



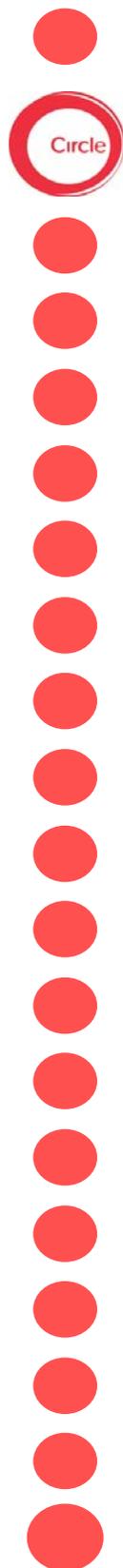
# Nottingham NHS Treatment Centre

## Quality Account

2010-11



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## What is a Quality Account?

In 2010 the Department of Health required all providers of NHS services to publish a report about the quality of their services as set out in the Health and Social Care Act 2008. This report is called a Quality Account. The primary purpose of a Quality Account is to enhance accountability to the public, to engage leaders of organisations in fully understanding the importance of quality across all of the healthcare services they offer and make continuous improvements on behalf of their patients.

A Quality Account must include:

- a statement from the Board summarising the quality of NHS services provided
- the organisation's priorities for quality for the forthcoming year
- a series of statements from the Board which are set out in regulation
- a review of the quality of services provided.

In developing a Quality Account and setting priorities for the future there is an expectation that providers of NHS healthcare will engage with their staff, patients, commissioners and governors.

## Who are we?

The Nottingham NHS Treatment Centre belongs to a group of companies owned by Circle, and is the largest Independent Sector Treatment Centre (ISTC) in Europe. Circle is based on the firm belief that healthcare is a professional service and that the best way to innovate and provide excellent services is for the professionals who deliver the services to be in control of that provision. To this end, Circle has created the largest UK Partnership of Consultant Clinicians with the objective of making every contributor an owner.

The Nottingham NHS Treatment Centre aims to deliver patient experience characterised by comfort and respect for the patient's individual needs and views with speedy access to out-patient, day case surgery treatments and diagnostic services in a first-class facility. Outpatient community clinics including new and follow up appointments have been established to provide care closer to home for our patients.

### Services provided at the Treatment Centre are:

Dermatology (including skin surgery)	Pain Management
Cardiology (non invasive)	Maxillofacial
Respiratory	Rheumatology
Vascular	Endocrinology
Orthopaedics	Urology
Gynaecology	Digestive Diseases

### The Treatment Centre comprises of:

71 Consultation rooms	3 Colposcopy/Hysteroscopy rooms
4 Endoscopy suites	3 Dermatology skin surgery theatres
5 Day case surgery theatres	Light Therapy
Computerised Tomography (CT)	Magnetic Resonance Imaging (MRI)
Ultra Sound (US)	X-Ray digital imaging

## Part 1. Statement from the Board



The Government's White paper, *Equality and Excellence: Liberating the NHS*, set out the importance of improvements in quality and healthcare outcomes. We therefore view our Quality Accounts as a critical part of the quality improvement infrastructure and a vital tool in ensuring that the members of our Board and clinical leaders assess quality across the range of services we provide. We have worked hard over the last year to bring the requirements of the NHS Constitution into our strategy and to drive improvements in clinical care and patient experience.

This is the second Quality Account for the Nottingham NHS Treatment Centre written in accordance with the Department of Health regulation and covers the period April 2010 to March 2011. This Quality Account sets out evidence that we are delivering our goal to build a great company, and that we are moving steadily toward being the best healthcare provider, dedicated to our patients. It also provides reassurance that we have the vision, systems and processes to ensure that our values set out in our Credo are being embedded and are considered in all that we do.

In 2010 we developed a number of indicators to measure quality, including clinical outcomes, patient experience, clinical effectiveness and our safety record. In this way we were able to provide the Board members with adequate information to be suitably assured that patients were receiving high quality care from competent staff. Throughout the year we listened to what 13,289 patients said and how they thought we could improve. Changes to the environment, services and processes have been implemented from this valuable information. The Circle Operating System (COS) was introduced across the Treatment Centre and proved an invaluable tool in engaging staff to develop their services, ensure safe care is delivered to all patients and raise quality.

In developing our priorities for 2011 we have consulted with our Board, our staff, and our patient advocate members. We are proud that our staff have taken the quality agenda to heart and we have been incredibly encouraged at their suggestions to improve services throughout the year. Our advocates have always been our 'sense check' and can be relied upon to keep the organisation's

aspirations real and patient focused. We would like to thank each and every one for their valuable contribution and the role they have played in assisting in our vision.

We have consulted with the Executive Board and reviewed the content of this Quality Account and can confirm on their behalf that the content is a balanced view of the quality of the services we provide and that, to the best of our knowledge, the information in this document is accurate.



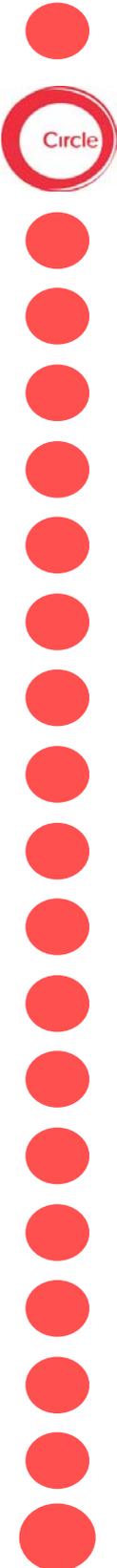
A handwritten signature in blue ink that reads "R.M. Magnani".

**Rachael Magnani**  
General Manager



A handwritten signature in black ink that reads "Roddy Nash".

**Roddy Nash**  
Clinical Chair



# Our Credo

## Purpose

Our purpose is to build a great company dedicated to our patients.

## Principles

Our actions are measured by success in meeting all of our three core principles:

### **We are above all the agent of our patients.**

We aim to exceed their expectations every time so that we earn their trust and loyalty. We strive continuously to improve the quality and the value of the care we give our patients.

### **We empower our people to do their best.**

Our people are our greatest asset; we should select them attentively and invest in them passionately. As everyone matters, then everyone who contributes should be a partner in all that we do. In return we expect them to give our patients all that they can.

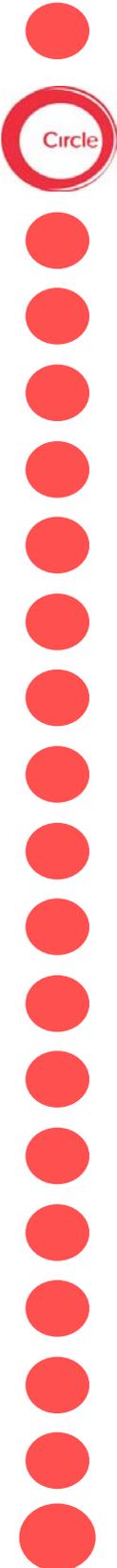
### **We are unrelenting in the pursuit of excellence.**

We embrace innovation and learn from our mistakes. We measure everything that matters, and share it with all to judge. Pursuing our ambition to be the best healthcare provider is a never ending process.

GOOD ENOUGH NEVER IS

## Part 2a

### Setting the Quality Improvement Objectives



We have chosen the following six improvement priorities for the coming year for several reasons. We acknowledge that although steady progress has been made against the priorities set in 2010-11, we want to maintain the high level we achieved this year. We continually review the quality of our services and assess our performance against other facilities within the company and nationally against other similar NHS providers. This offers the opportunity to identify areas where we can improve.

