NEW VICTORIA HOSPITAL

INTEGRATED GOVERNANCE and RISK ANNUAL REPORT

April 2022 - Mar 2023

Introduction

This report relates to the governance activity, both externally and internally, at New Victoria Hospital (NVH) from April 2022-March 2023.

For the purposes of this report the following meetings are held:

- Integrated Governance and Risk (IGRM) – monthly
- Infection Prevention & Control – quarterly
- Radiation Protection – annually
- Endoscopy User Group – quarterly
- Medication Safety & Optimisation – bi-monthly
- Medical Devices Safety – quarterly
- Board – quarterly
- Operational Executive Management Team (EMT) meeting – monthly
- Chief Executive (CE) Clinical Governance meeting – fortnightly
- Medical Advisory Committee (MAC) – quarterly
- Health and Safety (H&S) – quarterly

The Hospital consolidated the NHS England (NHSE) contract for female to male gender affirmation surgery. A total of 427 patients were treated during the financial year.

Elective private work continued to grow, alongside a continuation of supporting some breast cancer and upper Gastrointestinal (GI) surgeries and a weekly pain service for the Kingston Hospital Foundation Trust (KHFT).

The Hospital introduced two new surgical procedures, and these included:

- Breast reconstruction that uses a woman's own tissue to create a new breast following mastectomy (DIEP).
- Holmium Laser Enucleation of the Prostate (HoLEP).

The Private General Practitioner (GP) service continued to grow, and one GP was on site each day.

The Pre-Operative Assessment team introduced an online patient health questionnaire service to improve efficiency and communication. In addition, an initiative to send all admission information to patients via email was introduced. This has reduced paper usage and postal costs, as well as improved the delivery of the information in a timely manner.

The Hospital's commitment to the provision of exceptional standards of care and service to its patients remained the same.
As such, it operated a robust integrated governance and risk programme, which aimed to continually review and evaluate practices to improve the outcomes of care for patients and ensure the health, safety and wellbeing of staff, patients, and visitors.
These processes and outcomes were reviewed both internally and externally and the results used to validate that the services delivered were compliant with regulatory, legislative and best practice requirements and guidance.

Patient Activity

	Admissions	Outpatients	Imaging	Physiotherapy
Total 2022-23	**5875**	**54887**	**16819**	**9060**
Total 2021-22	**6146**	**49257**	**15657**	**8112**
% inc/dec	**-4.4%**	**11.4%**	**7.4%**	**11.7%**

NB: Ophthalmic service ceased from August 2022 hence the reduction in admissions.

External Validation/Review of Services

Care Quality Commission (CQC)

The Hospital is registered with and regulated by the CQC and is required to meet the Fundamental Standards of Care 2014 outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The CQC operate a risk-based approach to inspection and collaborate with other regulatory and professional bodies to identify possible areas of concern.

The Hospital's CQC compliance group continued to review performance against the Fundamental Standards and several quality improvement initiatives were implemented during the year.

An external provider (Elsiarc) carried out a review of the Paediatric Service, Medical Governance and how the Hospital undertakes Risk Management.

The review of Paediatrics was generally positive with no red flags identified.
Recommended actions were as follows:

- Compliance with mandatory training relating to paediatric life support needs to meet the Hospital target of >90%.
- Inpatient paediatric clinical records must have a copy of either a (GP) referral letter or consultant clinic letters.
- Implement a robust process to record when a child or young person is chaperoned by a member of staff rather than their parent/carer.
- Implement regular clinical supervision for bank paediatric nurses.
- Ensure that staff caring for children in the theatre recovery area, or adult trained nursing staff caring for young people on the ward have documented competency reviews.

The Review of Risk Management was generally positive with no red flags identified.
Recommended actions were as follows:

- Heads of Department (HoDs) should take responsibility for managing their risks and provide individual feedback at meetings.
- HoDs should have access to refresher training on the Datix Risk Module.
- HoDs should ensure their staff are aware of the top risks for the Hospital.
- The Executive Management Team and HoDs should review their risk scores to ensure that they are consistent and support the controls in place and further action required.
- The Risk Manager should ensure that HoDs know how to run reports which will capture all risks where a HoD is both the risk owner and manager for.

