effective sharing of lessons recorded in our incident reporting system, Datix, across services, and with staff that may not necessarily have direct access to the incident record.

Working in partnership with our commissioners and external stakeholders is another essential means of sharing our learning and promoting transparency in our services.

To promote this in Southampton, representatives from our Treatment Centre team attend Panel Review Meetings convened by commissioners.

These meetings enable teams of experts, including both senior managers and clinical staff, to get together to discuss and share learning derived from the root cause analysis of incidents.

Meetings are quarterly or as required. Inspectors from the Dental Deanery and NHS England have commented positively on the results of these meetings.

Table 1

This table provides the number of patient safety incidents as a percentage of all incidents per Treatment Centre.

	% of patient safety incidents as a percentage of patient attendances		
	All incidents including near misses	Severe Harm	Death
Barlborough NHS Treatment Centre	1.4770%	0.0000%	0.0000%
Devizes NHS Treatment Centre	1.0118%	0.0126%	0.0000%
Emersons Green NHS Treatment Centre	1.2029%	0.0000%	0.0000%
North East London NHS Treatment Centre	0.4659%	0.0000%	0.0000%
Peninsula NHS Treatment Centre	1.2589%	0.0000%	0.0000%
Shepton Mallet NHS Treatment Centre	0.6030%	0.0000%	0.0000%
Southampton NHS Treatment Centre	0.5599%	0.0023%	0.0000%
St Mary's NHS Treatment Centre	1.1611%	0.0055%	0.0055%
Will Adams NHS Treatment Centre	0.3217%	0.0000%	0.0000%

Table 2

This table provides actual numbers of incidents per Treatment Centre.

	Severe Harm	Death	No Harm	Total
Barlborough NHS Treatment Centre	0	0	261	337
Devizes NHS Treatment Centre	1	0	70	80
Emersons Green NHS Treatment Centre	0	0	252	279
North East London NHS Treatment Centre	0	0	101	128
Peninsula NHS Treatment Centre	0	0	71	111
Shepton Mallet NHS Treatment Centre	0	0	78	92
Southampton NHS Treatment Centre	1	0	169	243
St Mary's NHS Treatment Centre	1	1	180	212
Will Adams NHS Treatment Centre	0	0	31	43


NHS

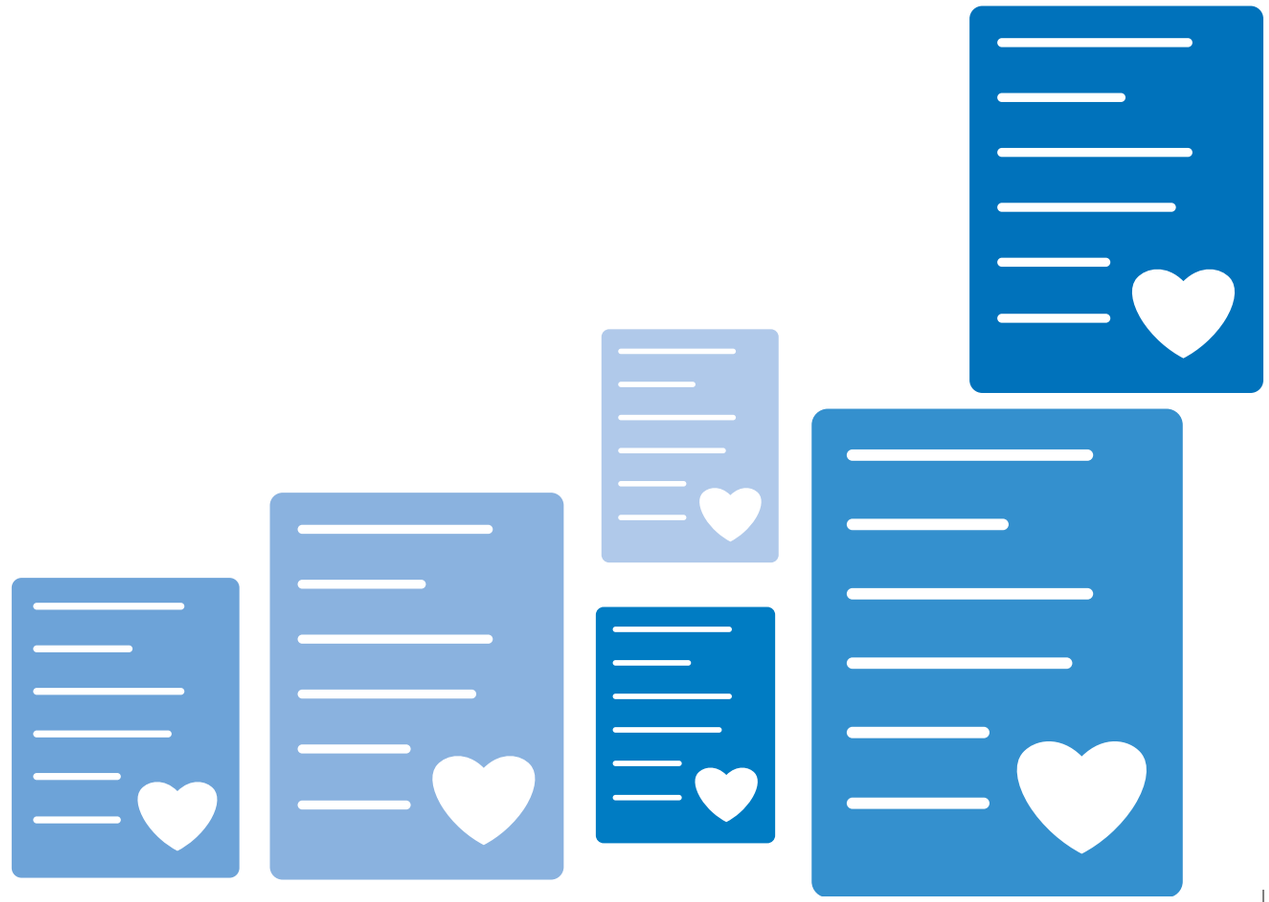
Part Five

Feedback from Key Stakeholders

We would like to thank all of the staff, patients, commissioning groups, Capital Healthwatch and other key stakeholders for reviewing and commenting on this Quality Account. Each year we learn something new and want to improve on how we present this account year on year. The feedback below is verbatim unless stated otherwise.

Appendix

Service Reviews



Barlborough NHS Treatment Centre

Details of last year's local quality priorities

There are 2 local and 2 national CQUINs

- Local 1 – Human Factors, Never Events & Duty of Candour.

In order to raise awareness of the legal aspects of Never Events and Duty of Candour and also to ensure compliance locally, centrally and with regulatory bodies this CQUIN was chosen as this could be monitored by staff attendance at training and also details, actions and lessons learned could be captured through Datix.

- The aim is have trained 90% of clinical staff by the end of the 3rd week April 2017
- All new starters will receive this training during their induction

- Local 2 – Urinary Catheter Care

The aim of this CQUIN was to capture how many patients were catheterised at Barlborough and was there a clear clinical indication to justify catheterisation. It was also to improve urinary catheter care and support patients going home with a urinary catheter in situ. An audit tool was developed to capture all this information.