Throughout the year we have discussed with clinicians and service users how we can best deliver high quality services. The strong message back was to provide the clinical teams with reliable quality data and a range of tools so that they can develop innovative improvements to their service. Although some progress was made during 2010-11 with a redesign of the governance infrastructure and the development of a quality dashboard, further progress is required through 2011-12 to ensure changes to service are better for patients, simpler for staff and smarter value for all.

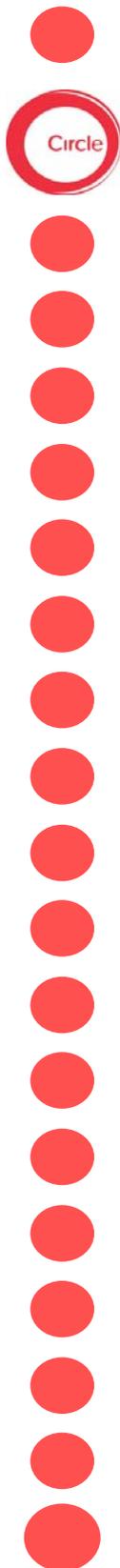
We will continue to listen to our patients and make improvements based on what they are telling us about our services. This year we want to ensure that clinical teams are focused on their own results and take every opportunity to make improvements based on what is important to their patients. We will continue to measure everything that matters and share it with all to judge. We will continue to publish patient feedback on a monthly basis so that all can see what our patients have to say and more importantly the improvements we have initiated as a result of feedback .

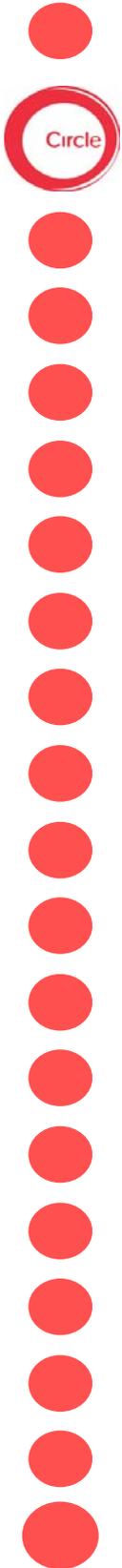
In developing our priorities we asked our Patient and Public Involvement (PPI) group to evaluate all that they had discussed throughout the year and review the annual feedback data with us. The members recommended that we include improvements that would improve access to services, communication and patient wait times.

Throughout the year we will continue to monitor our quality indicators through the monthly clinical unit meetings and accountable committees.

Table 1: Our priorities for 2011 -12

Quality Domain	Our quality priorities	Why we chose this	What success is	Who will make this happen
Patient Safety	1. Embed continuous quality improvement at local level	Strong clinical leadership and involvement in the quality agenda is critical to deliver innovative changes. In order to achieve this staff at the Treatment Centre have recognised that to make improvements relevant to their services, reliable data needs to be available.	Access to monthly quality data in the form of an electronic dashboard. 1. Evidence of review and validation of the data. 2. Local development and routine monitoring of quality matrix. 3. Demonstrable improvements shared with patients, staff and organisational committees.	Board Sponsor - Head of Healthcare Governance  Project Lead - Clinical Unit Leadership Teams
	2. Increase the opportunity to learn from our mistakes	During 2010-11 we benchmarked our incident reporting data against the data held by the National Patient Safety Agency. There was a significant difference between the numbers reported at the Treatment Centre and organisations of a similar size. This was considered by the Board and the Patient and Public Involvements Group as a missed opportunity to learn.	1. 90% of all our staff enrolled on a 2 year refresher programme where they will be trained in the reporting of incidents. 2. 90% of those identified in our training needs analysis as requiring investigation skills will be trained and competency assessed. 3. Develop and monitor an incident reporting matrix for each Clinical Unit.	Board Sponsor - Associate Clinical Chairman  Project Lead - Head of Healthcare Governance
Patient Experience	3. Listen and act on what our patients are telling us  1. Reduce wait times 2. Improve communication about appointments 3. Improve access to services for patients	During 2010-11 we received feedback from over 13,000 users through our rapid response cards and of those 420 stated 'they waited too long to see their doctor', 301 stated 'they wanted their relative with them' and 80 patients were concerned about access to treatment for disabled patients.  From the information we received through the NHS 4C's process - 42 patients raised concerns regarding their care, in terms of not being involved in decisions about them. 23	1. Clinical units to better understand their wait times and develop effective plans to reduce them. 2a. Provide information to patients about their choices when booking appointments. 2b. Where possible reduce cancellations and rescheduling of appointments but when essential ensure the details are communicated	Board Sponsor - Associate Clinical Chairman  Project Lead - Clinical Unit Leadership Teams





		<p>raised concerns about the appointment process. 12 patients raised concerns about the wait whilst at the centre.</p> <p>An audit 'Markers of Best Practice for Vulnerable Adults' was conducted in March 2011 and Level 1 was achieved. An action plan to move the facility to level 2 was developed.</p> <p>The PPI group reviewed the information and made recommendations on behalf of all patients based on the feedback received over the year.</p>	<p>effectively to patients</p> <p>3a.Ensure that actions from the Markers of Best Practice 2011 for Vulnerable Adults are implemented and re-audited in March 2012.</p> <p>3b. Roll out community services to bring care closer to home.</p>	
	<p>4. Undertake the Department of Health questionnaire in order to benchmark ourselves against other NHS providers</p>	<p>Understanding how our users view our services is vitally important; however it is less well understood how we compare against the rest of the NHS. Therefore, we will commit to undertake this feedback process along with our own rapid response process.</p>	<p>To undertake the questionnaire and for our results to compare favorably with other NHS Providers. Where this is not the case develop recommendations to improve services.</p>	<p>Board Sponsor - Registered Manager</p> <p>Project Lead - Head of Healthcare Governance</p>
<p><b>Clinical Effectiveness</b></p>	<p>5. Increase participation in National and Local Clinical Audits</p>	<p>Establishing clinical audit has been a challenge and throughout the latter part of 2010-11 systems and processes have been developed to support this agenda. A clinical audit program for each Clinical Unit has been developed.</p>	<p>To deliver all relevant national audits.</p> <p>For each Clinical Unit to deliver a minimum of 5 clinical audits during 2011-12, which must take into consideration national and local priorities such as NICE, NSF.</p>	<p>Board Sponsor - Associate Clinical Chair</p> <p>Project Lead - Clinical Unit Leadership Teams</p>
	<p>6. Increase the collection of data to further understand complications post surgery and improve clinical outcomes.</p>	<p>During 2010-11 we undertook a pilot to collate clinical outcome data regarding pain, surgical site infections, deep vein thrombosis and readmission rates. The information collated has been shared with clinicians and proven to be valuable. However further data is required to ensure that changes to service are based on reliable information.</p>	<p>Increase contact rate to 80% for 24 hour and 28 day calls.</p> <p>Data to be shared via the Clinical Unit dashboards for validation and action.</p> <p>Quarterly review of findings to identify trends and address required service changes.</p>	<p>Board Sponsor - Registered Manager</p> <p>Project Lead - Climbs Project Manager</p>

## Part 2b. Review of Services

During 2010-11 the Nottingham NHS Treatment Centre provided and / or sub-contracted 12 NHS Services (listed on page 3).

The Nottingham NHS Treatment has reviewed all the data available to them on the quality of care in 12 of these NHS Services.

The income generated by the NHS Services reviewed in 2010-11 represents 100% of the total income generated from the provision of NHS services by the Nottingham NHS Treatment Centre for 2010-11.

### National Clinical Audit

During 2010-11 4 of the National Clinical Audits and 2 National Confidential Enquiries covered NHS Services that the Nottingham NHS Treatment Centre provides.