A good governance structure was found to be in place around the management of medical practitioners and healthcare professionals. It was evident that there has been a lot of work in this area in the last three years.
Recommended actions were as follows:

- Improve the compliance with completion of consultant biennial reviews.
- Ensure consultant compliance with their Mandatory Training is 90% or above.
- Adherence to the MAC Terms of Reference with regards to being quorate at all meetings.
- Ensure MAC minutes clearly reflect the actions to be taken forward to future meetings and to be discussed at the start of each meeting.

The CQC Relationship Manager continued to provide support to the Director of Clinical Services (DCS) who is the Registered Manager and the Integrated Governance and Risk Director (IGRD) when required.
There was one remote engagement meeting on the 6th of December 2022. This incorporated an update on the CQC inspection model, Hospital activity and Quality and Performance and Practising Privileges overviews.

There were nine CQC notifiable incidents:

- Disruption to Business Continuity – Basement Flood.
- Serious Injury to a Patient:
    - Fracture pelvis following a fall.
    - Incompatible combination of implants in a Total Hip Replacement.
    - Expired cement restrictor used in a Total Hip Replacement.
    - Difficult intubation and subsequent transfer to an NHS Hospital.
    - Management of sepsis following discharge from an NHS Hospital.
    - Loss of phallus following a Radial Artery Phalloplasty.
    - Missed breast lesion on three separate CT scans.
    - Lost histology specimen.

There were no reportable Never Events during this period.

Two of the serious injury incidents occurred in the previous years' time frame and were reported retrospectively following the engagement meeting with the CQC.

The comprehensive investigation into the Imaging incident, that could have had significant implications for patient safety, was completed. Fortunately, no harm came to any patient as a result of this incident.

CHKS - Healthcare Accreditation and Quality Unit ISO 9001:2015

Continued accreditation requires annual surveillance visits to assess on-going compliance and a 3 yearly inspection visit of all International Organisation for Standardisation (ISO) and CHKS quality standards. The tri-annual inspection took place on site on the 23rd of February 2023.

The Hospital was successful in its application and was awarded full accreditation. No further recommendations were made from this visit.

In addition to this, the Hospital was commended for:

- The initiative to include a regular agenda item focussing on celebrating successes and achievements to the IGRM monthly meeting.
- By achieving 93% on mandatory training compliance at the time of inspection.

Public Health, England (PHE)
See Infection Prevention and Control Report below.

Controlled Drug Local Intelligence Network (CDLIN) NHS England, London region

The DCS is the Controlled Drug Accountable Officer for the Hospital and submits a quarterly report to CDLIN regarding incidents, concerns and adverse events relating to Controlled Drugs (CD). No concerns were raised by NVH for this period.
The DCS received minutes from the quarterly meetings of the CD National Group and disseminated pertinent information to staff via the Medication Safety and Optimisation Group.

Radiation Protection Advisor

Radiological policies, procedures, quality checks and activities are reviewed annually against Ionising Radiation Medical Exposure Regulation (IRMER).

The Radiation Protection Consultant (RPC) completed their annual external IRMER audit of the Hospital on 28 March 2023. The written report showed an overall rating of 'Nearly fully compliant with only few minor improvements necessary'.
These included:

- Quality Assurance (QA) of Computer Radiography (CR) reader
- Lead coat screening to be updated.

The Hospital is due to undertake the Medical Exposures/ Radiation Protection Committee annual meeting on 30 May 2023, where a review of the previous year's activity and any legislation changes will take place.

The required radiology audit schedules were up to date.
Some National Dose Levels for Computer Tomography (CT) have been changed and additionally new ones released, which were incorporated into the 2023 CT dose audit.

National Joint and Cosmetic Breast Registries

Hip, knee and shoulder implant data was submitted to the National Joint Registry (NJR) and breast implant data submitted to the Cosmetic Breast Registry throughout the year.
The Hospital received a commendation for the quality data submitted to the NJR.