- Monthly audits of 30 case notes to identify if there was a clear clinical indication for a catheter
- Patients discharged home with a catheter to have a discharge letter requesting referral to Urology, District Nurse and a Patient information leaflet on flip flow catheters
- Guidelines developed to support clinical staff with insertion and management of urinary catheters
- Patient leaflet developed for management of flip flow catheters

	Q2	Q3	Q4
	Submit evidence of 60% Clinical staff have been trained on Never Events, Duty of Candour and Human Factors	Submit evidence of 80% Clinical staff have been trained on Never Events, Duty of Candour and Human Factors	Submit evidence of 90% Clinical staff have been trained on Never Events, Duty of Candour and Human Factors
Number of staff trained	116	125	
Overall percentage trained	89%	96	
Meets milestone requirement	yes	yes	

- National 1 – Reduction in Antibiotic Consumption

  In order to support the prevention of antimicrobial resistance crisis an audit tool was developed to support auditing of all patients at Barlborough who were prescribed antibiotics.

  - All patients who are prescribed antibiotics at Barlborough must be included in the audit
  - Monthly audit of all patients who received antibiotics to review if there was a clear clinical indication and a 72 hour review.
  - Quarterly reports to include trends from audits including lessons learned and actions taken.

- National 2 – Frailty identification and care planning

  This is relevant to us as a treatment centre focused on delivering high quality patient care as frailty is associated with:

  - Extended hospital length of hospital stays.
  - Increased falls risk
  - Increased risk of post operative confusion
  - Poor skin quality
  - Poor nutritional status
  - Increased rate of institutionalisation post discharge
    - Audit tool developed to capture all patients over the age of 75 years
    - All patients aged 75 and over to complete the frailty assessment and pathways completed for frailty of 12 or above

- Locally awareness has been raised with regards to frailty through training, national awareness days and the dementia friendly patient room on the in-patient ward.

VTE

Month	% recorded of total procedures
January	100
February	100
March	96
April	99.3
May	99.1
June	90
July	100
August	95
September	100
October	100
November	88
December	100

NJR

Fiscal Year	Fiscal Quarter	Fiscal Month	No. of Operations	No. of Hips	No of Knees	No. of Ankles	No. of Elbows	No. of Shoulders	Consent Yes	Consent No	Consent Don't Know	Consent Rate	NHS Number Supplied	NHS Number Traced	Tracing Rate	No. with Validate Override	Validate Override Rate
2016	Q3	Oct	182	84	98	0	0	0	182	0	0	100%	182	182	100%	0	0%
2016	Q3	Nov	213	85	125	0	0	3	213	0	0	100%	213	213	100%	2	1%
2016	Q3	Dec	107	47	60	0	0	0	107	0	0	100%	107	107	100%	0	0%
		Total	502	216	283	0	0	3	502	0	0	100%	502	502	100%	2	0%

Barlborough's priorities for 2017

Human Factors/Never Events Training for all staff at Barlborough

In the case of Never Events, despite there being defined processes and procedures to prevent them, on occasions they continue to occur, often with tragic consequences for patients, their families and the staff involved..

In April 2015 - January 2016 Barlborough NHS Treatment Centre had 3 never events and also had a further two Duty of Candour incidents.

Immediate learning from these incidents showed a failure to recognise what was classed as a never event and when duty of candour applied to incidents.

This CQUIN is to provide clarity for staff who may be involved in identifying, investigating or managing Never Events.

Frailty Identification & Care Planning

Barlborough are continuing with Frailty identification and Care Planning through 2017/2018.

By the end of the year we aim to have delivered Dementia Training to 95% of clinical staff.

The Dementia friendly room on the inpatient ward is now nearly completed and fit for purpose.

Improvement of health & wellbeing of Barlborough Staff

This is a new CQUIN at Barlborough which is divided into two sections. The first part is to raise awareness of and support the uptake of the flu vaccination for clinical employees.

The second part focuses on health & wellbeing of all employees, supporting them to make healthier lifestyle choices both at home and at work.

Reducing the impact of serious infections (antimicrobial resistance and sepsis)

This is a new CQUIN at Barlborough. The aim is to have trained 90% of clinical staff in the recognition and management of sepsis using appropriate screening tools and early warning indicators.

Patient Story

Bill presented at Barlborough NHS Treatment Centre with his wife after being referred for a total hip replacement. We were made aware that he was suffering with a diagnosis of Dementia.

Bill's wife was the main carer for her husband and it was obvious that whilst she was worried about his operation, she was completely exhausted and staff had concerns about her health and well-being also.

The patient's 'passport' was completed which enable all staff to be aware of how Bill may react to noise, smells, his interests, fears, likes and dislikes.

Bill and his wife were reassured that the staff would be more than capable in providing an environment that would be safe, stress free and comfortable. We do allocate a double room to patients with dementia so that a relative can stay should they so wish. On this occasion Bill's wife mentioned that she would appreciate time to rest at home and prepare for her husband's discharge.

The multi-disciplinary team meet every Monday and Bill's case was discussed. The date and time of admission was known, staffing needs were increased to provide 'one to one' care for Bill with healthcare assistants and trained staff as necessary.

A memory box was provided for Bill so that conversations could take place between him and the staff to help the care delivery. Bill came with photographs taken at his place of work (British Steel) and old football programs (Sheffield United supporter). Bill was such an interesting patient. We agreed that he could stay for five days if necessary, in order to allow his wife some respite.

Bill's wife visited daily and was thrilled to see that her husband was settled and enjoying his time with us. The staff provided a laundry service for Bill's clothes to enable his wife to rest at home.

At the end of Bill's stay we were able to organise Social Services so that his wife had the support needed.

We found it to be a wonderful experience for Bill, his wife and the staff. There was a great sense of achievement and we were able to contribute to a truly good outcome for both the Bill and his wife.

Changes – no changes needed to be made to the patient pathway, although we are always prepared and open to make changes. We continue to raise awareness by promoting Dementia Friends and delivering dementia training.

Devizes NHS Treatment Centre

Details of last years local quality priorities

Our aims for 2016 were to focus on the following key areas:

1. Monitoring of safer staffing to minimise the risk of adverse outcomes to our patients
2. Achieving Joint Advisory Group Accreditation in Endoscopy
3. Further development of multi disciplinary working within our teams to expand our involvement within achieving patient centred care.

Safer Staffing

In order to provide safe patient care it is essential that each department is adequately staffed at all times, to ensure we achieve this we have implemented Red Flag Report (this is our opportunity re review data and results within a multi disciplinary environment) to enable us to quickly identify if there is a concern regarding staffing.

The Red Flag Report looks at our achievement in the following areas:

- Responsive to care – response to call bells
- Fundamental care needs – responding to prompt pain relief and early mobilisation. .
- Vital sign monitoring – monitoring for early detection of a patient's early deterioration.
- Medicines administration – review of any errors or omissions which have occurred.
- Staffing – reviewing the use of agency, staff skill mix or missed breaks and excessive sickness or overtime.