During that period the Nottingham NHS Treatment Centre participated in 100% National Clinical Audits and 100% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Nottingham NHS Treatment Centre participated in during 2010-11 are as follows:

*Table 2 - Participation in National Audit*

Name of Audit	Lead Clinician	Eligible	Participated	% Submitted
RCOG National Audit of Heavy Menstrual Bleeding.	Mr Martin Powell	√	√	Ongoing
National PROMs Programme (Hernia)	Mr Roddy Nash	√	√	100%
National PROMs Programme (Varicose Vein)	Mr Bruce Braithwaite	√	√	100%
BSG National Colonoscopy Audit	Dr Krish Ragunath	√	√	100%



Many of our users have a shared care pathway moving between the Treatment Centre and Nottingham University Hospitals NHS Trust. Where the Treatment Centre only manages a small part of a patient's pathway, an agreement is in place that information will be utilised from the shared healthcare record and included in relevant national audit.

The 4 National Audits in which the Treatment Centre have participated involve data collection within the centre and then submission to the relevant body for analysis and reporting. At the time of this account no information had been received from those bodies. On receipt of a report the Treatment Centre will review the results to identify any areas for improvement.

### National Confidential Enquiries

We have reviewed 2 National Confidential Enquires that relate to the activity at the Nottingham NHS Treatment Centre and noted the findings; recommendations identified were already in place.

### Local Clinical Audit

The reports local clinical audits were reviewed by the provider during 2010-11 and the Nottingham NHS Treatment Centre intends to take the following actions to improve the quality of healthcare provided.

- Share findings of clinical audit with others at the Clinical Risk and Governance Committee
- Register all clinical audits and ensure that findings and improvements are recorded centrally
- Increase participation in clinical audit as per priority 5

The Treatment Centre has developed a mandatory audit programme which is undertaken on a site wide basis and findings are reviewed both locally and centrally.

*Table 3 - Mandatory Audit Programme*

	J	F	M	A	M	J	J	A	S	O	N	D
1. Hand Hygiene	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment
2. Infection Prevention & Control	Completed by external assessor						Completed by external assessor					
3. Environmental Hygiene	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment
4. Departmental Health & Safety	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment
5. Health & Safety		Completed by external assessor						Completed by external assessor				
6. Fire Safety					Completed by external assessor							
7. HR Files					Completed by self-assessment							
8. Controlled Drugs			Completed by self-assessment			Completed by self-assessment			Completed by self-assessment			Completed by self-assessment
9. Privacy & Dignity											Completed by self-assessment	
10. Clinical Records	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment
11. Pre-Assessment Care	Completed by self-assessment			Completed by self-assessment			Completed by self-assessment			Completed by self-assessment		
12. Decontamination		Completed by self-assessment										
13. Waste Management						Completed by self-assessment						
14. Ionising Radiation								Completed by external assessor				
15. Optical Radiation								Completed by external assessor				
16. Association for Peri operative Practice audit											Completed by external assessor	
17. Information Security		Completed by self-assessment			Completed by self-assessment			Completed by self-assessment			Completed by self-assessment	
18. Fire Warden	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment	Completed by self-assessment
19. Medical Gases			Completed by self-assessment									
20. Anaesthetic Machine & Theatre Equipment									Completed by self-assessment			
21. Sharps Awareness												Completed by self-assessment

Completed by self-assessment

Completed by external assessor

## Local Research

The Nottingham NHS Treatment Centre jointly hosts research in conjunction with Nottingham University Hospitals NHS Trust.

Circle

The number of patients receiving NHS services provided or sub contracted by The Nottingham NHS Treatment Centre in 2010-11 that were recruited during that period to participate in research approved by a Research Ethics Committee was 23.

All Research proposals undergo rigorous checks before research can be undertaken at the Nottingham NHS Treatment Centre. Applications are made via the Local Research Ethics Committee before approval is considered.

The increasing level of agreement to support clinical research demonstrates our commitment to improving the quality of care we offer and contributing to wider health improvement.



## Registration and External Review

The Nottingham NHS Treatment Centre is required to register with the Care Quality Commission and its current registration status is **Compliant**.

The Care Quality Commission has not taken enforcement action against Nottingham NHS Treatment Centre during 2010-11

The Nottingham NHS Treatment Centre has the following conditions on registration:

Site	Regulated Activity for patients over the age of 14
The Nottingham NHS Treatment Centre, Lister Road, Nottingham NG7 2FT	Treatment of disease, disorder or injury Diagnostic and screening procedures Surgical procedures Termination of pregnancies (of pregnancy for patients at no more than fourteen weeks (14) gestation within the Nottingham NHS Treatment Centre).

The Nottingham NHS Treatment Centre has not participated in any special reviews or investigations by the CQC during the reporting period.

## Data Quality

The Nottingham NHS Treatment Centre will be taking the following actions to improve data quality: Accurate and reliable data about the healthcare we provide is essential for safely and efficiently managing our organisation. The existing checking and independent validation process remains in place and there has been no other circumstance that call into question the quality of the data that underpins performance.

## Secondary Users Service

The Nottingham NHS Treatment Centre submitted records during 2010-11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:

99.9 % for admitted patient care

100 % for outpatient care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

99.5 % for admitted patient care

99.7 % for outpatient care

The Nottingham NHS Treatment Centre is monitored on a monthly basis at the Patient Safety and Quality Sub-Group with NHS Nottingham City and NHS Nottinghamshire County.

KPI Scorecard and Quality Monitoring				
KPI Metric	Target	2010 / 2011	March	Status
KPI 1 DNA Day case (%)	2%	1.4%	1.9%	
KPI 2 Cancellations (%)	0.65%	0.1%	0.1%	
KPI 2 Non-Clinical (%) Cancellations	0.5%	0.2%	0.2%	
KPI 7 Day case In Patient Admissions (%)	2.0%	0.4%	0.4%	
<b>Infection Control</b>				
MRSA Bacteraemia (N)		0	0	
MRSA Screening (%)		100%	100%	
MSSA Bacteraemia (N)		0	0	
Clostridium Difficile (N)		0	0	
Mandatory Training (%)	80%	80%	81%	
Safeguarding Training - Level 1	90%	88%	90%	
Slips, Trips and Falls (N)		13	1	
Red, Adverse Incident (N)		3	0	
H&S Needlestick Injuries (N)		2	1	
CAS Alerts outside timeframe		0	0	
<b>Patient Experience</b>				
Is happy with service (%)	98%	99	99	
Would recommend (%)	98%	99.4	99.0	
Complaints / Concerns (%)	2%	0.07	0.8	

## Use of the Commissioning for Quality and Innovation (CQUIN)

### Payment Framework

Income in 2010/2011 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we are an Independent Sector Treatment Centre and are not on the NHS Standard Contract for Acute Services.

### Information Governance Toolkit

The Nottingham NHS Treatment Centre Information Governance Assessment Report score overall score for April 2010 - March 2011 was 69% and was graded **Green**.

### Payment by Results

The Nottingham NHS Treatment Centre was subject to the Payment by Results clinical coding during the reporting period April 2010 - March 2011 by the Audit Commission and the error rates reported in the latest period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses incorrect: 17%

Secondary Diagnoses Incorrect: 14%

Primary Procedures Incorrect: 2.4%

Secondary Procedures Incorrect: 1.3%

The Audit Commission stated "Under the terms of the contract between the Provider and commissioner, the Provider is coding using HRGv3.5 and has an agreed method of coding. The error rate using HRGv3.5 and in line with their arrangements would be 3 per cent. Overall the Provider has some excellent arrangements in place.