Data Protection and Information Governance

There were no information security incidents that warranted reporting to the Information Commissioners Office (ICO).
The Hospital maintained its NHS Data Security and Protection Toolkit and Payment Card Industry/Data Security Standard accreditation. The Hospital remains ISO27001 accredited.

Medical Profession (Responsible Officer) Regulations 2010 and Revalidation

Dr Amira Girgis continued in her role as the Hospital's Responsible Officer (RO) and was RO for 10 connected consultants. She provided support to consultants no longer working in the NHS regarding the requirements set out in the RO regulations, with particular regard to appraisal, 360° colleague and patient feedback, activity, and adverse outcome data.

Dr Girgis introduced the L2P appraisal system to manage the process electronically in January 2023 in line with NHSE guidance to move away from paper-based systems.

Private Hospital Information Network (PHIN)

The Hospital continued to submit data to PHIN in order to meet the requirements of the Competition and Markets Authority.

Kingston Hospital Foundation Trust (KHFT) Joint Working

NVH continued to work with KHFT throughout the year as part of the Increasing Capacity Framework. NVH supported breast cancer surgery and upper GI lists as well as weekly Pain Management lists in Imaging.

Regular operational and governance meetings were held with KHFT to share and resolve all matters relating to joint working.

NHSE Specialist Commissioning

The female to male surgical pathway for transgender patients continued. The Gender Dysphoria Surgical Service (GDSS) team consolidated with two fulltime (FT) administrator posts and one FT Clinical Nurse Specialist (CNS) dedicated to managing the service. A second CNS was appointed in January 2023 to support the increasing activity. This team was supported by the Business Analysis Unit Manager and DCS.

The significant cohort of patients, inherited from St Peter's Andrology, were categorised depending on where they were in their surgical journey.

Fortnightly Multidisciplinary (MDT) meetings commenced to ensure patients were being robustly reviewed and appropriate decisions made. In addition, a Morbidity and Mortality meeting took place once a month.

Monthly operational and governance meetings were held with NHSE.

Pathology Services

The Hospital continued to outsource most pathology services to Southwest London Pathology (SWLP). A limited amount of work continued to go to The Doctors Laboratory (TDL) and histology specimens were provided by St George's Hospital or Richmond Park Pathology (RPP).

All pathology incidents were discussed at the regular contract review/operational meetings. SWLP were responsive with investigating problems in a timely manner, however, ongoing issues with microbiology samples going missing persisted.

In the absence of an electronic reporting system, the Hospital worked closely with RPP to ensure histology results were received by email to the referring clinician in a timely manner.

Both, the revised contract with SWLP and the Service Level Agreement with Blood Transfusion Services to cover the provision of Blood and Blood Products, were agreed and signed off by all parties.

Grundon – Clinical, Offensive and Recyclable Waste Pre-Acceptance Visit

See Infection Prevention and Control Report below.

Education Support

The Faculty of Health and Social Sciences, at Kingston University and St Georges University of London, places pre-registration and return to practice nursing students at NVH for surgical experience.

The nursing teams provided supervised practice and educational support to four nursing students as follows:

- Two Return to Practice nurses were allocated to the Day Unit, both of whom completed their placement.
- Two student nurses were allocated to the ward, both of whom completed their placement.

The majority of registered nurses have now completed the Practice assessor/Practice supervisor e-learning module which helps to support the nursing students and facilitate the placements. Staff were encouraged to complete this training either as part of an update or as training for those who did not have any previous mentor qualifications.

Patient Feedback

Picker Howard Warwick Associates (Picker HWA) collect and collate patient feedback and provide regular reports to the Hospital. These reports were reviewed at the IGRM and the information within was disseminated to all staff. Any area raised as a concern was investigated by the relevant Head of Department.

1,595 patients completed feedback questionnaires across the year (an increase on the prior, year of 123) equating to a 27**%** response rate. Response rates have regained the pre pandemic levels. The patient questionnaires were provided on discharge and additionally sent electronically to patient's email addresses 3 days post discharge.