How we monitored progress

Our teams meet regularly to discuss safer staffing - we look at actual nursing staff in post as a proportion of our total staffing numbers. We also look at current staffing in relation to the number of planned patients to ensure we have the correct ratio of nurses to patients.

We undertake a monthly review of the locally agreed safety parameters across the hospital environment with an increased focus on our inpatient ward.

The focus is to identify any issues which have been flagged up in that month and may reflect on any clinical or adverse outcomes to patients and to discuss how they could have been prevented.

We compile a monthly Red Flag report which covers the following areas:

- Patient Safety parameters: staffing levels and the skill mix of the team; nursing observations; falls risks including pain management; pressure sores and access of ambulatory equipment.
- Any incident affecting:

  a) the patient i.e. falls, inadequate pain management, medication administration errors

  b) nursing levels on a shift (not staffed according to staffing module) and the levels of nursing at the time when an adverse event is documented.

At our monthly meetings the senior nurses discuss the report information and review any incident reports that month and identify any predisposing factors within their department areas and put in place actions to minimise the risk of future incidents occurring again.

Achieving Joint Advisory Group Accreditation in Endoscopy

We have been offering an Endoscopy service at the treatment centre for the past 6 years and have routinely submitted data to JAG regarding our outcomes

Our Endoscopy department have achieved high clinical outcomes and high patient satisfaction

How we monitored success?

We changed the layout of the building to include a new admission room. Once completed along with a new patient route throughout admission and procedure increased levels of privacy and dignity were achieved.

Our new facility has been inspected by the JAG assessors and has achieved full accreditation with no recommendations for further action – this is a very positive result.

We continue to monitor patient feedback to ensure the quality of our service is maintained at its highest level.

Multi Disciplinary Working

In order to ensure our patient journey from referral to discharge is as smooth and straight forward as possible we have entrenched a culture of multi-disciplinary working across the treatment centre.

Our culture ensures that any decisions which affect the patient journey and our internal processes are taken following full consultation with teams throughout the organisation – from our administration departments to our Consultants.

Our aim in fully embedding the multi-disciplinary culture was to ensure each department was considered in any potential changes or new initiatives, this allows us to keep the full patient experience in mind when improving our services.

We also wanted to ensure we could pro-actively plan for patients with increased needs, our Multi-Disciplinary team meetings allow us to plan a patient's journey before they arrive for their appointment.

How we monitored progress

The results of our Multi-Disciplinary team meetings are reviewed monthly and are shared at our Clinical Governance Meetings to ensure any learning's can be disseminated to the whole team.

Devizes Treatment Centre	Local results	National results
Proms Data Improved Outcomes Groin Hernia Varicose Veins	April 2014 to March 2015 finalised Data 53.8% 58.8%	50.7% 39.2%
VTE Compliance - audit looks at the percentage of patients screened for VTE risk	100%	No national results or benchmarking available.
Complaints	October 2015 to September 2016 5 – this equates to 0.03% of patient episodes	
Incidents	1 Dental procedure on a wrong tooth which was rectified the following day.	99.3

Devizes' priorities for 2017

Our aims for 2017 are to focus on the following key areas; these correspond with some of the quality targets set for us by commissioners:

1. Working to improve the health and wellbeing of our employee through a greater understanding of their perceptions and needs within their roles.
   - We aim to undertake two employee surveys over a two year period; the first will gauge and benchmark our current position on how staff view these areas of musculoskeletal health and stress in the workplace. This will enable us to take any relevant action to help improve this position.
   - We will then undertake a further survey and hope to see an improvement of at least 5% on the previous results.
   - We hope to also see a reduction of employee absence within the specific areas of musculoskeletal health and stress in the workplace.
2. Raising the profile of our initiatives around individualised patient centered care with a focus on patients with varying mental health requirements (this initiative corresponds with work across the NHS on parity of esteem).
   - Our aim is to provide an additional employee training programme focusing on the varying needs of patients' mental health issues.
   - The training programme will be rolled out to all staff across the centre over the course of the year – our aim is to achieve an attendance rate of 95%.
3. Working to protect our patients and visitors through minimising the risk of contracting influenza whilst visiting our centre – we aim to do this through increasing our staff uptake of the influenza vaccine.
   - Our aim is to increase vaccination to at least 75% of our staff in the lead up to the flu season. We will do this through education of staff around the importance of vaccination and ensuring ease of access to vaccination clinics throughout the working day.
   - We will hope to see a continuing decrease in our absence level throughout the winter period in comparison with previous years.
   - All patients to respond to requests to use the hand sanitisers on admission and throughout their visit.
4. Improve ease of access for both patients and referrers to our service through ensuring all Out-patient clinic appointments are available to book electronically on the Electronic Referral System.
   - All out-patient clinics will be published on the electronic system and waiting times will be kept as low as possible to ensure maximum choice for patients is available.

- This will apply to all of our specialties with the exception of oral surgery as the electronic system is currently not in use within dental practices.
- A greater number of GP's will include Devizes on their top 5 provider list.

Patient Story

Patients attending for diagnostic procedures within our Endoscopy Department often feel nervous and anxious. This anxiety is unpleasant for the patient and can also have a negative impact on the clinical procedure.

Our team work hard to alleviate this anxiety and try to take each patient's individual needs into account.

During a pre-assessment phone call ahead of an endoscopy procedure Michael mentioned his high levels of anxiety regarding his appointment.

It was identified that Michael enjoyed music and found it to be relaxing.

The team therefore agreed to play his favourite music throughout the duration of the procedure.

Michael was delighted with how smoothly the procedure went and how willing to accommodate his needs the team were.

Emersons Green NHS Treatment Centre

Details of last years local quality priorities

Our aims for 2016 were to focus on the following key areas:

1. Monitoring of safer staffing to minimise the risk of adverse outcomes to our patients
2. Enhancing our approach to maximise Privacy and Dignity of our patient's experience.
3. Further development of multi disciplinary working within our teams to expand our involvement within achieving patient centred care.

Safer Staffing

In order to provide safe patient care it is essential that each department is adequately staffed at all times, to ensure we achieve this we have implemented Red Flag Report (this is our opportunity re review data and results within a multi disciplinary environment) to enable us to quickly identify if there is a concern regarding staffing.

The Red Flag Report looks at our achievement in the following areas:

- Responsive to care – response to call bells
- Fundamental care needs – responding to prompt pain relief and early mobilisation. .
- Vital sign monitoring – monitoring for early detection of a patient's early deterioration.
- Medicines administration – review of any errors or omissions which have occurred.
- Staffing – reviewing the use of agency, staff skill mix or missed breaks and excessive sickness or overtime.

How we monitored progress

Our teams meet regularly to discuss safer staffing - we look at actual nursing staff in post as a proportion of our total staffing numbers. We also look at current staffing in relation to the number of planned patients to ensure we have the correct ratio of nurses to patients.

We undertake a monthly review of the locally agreed safety parameters across the hospital environment with an increased focus on our inpatient ward.

The focus is to identify any issues which have been flagged up in that month and may reflect on any clinical or adverse outcomes to patients and to discuss how they could have been prevented.