### Safeguarding Children and Vulnerable adults

The Nottingham NHS Treatment Centre has undertaken the Markers of Best Practice self assessment developed by NHS East Midlands for both children and vulnerable adults. The overall score achieved for the vulnerable adult's assessment was level 1. An action plan is in place to move the Treatment Centre

to Level 2 by the end of 2011. The Treatment Centre will continuously review its practice to ensure compliance with Outcome 7 (Safeguarding people who use services from abuse) of the Care Quality Commission's Essential Standards for Quality and Safety.



### Eliminating Mixed Sex Accommodation

The NHS Operating Framework 2011-12 requires all providers of NHS funded care to confirm whether they are compliant with the national definition 'to eliminate mixed-sex accommodation except where it is in the overall best interest of the patient, or reflects their patient choice'.

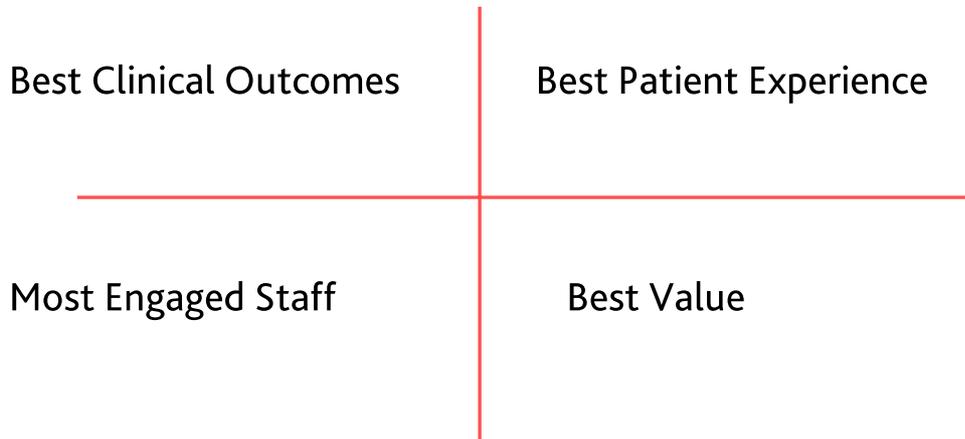
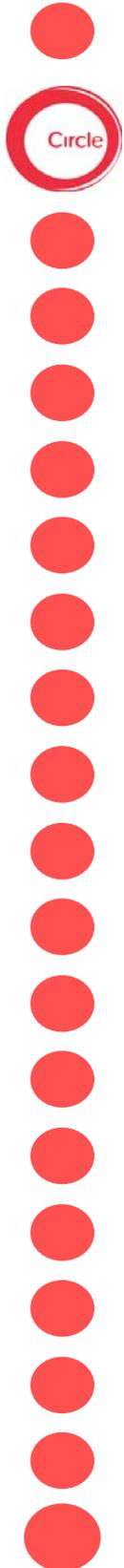
The Nottingham NHS Treatment Centre is pleased to confirm that it is compliant with the Government's requirement to eliminate mixed-sex accommodation. We have determined that we have the necessary facilities, resources and culture to ensure that patients who are admitted as day case patients to the Treatment Centre will only share areas with the same sex. Sharing with members of the opposite sex will only happen when clinically necessary, for example in theatre recovery where a short period of close observation is required, or if there is a high risk of a drug reaction. We have ensured that same sex waiting rooms and toilet facilities are close to bed areas and that the passing through of opposite sex areas has been reduced.

Patients who attend our centre will only share toilet facilities with members of the same gender, or in some specialist areas, unisex toilets for use by one sex at a time such as disabled toilets.

We believe that every patient has the right to high quality care that is safe, effective and patient centred, respecting the individual's right to privacy, dignity and independence. If our care falls short of the required standard, we will report it. We will also undertake compliance audits on a monthly basis to ensure that we do not misclassify any of our reports. We will publish the reports of that audit quarterly on the Nottingham NHS Treatment Centre and NHS Choices website.

## Part 3 - Review of Quality Performance

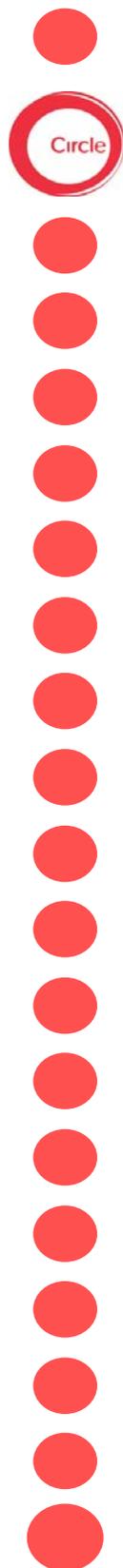
Our priorities for 2010-11 were based on our value equation:



The quality improvement initiatives that we chose were:

- Priority 1:** Develop and measure a range of relevant clinical outcome measures.
- Priority 2:** To feed back from patient experience surveys and ensure the percentage of patients who would recommend us is continuously greater than 98%.
- Priority 3:** To increase staff participation and engagement in service delivery.
- Priority 4:** To deliver 'best value' by increasing patient attendance per theatre list whilst maintaining the highest level of patient safety and quality.

Table 4 Summary of our 2010-11 achievements



	We said we would...	How did we do?
<b>Best Clinical Outcomes</b>	<p>Capture specific clinical outcome measures.</p> <ul style="list-style-type: none"> <li>- Meticillin Resistant Staphylococcus Aureus bacteraemia (MRSA) infection</li> <li>- Unplanned transfers</li> <li>- Post operative surgical site</li> <li>- Returns to Theatre within 28 days</li> <li>- Re-admissions within 28 days</li> <li>- Post operative DVT</li> <li>- Post operative Pain</li> </ul>	<p>We achieved this.</p> <ul style="list-style-type: none"> <li>- There have been no confirmed cases of MRSA bacteraemia during 2010-11. We swabbed 100% of eligible patients and where colonisation was evident provided suitable treatment. (See table 5 for further details)</li> <li>- As we are a day case facility we have arrangements in place with a local healthcare provider for patients who require an overnight stay for further observation and monitoring. During 2010-11 we transferred 58 patients (0.4% of day case activity) for admission, which is under the key performance indicator target of 2%. Trending of this data has prompted a clinical audit into the access criteria for patients undergoing laparoscopic cholecystectomy.</li> <li>- We have developed and piloted a process for the collation of data to measure the following clinical outcomes - surgical site infection rates, re-admission rates, post operative DVT and post operative pain. This we call CLIMBs. Patients are contacted 24 hours after their procedure and then a further 28 days later and asked a range of questions. During 6 month pilot period we have managed to contact 66% of patients who have undergone a surgical procedure. In order to provide reliable data to clinicians further data collation is required therefore we have included this work as a priority for 2011-12.</li> </ul>
<b>Best Patient Experience</b>	<p>Patients and public will be aware of the improvements made in relation to patient experience feedback. Patients who recommend us will be continuously greater than 98%</p>	<p>We have achieved this.</p> <ul style="list-style-type: none"> <li>- Of the 13,289 patients who completed a rapid response feedback card during 2010-11, 99.4% of users stated that they would recommend the facility.</li> <li>- All patient comments are published on our website each month for each of the specialties.</li> <li>- Patient feedback is provided monthly to each of the clinical units who review the information for suggested areas of improvement. Improvements are shared with staff on the patient champion's boards and to the patients via the televisions in the waiting areas.</li> </ul>
<b>Most Engaged Staff</b>	<p>To increase staff participation and engagement in service delivery</p>	<p>We have achieved this.</p> <ul style="list-style-type: none"> <li>- In our 2010 staff survey two main areas were identified for improvement - internal communication and encouraging and involving staff in decision making.</li> <li>- Throughout the year a communication group was established and developed a regular staff newsletter called 'What's up doc'.</li> <li>- The Registered Manager introduced a messages of the week, an email update sent to all staff.</li> <li>- Partnership days were established and held every 4-6 weeks for each of the specialties. This allows all staff to understand their own activity and performance and be empowered to suggest improvements.</li> <li>- The Circle Operating System (COS), a service improvement tool, was piloted in theatres. Staff were encouraged to be part of 5 work streams which undertook a mapping exercise to identify areas of their service that could be improved. This led to an improvement in patient information, greater choice of analgesia, improved medication information at discharge and staggered lists to reduce waiting times.</li> </ul>
<b>Best Value</b>	<p>To deliver 'best value' by increasing patient attendance per theatre whilst maintaining the highest level of patient safety.</p>	<p>We have achieved this.</p> <ul style="list-style-type: none"> <li>- We have implemented confirmation calling for all day case patients ahead of their planned procedure date. This has reduced the level of DNA's by 1.1%, leading to an equivalent percentage increase in the number of procedures undertaken per list.</li> </ul>