98% of responding patients said they would be 'likely' or 'extremely likely' to recommend NVH to family and friends; 1% less than the previous year.

On other key issues the ratings for the Hospital were as follows:
(% includes Excellent, Very Good and Good):

Overall nursing care:	**99.5%**
Treated with respect and dignity:	**98.3%**
Involved as much as they wanted in decisions:	**93.5%**
The catering service:	**98.2%**
Recommend your consultant:	**98.9%**
The discharge procedures:	**98.3%**
The overall quality of care:	**98.9%**
Overall impression of room:	**98.7%**

Comparative Summary for 2022

The following table is a summary of the Patient Feedback Benchmarking Report January – December 2022.

These figures were compiled by Picker HWA Ltd and show the overall results for 2022 based on NVH patient feedback compared to the figures for all 23 London Hospitals for which Picker HWA Ltd has data on.

SECTION 1 - KEY QUESTIONS	Measure	High Score	Ave.	Low Score	NVH	MONITOR
RESPONSES	Count	4795	1533	80	1595	
Likely to recommend	Ex. Likely	92.8	82.8	68.8	84.9	
Welcome on arrival	Excellent	84.4	70.2	52.6	73.4	
Overall admission	Excellent	83.5	71.5	55.9	73.8	
Pain control	Excellent	98.2	84.3	64.3	83.6	
Overall nursing	Excellent	95.9	84.8	68.7	87.0	

Overall accommodation	Excellent	84.0	68.3	45.3	65.8	
Overall catering	Excellent	79.8	64.8	41.2	65.2	
Did you find someone to talk to about your worries and fears?	Definitely	95.3	84.5	66.1	86.3	
Were you involved as much as you wanted to be?	Definitely	98.0	92.1	80.0	93.5	
Treated with respect and dignity?	Definitely	100.0	97.0	91.8	98.3	
Overall discharge	Excellent	82.5	71.6	53.1	68.5	
Advised side effects of medication?	Definitely	95.0	84.2	72.2	81.5	

MONITOR RATINGS	
ABOVE AVERAGE	
0% - 10% BELOW AVERAGE	
10% OR MORE BELOW AVERAGE	

Internal Review

Infection Prevention and Control

IPC Report 22-23.pdf

Integrated Governance and Risk Data

The following data was collated and reviewed at the IGRM. This was then disseminated at various departmental and organisational meetings, including the Board and MAC meetings.

Audit Outcomes

The Hospital has a quality framework whereby internal audit is integral to all service delivery. The programme comprises a combination of Quality Assurance and Quality Improvement audits and both clinical and non-clinical processes are covered within it.

Action plans for areas of non-compliance were agreed. HoDs continued to feedback findings from audits at the IGRM. This resulted in good cross fertilisation of information throughout the Hospital. Actions outstanding from audits were also reviewed at the IGRM. Audit findings helped drive quality improvements in practice.
A total of 151 audits were undertaken throughout the year.

Practising Privileges (PPs)

271 Consultants and Allied Healthcare Professionals currently hold PPs/Licence to Attend at the Hospital. PP documentation is managed electronically, and a monthly compliance report is provided by the governance team.
This is split by the 'top four' documents (Medical Indemnity information, Appraisal, ICO and Disclosure & Barring Service (DBS) certificate) and mandatory training.

The Key Performance Indicator (KPI) for the 'top four' document compliance was **95%** and for training was **85%.**

	Top 4 documents	Training
Surgeons & Physicians	98%	84%
Anaesthetists	99%	82%
Radiologists	99%	86%