We compile a monthly Red Flag report which covers the following areas:

- Patient Safety parameters: staffing levels and the skill mix of the team; nursing observations; falls risks including pain management; pressure sores and access of ambulatory equipment.
- Any incident affecting:

  a) the patient i.e. falls, inadequate pain management, medication administration errors

  b) nursing levels on a shift (not staffed according to staffing module) and the levels of nursing at the time when an adverse event is documented.

At our monthly meetings the senior nurses discuss the report information and review any incident reports that month and identify any predisposing factors within their department areas and put in place actions to minimise the risk of future incidents occurring again.

Privacy and Dignity

Our teams work hard to ensure the privacy and dignity of our patients is maintained throughout their treatment with us.

In order to ensure the high profile of Privacy and Dignity across our treatment centre we have implemented a new Dignity Champion role. The focus of the role for a staff member was to review all of our processes and pathways to ensure privacy and dignity was not compromised at any point of care.

Privacy and dignity forms part of the government's strategy, Essence of Care. This strategy was implemented in 2009 as a way to standardise fundamental aspects of nursing care across all providers of health care.

How we monitored success?

We developed a training programme based on The Skills for Care Dignity Standards and Standard seven of the Care Certificate. Staff learning was assessed at the end of the short course.

Dignity Leads observe their departments and report on a quarterly basis regarding any findings or learnings. We use the Essence of Care tool for Privacy and Dignity to monitor current practice and then repeat the same data collection exercise (qualitative information) to review where and what improvements have been made within both patient and staff experience/ knowledge and understanding.

Multi Disciplinary Working

In order to ensure our patient journey from referral to discharge is as smooth and straight forward as possible we have entrenched a culture of multi-disciplinary working across the treatment centre.

Our culture ensures that any decisions which affect the patient journey and our internal processes are taken following full consultation with teams throughout the organisation – from our administration departments to our Consultants.

Our aim in fully embedding the multi-disciplinary culture was to ensure each department was considered in any potential changes or new initiatives, this allows us to keep the full patient experience in mind when improving our services.

We also wanted to ensure we could pro-actively plan for patients with increased needs, our Multi-Disciplinary team meetings allow us to plan a patient's journey before they arrive for their appointment.

How we monitored progress

The results of our Multi-Disciplinary team meetings are reviewed monthly and shared at our Clinical Governance Meetings to ensure any learning's can be disseminated to the whole team.

Emersons Green Treatment Centre	Local results	National results
National Joint Registry (NJR) - procedures recorded for this hospital are: Hips 90 day mortality Hip Revision Rate	Data for 1 April 2003 - 31 July 2016 0.22 0.66	 1.0 1.0
National Joint Registry (NJR) - procedures recorded for this hospital are: Knee 90 day mortality Knee Revision Rate	Data for 1 April 2003 - 31 July 2016 0.67 1.0	 1.0 1.0
Patient Reported Outcome Measures (PROMS) Groin Hernia Hip Primary Hip Revision Knee Primary Varicose Veins Primary	April 2014 to March 2015, finalised data, April 2015 Improved Outcomes 38.6% 98.3% 100% 97.4% 82.5%	April 2014 to March 2015, finalised data, April 2015 Improved Outcomes 38.1% 97.3% 85.7% 93.8% 82.5%
VTE Compliance - Monitors the number of patients screened for VTE	100%	No national figures available
Complaints	October 2015 to September 2016: 20 – equivalent to 0.04% patient episodes	
Serious Incidents	1 Late diagnosis of an infection which required further treatment at another hospital 1 foot drop 1 delayed diagnosis (gynae)	

Emersons Green's priorities for 2017

Our aims for 2017 are to focus on the following key areas; these correspond with some of the quality targets set for us by commissioners:

1. Working to improve the health and wellbeing of our employee through a greater understanding of their perceptions and needs within their roles.
    - We aim to undertake two employee surveys over a two year period; the first will gauge and benchmark our current position on how staff view these areas of musculoskeletal health and stress in the workplace. This will enable us to take any relevant action to help improve this position.
    - We will then undertake a further survey and hope to see an improvement of at least 5% on the previous results.
    - We hope to also see a reduction of employee absence within the specific areas of musculoskeletal health and stress in the workplace.
2. Raising the profile of our initiatives around individualised patient centered care with a focus on patients with varying mental health requirements (this initiative corresponds with work across the NHS on parity of esteem).
    - Our aim is to provide an additional

employee training programme focusing on the varying needs of patients' mental health issues.

- The training programme will be rolled out to all employees across the centre over the course of the year – our aim is to achieve an attendance rate of 95%.

3. Working to protect our patients and visitors through minimising the risk of contracting influenza whilst visiting our centre – we aim to do this through increasing our employee uptake of the influenza vaccine and increase patient awareness in how they can assist in preventing the spread of infection.
   - Our aim is to increase vaccination to at least 75% of our staff in the lead up to the flu season. We will do this through education of staff around the importance of vaccination and ensuring ease of access to vaccination clinics throughout the working day.
   - We will hope to see a continuing decrease in our absence level throughout the winter period in comparison with previous years.
   - All patients to respond to requests to use the hand sanitisers on admission and throughout their visit.
4. Improve ease of access for both patients and referrers to our service through ensuring all Out-patient clinic appointments are available to book electronically on the Electronic Referral System.
   - That all out-patient clinics will be published on the electronic system and waiting times will be kept as low as possible to ensure maximum choice for patients is available.
   - This will apply to all of our specialties with the exception of oral surgery as the electronic system is currently not in use within dental practices.
   - A greater number of GP's will include Emersons on their top 5 provider list.

Patient Story

We received a referral for an endoscopy procedure. During the triaging of the referral it was identified that Olga had learning difficulties and was known to demonstrate challenging behaviour.

A multi-disciplinary team meeting was convened to discuss the referral and implement an individualised care plan for Olga to ensure a good patient experience and a good clinic outcome.

The following measures were implemented:

- Olga and carer were invited to visit the department prior to the day of the procedure to meet the team and view the environment to relieve anxieties that may have presented.
- We ensured that all members of the team were aware of the importance of the use of accessible language throughout the visit and on the day of the procedure.
- We discussed with the Olga and her carer ways to manage anxiety. Music was identified as a key factor in this so it was arranged that the Olga's favourite music would be played throughout the procedure.
- On the day of the procedure the Olga's carer remained present throughout the sedation process and was again present in the recovery area to provide emotional support and familiarity.
- Olga's appointment was scheduled at a specific time of day appropriate for her to ensure that he felt calm and relaxed throughout the total experience.

The procedure went very well and both Olga and her family were delighted with the outcome and the efforts that had been made to ensure the best possible experience.

North East London NHS Treatment Centre

Details of last years local quality priorities

What are we were trying to improve

We have been trying to improve an ongoing local measure which gives us an indication of our success:

Friends and Family Test score in all departments.

There was a lack of consistency with our Friends and Family scores and response rates and we set out to improve the consistency of our data collected and through a process of ongoing improvement raise the standard of our data collected.