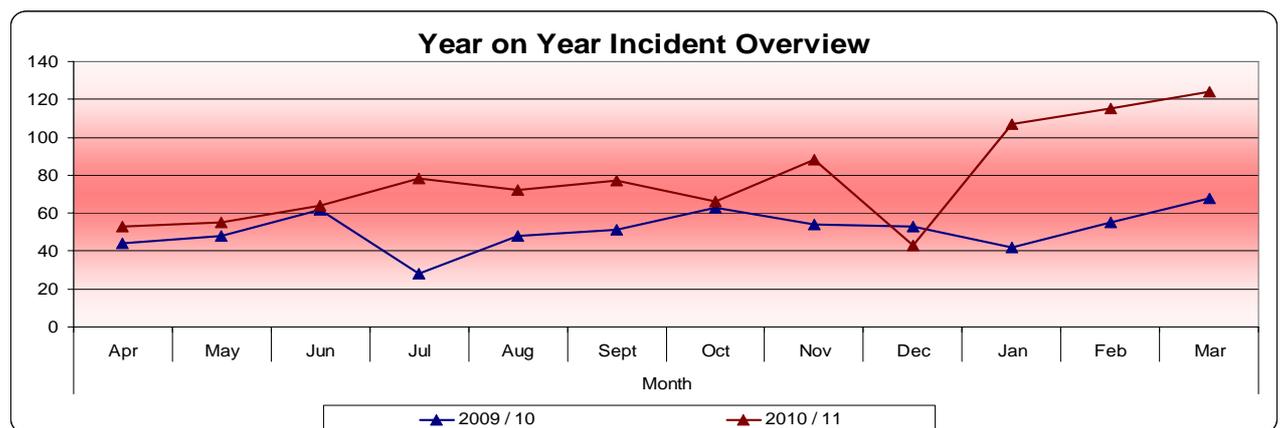
# Patient Safety

## Incident reporting

Incident reporting provides an organisation with an opportunity to learn from its mistakes and poor patient outcomes. In order to have effective reporting systems staff need to feel supported and free from retribution and blame. An organisation that has a good reporting culture has staff that care and will use the information they have to make positive changes to improve patient safety and experience. Therefore an organisation with a high number of near miss incidents reported is a safe place to be.

During 2010-11 the Treatment Centre reported 942 incidents on its risk management tool (Datix) compared with 616 the previous year (see graph 1). Although this is an increase in the number of incidents reported, this has to be measured against an increase in activity during 2010-11 and in comparison with national incident figures. The monthly reporting rate against activity for this period has increased month on month and in March 2011 it was 0.5% with a range across the services from 2.2% to 0.01%. We believe the total rate to be low and intend to increase the rate by setting Clinical Unit tolerances as part of the executive performance score card (Quality Quartet).

Graph 1 - Incident Reporting



The key themes identified in our incident data are:

- Delay in procedures being undertaken
- Delay or no access to medical records
- Appointment recording errors

- Access to medical devices / sterile services

In response to this information we have reviewed the Service Level Agreement (SLA) for access to medical records and solutions have been put in place to reduce the frequency of problems. The number of incidents regarding access to medical devices has also prompted a review of the Service Level Agreement; from this review we anticipate a closer working relationship with the provider of the service to improve access to equipment. We have triangulated the themes with the patient experience data and used this to develop our priorities for 2011-12. (see table 1)

The Nottingham NHS Treatment Centre reported 2 incidents within the reporting period to the Department of Health in accordance with the Independent Sector Treatment Centre definitions.

Examples of change following Root Cause Analysis:

- Implementation of e-requesting for diagnostic services
- Update of administration standard operating procedures
- Access policy updated and published on the Treatment Centre website
- Theatre trolley battery replacement programme

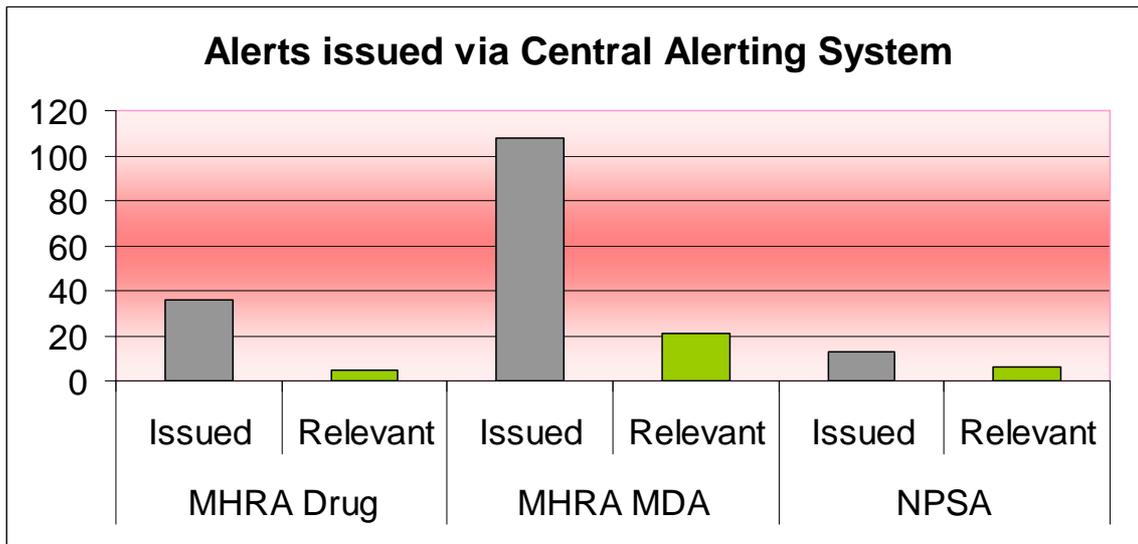
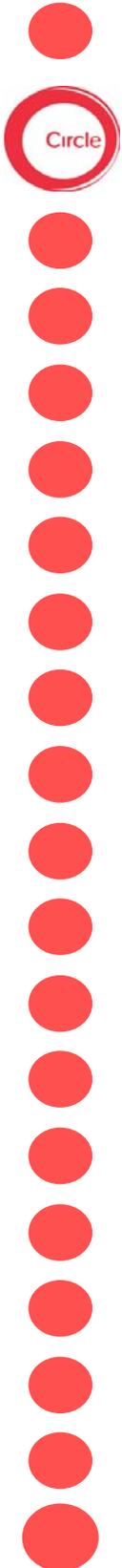
### Claims

The Nottingham NHS Treatment Centre has had no successful claims during the reporting period.