Why we are trying to improve

This measure is reportable to the HSCIC and gives us an indication of our success; The Friends and Family Test score is a measure for us that is indicative of our employees performance.

How we monitored progress

We collated data at the end of every month and presented this at our Quality and Governance meeting and feedback to all employees.

Friends and Family Test Score Outcomes

		April 16	May16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
Inpatient Friends and Family Test - Would recommend %	ISTC - 99% NHS - 94%	96%	100%	100%	100%	100%	98%	100%	97%	100%	100%
Inpatient Friends and Family Test - Response rate %	>50%	68%	59%	60%	33%	88%	80%	91%	45%	100%	100%
Daycase Friends and Family Test - Would recommend %	ISTC - 99% NHS - 94%	99%	97%	98%	97%	96%	97%	98%	100%	99%	99%
Daycase Friends and Family Test - Response rate %	>50%	89%	90%	98%	93%	97%	100%	89%	87%	96%	99%

NEL Treatment Centre	Local results	National results
NJR	The consent rate for North East London Treatment Centre in 2016 was 100%	Nationally the consent rates for NHS providers is 92% And independent providers is 95%
PROMS	100% of hip replacement patients stated that their condition had improved	Nationally 97.8% of hip replacement patients stated that their condition had improved
VTE	Quarter 2 2016-17 July-Sept 2016 99.81%	Quarter 2 2016-17 July-Sept 2016 95.51%
Complaints	A reduction of 6% in the number of complaints (2015 54 complaints and 2016 51 complaints)	Nationally there a fall of 3.8% in the number of written complaints
Incidents related to patient harm	NHS safety thermometer 100%	National average 94%

Details of next year's priorities

- There are a high number of both non clinical and clinical cancellations, and Did Not Attend (DNA) appointments. This issue leads to poor patient experience, lost slots and the fact that these patients then have to be booked into another list at a later date.
    - Cancellations and DNAs will reduce month on month

Patient Story

Received from Joan on 25th December 2015

"I have had pain in my hip for about 16 years now and had previously been to my GP about it around 2008-2009. At that time I was told to wait until I was older to have anything done to it.

Recently I did some research on the Internet and spoke to family members and friends about where would be the best place to have my hip looked into.

After doing some research on the Internet I decided I would like Mr Fabula at the North East London NHS Treatment Centre (NELTC) to assess me for a hip replacement.

I booked in to see my GP on 15th July 2015. I asked for a 'choose and book referral' to Mr Fabula at NELTC.

My doctor referred me and in early August I received a phone call from NELTC. They booked me in for a pre-assessment appointment, which can take up to 3 hours, at 11:20 am on 3rd September 2015.

I also received written confirmation of this appointment. On 3rd September 2015 upon arrival at NELTC there were no delays.

The pre-assessment includes height measurement, weight measurement, blood samples, ECG, X-ray, filling out forms regarding medical history, an appointment with the anaesthetist (with whom I agreed to have an epidural for the procedure) and an appointment with the consultant Mr Fabula.

The pre-assessment ran like clockwork, moving from room to room to see nurses, anaesthetist, consultant with only a few minutes wait between each assessment.

In view of the x-ray and clinical findings Mr Fabula offered me a total right hip replacement. NELTC wished to carry out my hip replacement within six weeks however due to work commitments I asked for this to be delayed.

My orthopaedic procedure was booked in for 12 noon on 23rd November 2015.

Monday 23rd November soon came and at 12 noon I was at NELTC. By 1:00 pm I was having my epidural and I was taken into theatre.

I remember looking at the clock in the recovery room and it was 3:10 pm. My procedure was done. By 4:00 pm I was back in my bed on the ward eating toast with family members around me.

Next I was asked what I would like of the menu for dinner; dinner was served about 6:30 pm.

The next important thing was to get my waterworks to kick back in.

This happened slowly at first around about 10 or 11 pm but got better as the night went on.

At all times the team at NELTC were attentive and made sure I was comfortable."

Peninsula NHS Treatment Centre

Details of last years local quality priorities

What are we trying to improve?

Response to calls to the patient 24hr Clinical helpline.

Why we are trying to improve?

A number of patients had indicated that calls made to the helpline had not been answered and the patient had to seek assurances elsewhere.

How we monitored progress

Initially we audited the helpline call monthly and monitored the calls made. We found that a number of calls were not answered as messages had been left on the answer phone and not actioned. Also calls to the admin team for appointments and booking were coming through the clinical helpline. In addition a number of calls were received from patients with general enquiries about the centre and pre-operative questions.

We employed a Senior support nurse to answer the calls during the core hours of the day.8-5, and gave training to the ward Registered Nurses to answer calls out of hours and direct to the most appropriate person for action. The Senior support nurse audited all calls and discussed themes at monthly Quality governance meetings. We also changed the information given to patients in Out Patient Department (OPD) and on discharge so that calls for administration or pre-operative issues were referred directly to the admin, OPD team and not via the clinical helpline.

We found that the number of patients reporting that calls had not been answered dropped significantly and the total number of calls to the helpline reduced. Continued monitoring showed that the number of admin and pre-op calls stopped.

We were also able to address the most common themes e.g. anti-embolic stocking usage and put systems in place to answer the questions asked in more detail to the patients at discharge.

Local outcomes

Jan 16-Jan17	Local results
NJR	98.5%
VTE	99.06%
Complaints	9
Incidents related to patient harm	5

Details of next year's priorities

What are we trying to improve?

- Embed the new build including the Endoscopy suite working towards and achieving JAG accreditation.
- Ensuring patients identified with a potential cancer diagnosis at Endoscopy are referred to cancer 2 week pathway.
- Reduction in antibiotic prescribing for patients identified with suspected Urinary tract infection (UTI).
- Improved discharge planning. >60% of patients are currently discharged in the afternoon and this has an impact of bed capacity.
- Day one mobilization of >75% of patients to ensure timely discharge.

What will success look like?

- A fully functioning, compliant Endoscopy suite and pathway that is JAG accredited
- Patients referred on the day of procedure and seen within 2 weeks by an appropriate Consultant.
- Patients with confirmed UTI treated with antibiotics.
- Patients discharged in a timely fashion with >75% of patients discharged home before 12 noon. Dedicated discharge nurse co-coordinator.
- >75% of patients for hip and knee arthroplasty are mobilised on day 0.

How will we monitor progress?

- The Theatre Manager and Endoscopy lead nurse to oversee the process and ensure milestones are achieved as per requirements of JAG.
- Spreadsheet kept of all patients referred to cancer 2 week pathway to ensure care is received in a timely fashion.
- Reporting of all suspected infections, overseen by the Infection Prevention and Control lead and patients with confirmed infection only treated with appropriate antibiotics. Review at Antibiotics stewardship meetings quarterly.
- Ward Manager to oversee discharge times and collated data in a locally agreed format.
- Physiotherapy lead to oversee day 0 mobilisation and collate data in a locally agreed format. To feedback achievements and actions at QG meetings.

Patient Story

Adam was a gentleman who was to be admitted for joint replacement during May.

He was known to have some degree of learning difficulties and lived with his carers Mr and Mrs B. They had employed him to help out at their guest house, subsequently he was invited to live with them and from this time he called Mrs B "mum". Previous to this Adam was living in an institute for the mentally infirm and he did not have any parents as they had given him up at birth.

Prior to his admission Adam's needs were discussed with the triage nurse and Mr and Mrs B so that his stay within the unit would be as smooth as possible. A side room was arranged for him and an extra bed was made available for his "Mum" to stay with him, if he became anxious.

Both Mr and Mrs B also had rooms booked in a nearby hotel. They were both keen to be very involved in Adams care so were allowed to have free access to the ward as and when they needed and were issued a patient passport.

Adam had never had any major surgery; his carers wanted this to be a positive experience for him so that if he needed any further hospital admissions he would not be afraid.

Adam was admitted for a total knee replacement procedure; Mrs B stayed with him throughout his admission and explained everything to him in simple terms so that he was able to understand exactly what would be happening to him.

She was there on the ward when he returned from theatre and was available to go into recovery had she been needed. Both her and Mr B were able to stay with Adam later than most visitors and were grateful that we had accommodated both Adams needs and theirs. As he settled well into the ward environment they did not stay the night with him, but were "on call" at the local hotel.

Adam had an unremarkable recovery; mobilised well and reached all physiotherapy goals. His pain was well controlled, his vital signs were stable and he was able to easily do everything asked of him. He needed additional time but the ward team ensure he had everything he needed.

His carers were involved in all aspects of his care and were shown how to look out for any skin issues, infection, Deep Vein Thrombosis (DVT). They were able to encourage Adam with his physiotherapy and were also taught how to continue administering his medication post discharge.

As the family were re-locating away from the area the family had organised a 2 week stay for Adam in St Austell community hospital whilst they moved.

Mr and Mrs B were very impressed with the way the Peninsula made everything easy for them and Adam during his stay, especially the fact that plans were made for them to be with him 24 hours a day if there was a need.

They found the centre to be a very caring and welcoming environment with all of his needs taken care of, making the whole experience for them and Adam, a positive and happy one.

Shepton Mallet NHS Treatment Centre

These quality objectives have been discussed and agreed with the CCG – they are combined set reflecting local Somerset-wide and Care UK priorities. Three have been locally developed to reflect actions following variant clinical outcomes.

Details of last year's local quality priorities

- Antimicrobial stewardship programme
- Introduction of pre-operative multi-disciplinary meetings for patients with a prolonged pathway or chronic conditions which require management prior to admission
- Acute Kidney Injury (AKI) risk assessment tool
- Introduction of risk assessment to reduce routine catheterization of patients - receiving spinal anaesthesia
- Implementation for the Local Safety Standards for Invasive Procedures (LocSSIPs)
- ISO accreditation for Quality ISO 9001 – achieved with no non-conformities
- JAG re-accreditation for 5 years - achieved
- Renewal BSI Quality Management System 13485:2003 and EN ISO 13485:2012 accreditation for decontamination

What are we were trying to improve (last year):

- Reduction in the usage of antibiotics to reduce the antibiotic resistance – antibiotic audit introduced. All reviewed at Antibiotic Stewardship meetings
- The cancellation of patients on the day of surgery through pre operative management/the transfer of care sooner to reduce the patients referral to treatment time – MDT's introduced
- To identify patients pre operatively who would be at greater risk of AKI post operatively – AKI risk assessment created by consultant anaesthetist
- To reduce the impact of unnecessary invasive procedures on suitable patients, Urinary Tract Infections (UTIs)

Local outcomes

Jan 16-Jan17	Local results
PROMS (See below)	99.8% THR/TKR
Complaints	15 formal
Compliments	248 formal
Incidents related to patient harm-(202 incidents reported all categories)	1 patient incident which caused actual harm – a skin tear following a fall.

Details of next year's priorities (on site)

- Clinical frailty – continuation Rockwood score deviation from Care UK corporate policy and in line with Commissioner requirements
- Dementia strategy – more work on environment, additional training
- Medication intervention reporting
- Participation in VTE committee
- Commencement of anaesthetist led pre-assessment clinics for complex patients with multiple comorbidities and patients who are taking anti-coagulants/anti-platelet medication.

What are we trying to improve?

- Individual care planning for all patients attending Shepton Mallet Treatment Centre – particularly patients over 75 who are risk assessed at their first Out Patients appointment for clinical frailty and dementia.
- Relationship with GPs – introducing signposting to community services third sector via increasing knowledge through members of the Community Participation Group in line with Five Year Forward View national objectives and the post of Health Care Co-ordinator – a joint venture with Health Connections.

Patient Story

When marathon running and cycling policeman, Daniel Bishop, 41, from Taunton experienced pain while out running, he thought it was simply groin strain.

However, the pain became progressively worse to the point where he was unable to walk let alone run any distance, carry out his operational duties as a police officer or even sleep at night. He went to his GP who referred him for an x-ray at Musgrove Park Hospital.

"I first saw my doctor at the beginning of August and I had the x-ray the following day. The very next day after that I began physiotherapy, said Daniel. "It was the physiotherapist referred me to an Orthopaedic Assessment Centre in Taunton who in turn referred me on to see an Orthopedic Consultant at Shepton Mallet NHS Treatment Centre where it was decided that I would need a hip replacement – unusual for someone of my age but there was no other option."

Daniel had his surgery at Shepton Mallet NHS Treatment Centre on 19th December.

"It was the first time in my life that I had stayed in hospital and my first operation," said Daniel. "I was understandably anxious, but from the moment I got to Shepton Mallet NHS Treatment Centre I felt so relaxed, the staff were fantastic."

At his first outpatient appointment Daniel discussed his treatment with his consultant. "I was able to speak about my life and my work and take into account my occupation when deciding what was best for me."

As a consequence Daniel received a ceramic hip and plastic socket, which is a combination better suited to deal with impact and which will allow Daniel to return to work once his convalescence is over.

Daniel is delighted with the results of his operation and the care he received from Shepton Mallet NHS Treatment Centre said: "I have gone from experiencing acute and chronic pain which leads to feeling permanently exhausted, to no pain and feeling confident about getting active again. As someone who ran and cycled it has been immensely frustrating not to be have been able to do those things. I know that my marathon running days are over but I am really looking forward to getting back on my bike and to taking our two dogs for long walks again."

He added: "I've been telling everyone about how great the treatment was from Shepton Mallet NHS Treatment Centre. The staff are fantastic, as is the catering. You're given plenty of time by everyone which made it feel more like I was staying at a friend's house than being in hospital. I felt completely at ease during my stay and never felt worried or has reason to feel embarrassed in any way. I loved the fact that what I do for a living was taken into account when my treatment was planned. It was good too to be able to get the operation relatively quickly, for it means I can be back at work sooner rather than later. I feel very fortunate to have had my surgery at Shepton Mallet NHS Treatment Centre."

Southampton NHS Treatment Centre

Details of last years local quality priorities

What are we were trying to improve?