### Safety Alerts

The Nottingham NHS Treatment Centre manages Safety Alerts via the Central Alert System (CAS). Alerts are shared with relevant personnel (procurement, facilities, stores and clinicians) to assess relevance and compliance with the recommendations.

During 2010-11 all relevant alerts were actioned within timescales and compliance monitored as part of our Key Performance Indicators by the Commissioning PCT.



### Infection Control

The Nottingham NHS Treatment Centre’s Executive Board has published on our website its commitment to Infection Prevention and Control. We pride ourselves on the cleanliness of our facility.

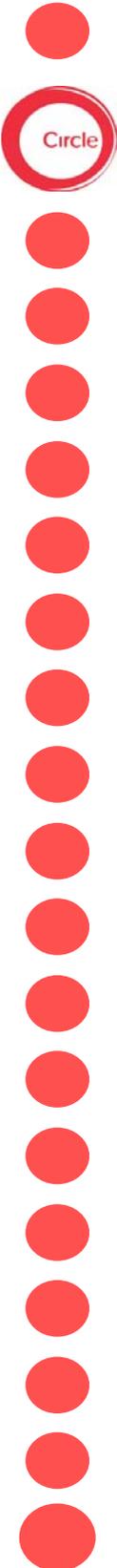
“We were seen on time. Very friendly Doctor. Pleasant & clean surroundings”  
– February 2011

We have had no alert organism infections to report to the Health Protection Agency including Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, Clostridium Difficile, and as of January 2011 Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia.

We are fully compliant with the Department of Health guidance for MRSA screening. In all cases of MRSA identification decolonisation before surgery is implemented.

**Table 5: MRSA Screening**

	Apr - June 2010	July - Sept 2010	Oct - Dec 2010	Jan - Mar 2011	Total
Eligible patients	1,926	2,061	1,821	1,994	7,802
No. Screened	1,926	2,061	1,821	1,994	7,802
% Screened	100%	100%	100%	100%	100%
No. Colonised	5	12	2	3	22
% Colonised	0.3%	0.6%	0.1%	0.2%	0.3%



All staff attend mandatory annual Infection Prevention and Control training and hand hygiene training. In the reported period 84% of staff undertook this. Each clinical unit has a link practitioner who provides support and advice to colleagues. Monthly hand hygiene audits are completed by each link worker. During the last quarter of 2010-11, the average audit score was 85%.

Regular audit is undertaken by the corporate lead the last being undertaken in January 2011. The Treatment Centre was 93% compliant with the standards recommended by the Infection Prevention Society.

### Health and Safety

It is an annual requirement to undertake a Safety, Health and Environment audit to measure our compliance against legislation and regulation. The audit is divided into the following sections:

- Management of Health & Safety :
  - Planning
  - Communication & Training
  - Control
  - Monitoring & review
- Slips, Trips and Falls
- COSHH arrangements
- Medical gases, including liquid nitrogen
- Facilities, PPM & Statutory Insurance Inspections
- Control of Contractors
- Fire Safety
- Stores

Of the 107 standards relevant we were compliant with 75%, with partial compliance for a further 5%. An action plan is in place to ensure improved compliance by Quarter 2 of 2011-12.

### Improvements made in 2010-11

- Appointment of a dedicated Health & Safety Co-ordinator for Nottingham
- Establishment of monthly Health & Safety Meetings
- Introduction of link worker responsibility agreements

- Update of Clinical Unit Risk Assessment folders
- Health & Safety training program for link workers and general staff
- Improved staff awareness of Health and Safety
  - 78% of staff who were asked where the Health & Safety folder was kept
  - 83% knew the location of the Risk Assessment folder
  - 70% were aware who their link worker was
  - 74% were aware who their first aider was

## Patient Experience

### Patient Surveys

Patient feedback is essential and provides a rich source of information about the quality of the services we provide. As an organisation we have set out our key principles in our Credo to ensure we listen and take action from what our patients tell us. We have developed a number of ways to do this but feel that by far the most effective way has been through the development of a rapid response card providing real time information which is promptly acted upon by the clinical teams.

Every patient is offered the opportunity to provide 'real time' feedback following each attendance via the postcard; this asks 3 simple questions:

- What did we do well today?
- What could we have done better?
- Would you recommend us to family/friends?

During 2010-11 we received 13,289 responses from our users. Of those 99.4% would recommend us to their family and friends exceeding the target we set ourselves at 98%.

When we asked our patients what we did well:

- 1,815 comments related to the efficiency and attentiveness of the administration staff
- 1,142 comments related to the clinical staff (Doctors and Nurses) being helpful and caring

"The attitude and care from all the staff involved in my treatment at this clinic was 1st class." – June 2010

- 878 comments related to the seamless service provided.

When we asked what we could have done better our patients stated:

- 420 comments related to long wait times for consultations and treatment
- 301 comments related to wanting a relative to wait with them in the clinical area
- 79 comments related to access to the centre.

Improvements made by the units during 2010-11:

- Roll out of buzzers so that patients can move around the atrium and be notified when the doctor is ready to see them
- A meet and greet staff member placed in the reception area to direct patients to where they need to be
- A car park attendant assists visitors in allocating a space
- Staff were allocated a parking space offsite to provide more parking for visitors
- Waiting times are communicated on the TV screens in waiting rooms
- Day case appointments have now been staggered to reduce waiting times
- Appointment letters were amended to provide more relevant information
- The catering provider was changed and a wider, healthier selection of food is now available.

The Treatment Centre has an active Patient and Public Involvement Group, whose role is to be advocates for all of our patients and work with us during service development and improvement. The group meets on a quarterly basis and during 2010/11 was consulted on the following topics:

- Effective communication of waiting times
- Eliminating mixed sex accommodation
- Methods for collecting patient experience data
- New pharmacy solution
- New catering provider.

## Complaints, Concerns, Comments and Compliments

We believe that all feedback is valuable and if utilised well is an ideal opportunity to make positive change. Therefore we view complaints and concerns as positive and encourage our staff to inform our users how to actively tell us about their experience. In 2010-11 we received 140 complaints / concerns, compared to 103 in 2009-10.

The resolution of complaints and concerns in a timely and effective manner is of utmost importance to us. All complaints and concerns received are acknowledged within 3 working days and a plan for management agreed with each complainant.

	Clinical Unit	2010 -11		2009 - 10	
		Complaint	Concern	Complaint	Concern
Outpatient	Dermatology		20		17
	Digestive Disease		25		9
	Gynaecology		11	5	11
	Orthopaedics		11		9
	Cardiology		6		7
	Rheumatology		6		5
	Vascular		3		2
	Endocrinology		3		0
	Respiratory		3	1	3
	Radiology		5		0
Day case	Skin Surgery	1	1	2	0
	General Surgery		5	1	6
	Pain Management		11	2	2
	Maxillofacial		1		1
	Orthopaedics	1	6	3	2
	Gynaecology		2	1	2
	Vascular		1		0
	Endoscopy	1	5	2	5
In-house Facilities	Facilities		3		1
	Transport		2		1
	Car Park		3		1
Outsource Services	Pharmacy		1		1
	Phlebotomy		1		
	Interpreter				1
	Hotel Services		2		

The main themes identified from complaints and concerns were:

- 42 patients felt that the standard of care was lacking

- 27 patients were displeased with the attitude of the staff caring for them
- 23 patients were unhappy with their appointments (cancellation / delay)
- 12 patients were unhappy with their wait whilst at the Treatment Centre.

#### Improvements made during 2010-11

- Further study undertaken in Endocrinology to understand which patients were leaving the Treatment Centre unsatisfied with their consultation. (see below)
- Implemented customer care training for administration staff (Motion Learning)
- Review of pharmacy services and a re-tendering for the provision of the service
- Change of catering provider to ensure the provision of food for all patients and visitor groups (provision of gluten free food for the coeliac clinic)
- Change of sterilisation pathway to ensure clarity around consultant only patients
- Review and change protocols for analgesia and anti-emetic in day case.