- Safety procedures for oral surgery pathway
- Groin hernia PROMs
- AKI (acute kidney injury) provision of care and prevention
- Implementation of multifactorial assessment to identify patient's individual risk factors for falls
- Sepsis Pathway

How we monitored progress

- Local procedural teams engaged to develop Standard Operating Procedures (SOP) for Oral Surgery pathways: action plan log, ongoing implementation of monitoring framework embedded in to standard monitoring, going forward.
- In line with PROMs database publications.
- Acute kidney injury (AKI) – training of staff, and audited AKIs reported
- Falls – education, audit and monitoring risk assessments
- Auditing sepsis against NEWS scoring system, and implementation of sepsis tool

Local outcomes

	Local results
AKI	Improved recognition and early management. Over 95% of appropriate staff trained on AKI.
Falls	Implementation of risk assessment tool for at risk patients. No high harm falls.
Sepsis	Implementation of sepsis tool, audit tool in place, high attendance on training sessions and awareness displays in place.
Complaints	Complaints well managed, average 3.5 per month (0.28% of activity in 2016), these are themed and analysed. Trend downwards.
Incidents related to patient harm	Never events – actions, HF and monitoring framework.

Details of next year's priorities

What are we trying to improve?

- Reporting of near miss and no harm events with corresponding reflection and learning
- Full LocSSIPs implementation and monitoring in line with NatSSIPs framework
- Influenza uptake
- Suggested – 'My name is..' audit
- Handover processes, including a daily safety briefing

Patient Story

Tonsilectomy carried out 2 December 2016

Patient was anxious upon arrival for her operation due to a previous bad experience at another facility. Patient states the care and compassion shown to her was over and above her expectations.

The post-operative care was also outstanding. Patient also noticed how united the staff were, working together as a team, in good humour.

They all helped each other with lots of praise and thanks being exchanged between each other which also enhanced the patient's experience.

The actions of the staff helped reinforce to the patient that the values she thought had been lost within the NHS do still exist.

St Mary's NHS Treatment Centre

Details of last years local quality priorities

Over the past year there have been many new initiatives that have helped to improve the quality of care we provide to our patients and improve the patient experience as listed below.

We remain focused that our patients should be and are, at the heart of everything we do.

Pre-op calls by Health Care Assistant's (HCA)

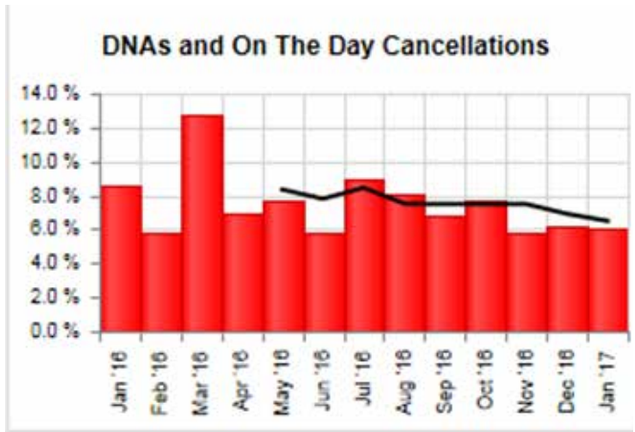
This was previously undertaken by administration staff and the change has resulted in a reduction of DNAs, cancellations and improvement of patient experience

Working on the premise that patients would prefer, prior to their clinical procedure, to talk to a clinician about what to expect via the pre-op call process, the centre introduced Health Care Assistants within this role.

This has helped to support patient care with HCA's being more experienced to identify and flag clinical concerns on behalf of the patient and works to reduce clinical cancellations and DNAs.

The reduction of clinical cancellations and DNAs ensures that the patient receives treatment at the earliest opportunity and allows us to run efficient lists to support the care of the local community with good wait times.

Below shows the DNA and On The Day cancellation data extracted from the internal Pisces effectiveness tool.

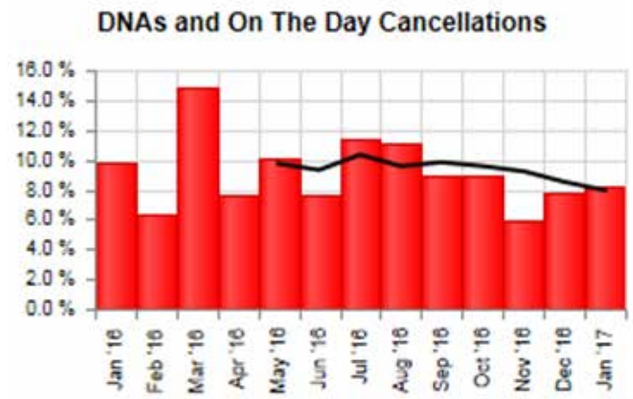


Endoscopy Anxiety Score

The Endoscopy anxiety score was introduced to combat the higher levels of cancellations and DNAs for this specialty. Patients scoring high on the score when they undergo their pre-operative phone call are passed to the Endoscopy Lead Nurse, who is able to contact the patient again and discuss their concerns in order to provide the reassurance needed.

It cannot be underestimated the importance of being able to speak to a staff member who really understands and knows the clinical process. This, we consider, has really helped to reduce the anxiety levels of patients who undergo this evasive and sometimes intimate procedure.

It is important that patients have this diagnostic procedure at the earliest opportunity to decide on the pathway of care needed. Whilst we are not a cancer pathway, this is identified for some patient on a frequent occurrence. The reduction of DNA's supports timely patient care which is something we are passionate about.



Patient Forum and Joint Patient Forum

The Patient Forum was reintroduced at the centre to further engage with the general public and meets quarterly to discuss the service and oversee the patient experience by reviewing complaints and compliments. This year we have been able to 'join forces' with the Southampton Patient Forum to exchange ideas and understand the local differences of the area in which they serve. This exchange of information has been invaluable and we have changed how our Patient Forum undertakes its role in a more focussed way.

A recent visit to the Joint Forum in September 2016 by the Head of Governance and Quality in Secondary Care really cemented the importance of their role in advocating for patients. Members of the forum have supported the Centre at the Open Day in February 2016 and marketing events that 'fly the flag' for the local services we provide. Future priorities include members becoming more involved in the Patient Satisfaction Survey, and this forum is planned to continue through the coming year.

Optometrist training and Optometrist Forum

The first Optometrist Forum was held in January 2016 and has gone from strength to strength. This improved collaboration with our important community referrers, supported by our two Consultant Ophthalmologists and Ophthalmology Team and incorporates Clinical presentations on a range of ophthalmic disorders. It has united and supported these often isolated clinicians. This has been further enhanced by the organising of clinical visits / observational sessions by local Optometrists into the Centre, which supports their Continuing Professional Development.

The aim here is to share our learnings, provide education and provide confidence to the referrer to enable them to refer to the service ensuring the growth of our ophthalmic service. Feedback is very positive and these forums are well attended with an increase of referrers attending. These are held in the evening to maximise the opportunity for the referrer to attend.