No cases have been escalated by a complainant to the Parliamentary and Health Service Ombudsman (PHSO) for independent review.

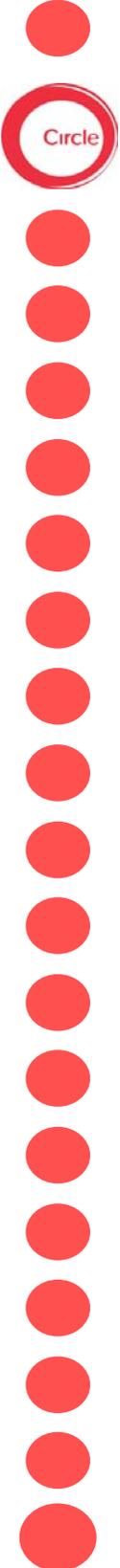
#### **28 Day Questionnaire (Based on the General Medical Council patient satisfaction)**

The 28 day questionnaire was undertaken by the Endocrinology team to build upon the information they had received from the feedback cards and the 4C's. This concentrated on the experience of patients in relation to the pre clinic administration process, their consultation with their doctor and the information they received following their appointments.

A questionnaire was sent to 200 patients with a return rate of just over a 50% (107 replies).

#### Results:

- 20% of patents didn't receive a confirmation call regarding their appointment



- 1 patient was not happy with their consultation and felt that the doctor didn't listen to them, they hadn't enough time to ask questions and that they were not involved in the decision to treat. This was later followed up as a concern and investigated
- 87% of patients felt that the copy letter to them was useful.

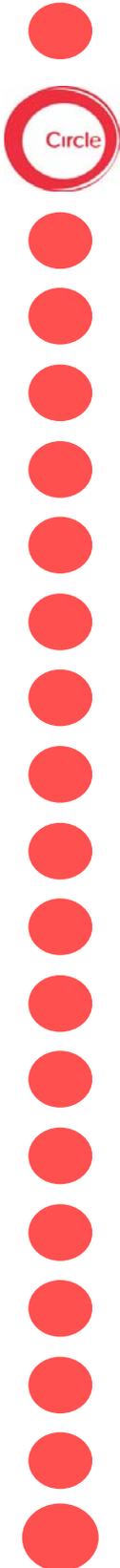
The results of this questionnaire identified another valuable source of information which could be utilised to improve our services and this questionnaire will be rolled out across the Treatment Centre during 2011-12. The results of the survey have been shared with all those who participated in the survey.

## Most Engaged Staff

The Nottingham NHS Treatment Centre undertakes an annual staff survey, as part of the performance management process and staff appraisals. We ask our staff to score the following statements (1=strongly disagree: 5=strongly agree)

- At work I have clear, well understood objectives
- I have adequate material and equipment to do my work
- During the last week, I have received praise for my work
- My immediate manager is supportive of me
- I am consistently free to make ethical decisions
- I feel that my opinions at work are valued
- I have the opportunity at work to do the best every day





1= strongly disagree - 5 = strongly agree		Nottingham		
		2009 H2	2010 H1	2010 H2
<b>Actual Scores...</b>				
At work I have clear, well understood, objectives.		4.0	4.1	4.0
During the last week I have received praise for my work.		3.5	3.6	3.6
I am consistently free to make ethical decisions.		3.8	3.8	3.9
I feel that my opinions at work are valued.		3.8	3.9	3.8
I have adequate materials and equipment to do my work well.		3.7	3.7	3.7
I have the opportunity at work to do what I do best every day.		3.8	3.9	3.8
My immediate manager is supportive of me.		4.2	4.2	4.2
		<b>3.8</b>	<b>3.9</b>	<b>3.9</b>
	% responses 5+		26%	23%
	% responses 4+		72%	71%
	% responses 3+		93%	91%
<b>Movement over last 6 months...</b>				
At work I have clear, well understood, objectives.		0.1	(0.1)	
During the last week I have received praise for my work.		0.1	0.0	
I am consistently free to make ethical decisions.		0.0	0.1	
I feel that my opinions at work are valued.		0.1	(0.1)	
I have adequate materials and equipment to do my work well.		0.0	0.0	
I have the opportunity at work to do what I do best every day.		0.1	(0.1)	
My immediate manager is supportive of me.		0.0	0.0	
	<b>Increase in site overall engagement scores</b>		<b>0.1</b>	<b>(0.0)</b>

From the data it appears that our staff felt supported and clear about their objectives. We have worked hard to make our staff feel empowered. We have listened to what they have told us and developed a range of initiatives to improve communication:

- Established a communications group who produce a regular staff newsletter 'What's up Doc' which includes information about the Treatment Centre, Clinical Units, quizzes and staff updates
- The Registered Manager has introduced a 'Message of the Week' a weekly email update sent to all staff
- A planned schedule of regular social events such as a Summer Barbeque, Christmas Party and a Staff Awards Ceremony.

We held a Staff Award Ceremony to celebrate our staff and their successes. There were ten award categories reflecting the Circle Credo. All staff and patients were invited to nominate staff in the categories and the nominations were reviewed by 5 independent judges. All shortlisted nominations received a certificate and the winners received an engraved glass trophy in recognition of their achievement

The Staff Award Categories were:

### Agents of our patients

**The Florence Nightingale Award** - This was for any clinical member of staff who had gone above and beyond their role to improve the experience for the patient.

Won by: Polly Mercer - Nurse - Rheumatology

**The Marvel Award** - This is for any non clinical member of staff member who acts as a “Super Hero” for our patients.

Won by: Eddie Hitchen - Car Park Attendant

**The Everest Award** - This is for any person or Team who have had to overcome great challenges and obstacles and really gone the ‘extra mile’ to improve the patient experience.

Won by: Day case team



### Un-relenting in our pursuit of Excellence Awards

**Innovation Award** - for teams and individuals whose ideas have embraced the better - simpler -smarter, value model.

Won by: Stores Team

**Green Award** - Environmental and waste awareness/reduction.

Won by: Kate Meakin - Contracts Manager

**Best in Healthcare** - for any individual or team who have helped develop and implement a process or practice which would be considered the “best in healthcare”.

Won by: Julie Douglas - Cancer Service Manager



## We empower our people to do their best Awards

**Partner/Colleague of the Year** - an individual who has supported others to do their best - this is not exclusive to managers, and can be any team members.

Won by: Nick Guillick



**Outstanding Contribution Award** - an individual who has made an outstanding contribution to the Treatment Centre over the last year. Won by: James Pearson - Senior Operating Department Practitioner

**Team of the Year** - Any team can nominate themselves for this award; this award is open to all departments within the TC.

Won by: Registrations and Referrals and Front of House



# The Circle Operating System

The Circle Operating System or COS, is a unique continuous improvement model designed to support partners bring the Circle Credo 'to life' and improve patient safety and quality. Some of the key foundations have been created from the ideas and principals of the Toyota Product System (TPS) and the TPS inspired Virginia Mason Product System (VMPS).

The engagement of partners is a key principal within the COS methodology, particularly in a clinically led organisation. All the activities are designed with the concept of devolving the decision making and ability to make changes directly to the front line.

COS helps eliminate waste and identify failures in the process and systems currently in place. These are then implemented as projects by the staff members, with the ultimate aim of standardising processes which consistently occur and can then be improved upon.