Introduction of Clinical Educator Role

The introduction of the Clinical Educator that covers both sites delivering bespoke training to the needs of the service has without a doubt improved focus on the continuing support and education of our clinical staff members. This has supported and improved morale, motivated individual clinicians and is supported by Clinical Leads and an essential part of Continuing Professional Development. Without a doubt this improves the quality of care the clinicians provides to their patients.

Local outcomes

	Local results	National results
NJR	N/A	N/A
PROMS	96% (3 QTRS)	74.5%
VTE	100%	96%
Complaints	2016 - 97 complaints 0.09% of Activity	
Incidents related to patient harm	16 (incl. 1 SIRI) 0.01% of Activity	

Details of next year's priorities

X-ray Equipment

To replace with up to date technology the X-ray equipment used at St Mary's and Havant Diagnostic Centre to ensure safe, effective and reliable service, ensuring the highest quality of images are provided to aid patient diagnosis .

This will be project managed by the supplier of choice with Care UK ensuring a team of expertise also support this project to provide a seamless transistion. The image quality and subsequent diagnosis will be testament to the investment made here.

Navigation systems in Minor Injuries Unit (MIU)

This system has been introduced to ensure the safe and effective assessment of patients by a Nurse Practitioner in the Minor Injuries/Illness Unit at St Mary's NHS Treatment Centre and involves nurse intervention prior to checking in with the reception staff.

This will ensure patients are correctly assessed within the KPI timeframe and appropriately directed to the appropriate clinician from the first initial contact of the patient attending the department. This will provide the safest assessment process to date at St. Mary's Treatment centre.

Introduction and continuation of transferred activity or additional specialties being provided at the centre

Our focus will remain on providing high quality care to the local community. We currently have the opportunity to provide transferred activity in orthopedics, endoscopy, colorectal, general surgery and urology. By the 1st April it is proposed that all urology referrals will be received at the centre for us to triage in the first instance.

KPI performance, referral patterns, internal and external audits, trained staff, will validate the high quality of care being provide and will provide opportunity to address any issues that present.

Documentation live audit and review of transfer of care documentation in MIU

This review will look at the quality of documentation within the Minor Injuries Unit at St Mary's NHS Treatment Centre, looking at LIVE data and assessing the quality of that information and whether it is safe and effective for purpose.

This is due to start mid February 2017. All transfer of care documentation will also be reviewed, to ensure the quality of that information and appropriateness of transfer and if necessary produce action plans to assist the continual improvement process through training and support.

Patient Story

Graham was due to come in for an Endoscopy procedure, he had some mental health issues and some severe anxieties.

Graham felt unable to attend and undergo the procedure and phoned the centre to cancel the appointment.

It was due to the compassionate and sensitive approach by the whole team from the schedulers, administration colleagues and clinical staff that extra care and support was put in place.

Graham was able to attend the Centre before the procedure date, in order to meet some of the team and be showed around the building. From that time on the team took full respo

nsibility to make sure he felt able to attend. The team met him on arrival for the procedure and supported him directly on to the Wards. Graham was positioned first on the Theatre list and he was able to have his procedure successfully.

The personal touch by one our Patient Administrator Supervisor alerted her to ask the right questions and discuss with Graham and the team to ensure the care package provided for him was appropriate, empathetic and understanding.

Communication being the key- the guiding principle being if the centre are aware of potential difficulties, subtle temporary changes can be made to help patients who may need extra support.

Will Adams NHS Treatment Centre

Details of last year's local quality priorities

What are we were trying to improve

The CQUIN which we were allocated for 2016/17 was improving the health and wellbeing of staff by uptake of the flu injection. Our aim was to protect our service users from the flu and our colleagues.

How we monitored progress

Clinics were set up on 2 convenient days for staff to receive their vaccination and staff booked themselves an appointment. Extra days were added for staff who were unable to attend the first dates. Promotional material was used throughout the centre to encourage staff to have the injection. Verbal encouragement was also given and members of staff were given the opportunity to discuss any concerns.

Reminders were given at Unit Meetings, Head of Department meetings and Ward and Theatre Meetings. The Infection Control Lead discussed the benefits of having the injection at the mentioned meetings. The data was submitted to Care UK and the CCG.

Local outcomes

	Local results
VTE	Apr 99.4% May 98.7% June 99.6% July 99.1% Aug 99% Sept 98.3% Oct 99.5% Nov 99.8% Dec 99.6%
Complaints	6 complaints were received in 2016. All were responded to within 3 & 20 days they were all first stage. We are waiting for the results of the recent (Jan 2017) CCG audit however we were informed at the time that there were no concerns.
Incidents related to patient harm	There were 2 incidents which involved a leur lock syringe and needle which became separated causing injury to the patients eye. There was one incident where an expired lens was inserted into the patients eye.

Details of next year's priorities

Discussions are underway with the CCG to identify key priorities for the coming year.

Patient Story

When Mrs Joyce Sutherland received an unexpected double diagnosis of Wet Age-related Macular Degeneration (Wet AMD) and cataracts from her trusted family optician at Burnett, Hodd & Jenkins, in Sidcup, she listened to his advice and opted to use the Will Adams NHS Treatment Centre in Gillingham, Kent, despite the 50-mile round trip.

"He explained that the Consultant Ophthalmic Surgeon at the centre, Mrs Mahboub Hawkes, had an excellent reputation in the treatment of both conditions - and the centre also had very short waiting times," she explained.

Wet AMD can develop very suddenly and it can only be treated if caught quickly. A fast referral to a hospital specialist is essential.

Mrs Sutherland said: "The team at Will Adams NHS Treatment Centre were incredible, especially the nurses who were very caring and professional. They treated the Wet AMD first, putting me at ease during the series of injections into my right eye. I was very impressed by the cleanliness of the centre too and the free and plentiful parking meant the trip from Welling was not really an issue."

Once the team had treated the AMD, Mrs Hawkes scheduled the first cataract removal. She suggested operating on the right eye first: Mrs Sutherland had some sight in her left eye and so she would have some vision while the right eye healed.

The operation was a success and Mrs Hawkes scheduled the second operation. Mrs Sutherland said: "She was wonderful: she gathered from our conversations during my treatment that we had booked a holiday to Australia to see our son and she wanted to help me make the most of it. And she did: my vision cleared almost immediately. I was amazed."

Two months after her operation, Mrs Sutherland and her husband shared the 800 miles of driving as they travelled around Darwin and the Northern Territories, where her son works as an engineer.

She said: "It was incredible. Before the treatment, I could no longer drive and I had to stop teaching my regular arts and crafts group at Hall Place, in Crayford. Now I am back doing everything I love to do and it is all thanks to the team.

"To anyone who is placed in a similar situation, I can only urge them to go to their optician as quickly as possible. To lose one's sight is so debilitating and frightening. There is hope and great professionals who can help."

Mrs Hawkes said: "We were very happy to help Mrs Sutherland, who gives so much to her community with her work with older people.

"Wet AMD is a particularly troubling condition because, if it is not quickly spotted and treated, patients can be left with severe visual impairment. I am delighted Mrs Sutherland's optician so quickly diagnosed her condition and referred her to us - that played a significant part in our ability to stop the degeneration and get Mrs Sutherland back behind the wheel."

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