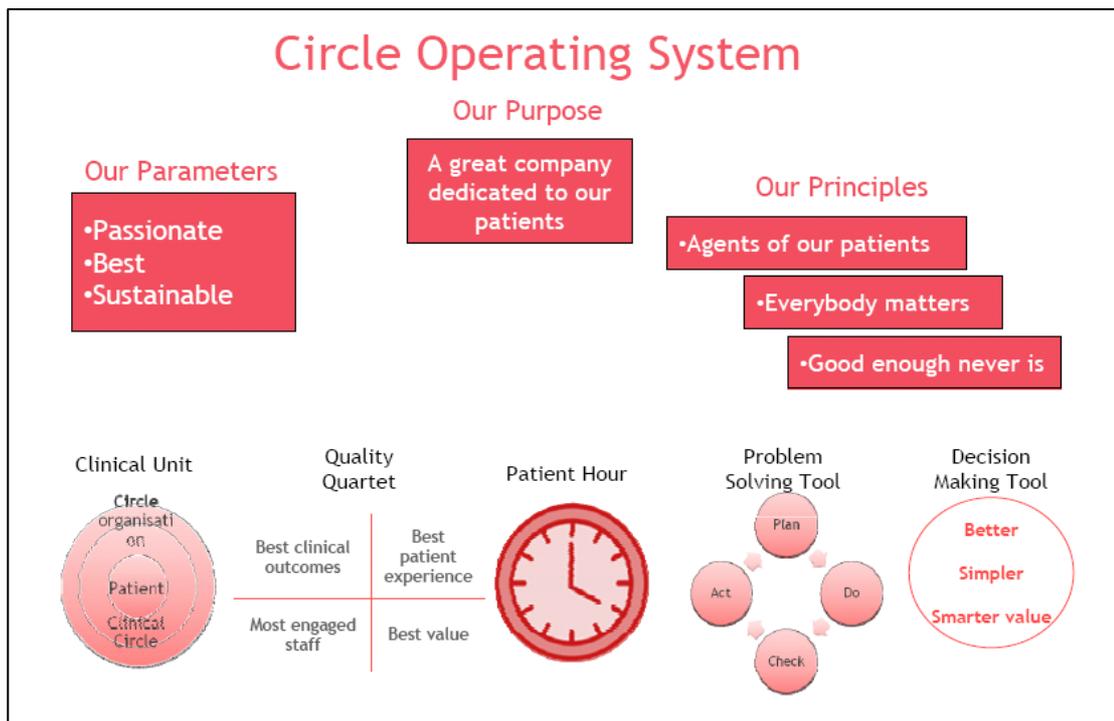
## How COS works

A key component to success is that the staff who do the work know what the problems are and have the best solutions. COS projects or "tasks" range from small-scale ideas tested and implemented immediately to long-range planning that redesigns new spaces and processes.

COS uses several continuous improvement activities such:

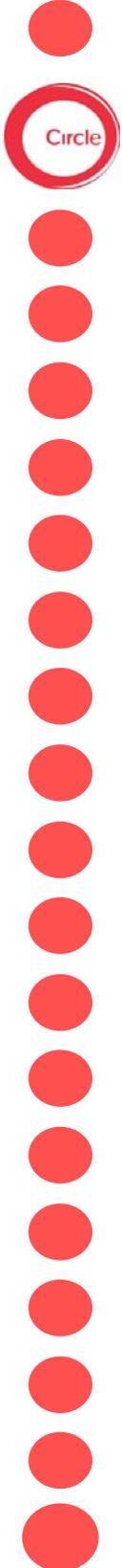
- Patient Pathway Mapping where staff utilise their knowledge of the systems and processes within their own area of work to map the current patient pathway in order to identify variation and process failures. This also ensures that staff go and see for themselves that is happening throughout each stage of the process. We call this Go, Look, See.
- The Patient Hour is where the staff take dedicated time to discuss issues which affect the patient experience and consider what the quality metrics in the Quality Quartet are showing them. They then review and agree what changes should be made to improve patient care.

- Plan Do Check Act (PDCA) is a problem solving tool which enables staff to develop solutions and redesign their own working practices. This is an empowering tool by which staff are more likely to execute changes if they have designed them.
- Quality Quartet is a range of measures designed by Clinical Units to enable them to track progress and improvements in quality. This tool measures everything that matters for patients.



As an example COS was introduced to the Day Case unit in November 2010 where the whole patient pathway was mapped and redesigned. Over 140 continuous improvement projects were identified. Of these the following improvements have been made:

- A review of the information provided to patients led to the inclusion of useful contact numbers and medication advice
- A review of skill mix was undertaken to ensure speedy discharge with a review of the Health Care Assistant (HCA) roles and responsibilities. This led to their remit being extended to include admission functions and the trained nurses being released to concentrate on the discharge process



- A review of discharge medication led to the introduction of a wider range of analgesics and anti-emetics being offered to patients. The information leaflets were updated to reflect these change
- Two dedicated wheelchairs were purchased for day case to enable easier manoeuvrability and reduce manual handling risks
- Improved record keeping was initiated to capture clinical information post discharge (24 hours) to ensure patients were pain free and well.
- Releasing time to care - tidy desk project initiated
- A review of discharge letter was undertaken to ensure all relevant information was included. These letters are also now forwarded to community nursing teams as well as GP practices.

The COS is also being implemented across a further six Clinical Units with the roll out to all clinical units proposed by the autumn.

#### Case Study

##### **It's not just Farmers who can drive tractors.**

The challenge for the Nottingham day case team was to reduce the amount of time patients waited to be discharged. Once the pathway was mapped it was evident that this was a bottle neck and additional nursing capacity was required.

The solution proposed was to extend the HCA's role when performing local anaesthetic and pain patient admissions and stagger the start of theatre; this would then release more qualified nurses from the beginning of the patient pathway to focus on the discharge process at the end.

An in-house competency pack for the HCAs was developed, which once completed and signed off by a trained member of the day case nursing team, would enable the HCAs to perform admissions. The competency framework was introduced into the rotation programme to ensure all HCAs received the opportunity to receive this additional training.

## Statement from NHS Nottingham City



NHS Nottinghamshire City monitors quality and performance at Nottingham NHS Treatment Centre throughout the year. The information contained within this quality account is consistent with information supplied to commissioners throughout the year.

There is a well established patient safety and quality group and a joint service review meeting to review and monitor performance, governance arrangements and quality standards and there is frequent ongoing dialogue as issues arise.

The Nottingham NHS Treatment Centre works constructively with commissioners and other partners to develop integrated care pathways that improve the health of the local community. Quality goals and indicators are jointly agreed in order to reduce health inequalities and improve the health of Nottingham and Nottinghamshire residents.

When serious incidents, including those reportable under the Department of Health criteria for Independent Sector Treatment Centres or complaints occur, robust investigations are carried out so that lessons are learned and improvements can be made. These are shared in a systematic way with staff and monitored appropriately. Complaints are treated seriously and genuine efforts are made to improve services following patient feedback.

The Nottingham NHS Treatment Centre has demonstrated a high level of commitment to improving patient safety and to enabling patients / service users to feedback their experiences of services and care so that good practice can be continued or improvements made.

**Nottingham NHS City - Executive Board**

**June 2011**

# Statement from Patients and Public Involvement Group



We, the Patient and Public Involvement group, have been established within the Treatment Centre for approx 18 months and meet on a quarterly basis. There are 14 members in the group.

During 2010-11 we have been consulted on a range of matters and have provided advice and suggestions to the Treatment Centre so they may improve their services. We have reviewed the annualised quality data and make the following suggestions:

- Improve access to services
- Communication
- Patient wait times

The group has committed to support the Treatment Centre in delivering on their priorities and will monitor the progress throughout the year.

**Maureen Cooper**

**Carol Mander**

**PPI Representatives - June 2011**