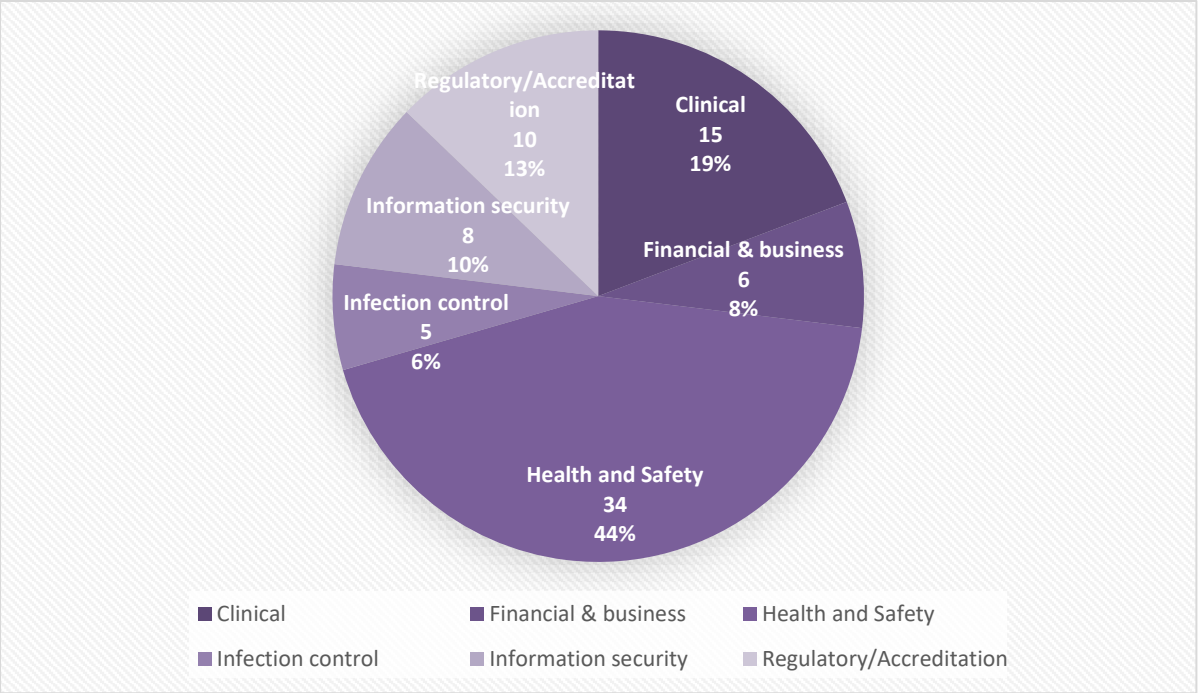
Biennial/annual PP review meetings were carried out on a monthly basis, mostly attended by the Chief Executive and the Medical Director.
31 PP reviews were hosted in 2022/2023. As part of the reviews, practitioner's scope of practice, appraisal and activity analysis were discussed. Diarising these meetings remained challenging.
30 new consultants (18 surgeons/physicians) were granted PPs this year. Formal onboarding interviews are now held. In addition to this, new consultants received an introduction to key personnel and processes.
A total of 25 consultants or practitioners (14 surgeons/physicians, 4 Radiologists, 5 Anaesthetists, 2 Other Supportive Practitioners) relinquished their PPs this year.

Medical Devices Management Group (MDMG)/Safety Alerts

The MDMG is responsible for ensuring devices are managed in accordance with best practice and manufacturer's guidance and that the Hospital is kept abreast of all Medicine & Health Product Regulatory Agency (MHRA) alerts.
Safety alerts were received by the Integrated Governance Administrator who disseminated them to the relevant personnel for review and action, if necessary. A summary of all alerts was documented on a spreadsheet and relevant alerts shared at the IGRM.
The MDMG met three times during the year.

Risk Register

At the time of writing the report, there were 78 risks identified on the 'live' Risk Register (Datix Reporting System), the breakdown by subtype is illustrated below. This showed a decrease of 38 risks in comparison to the previous year (116). 1 risk was rated as high, (4 in the previous year) which is an Information Security risk regarding the interface between Meditech and the Imaging systems and equipment.



A summary of the Risk Register and activity was presented monthly to the EMT, who form the Risk Committee.
Risks were discussed at the H&S Committee meetings, IGRM, Information Governance and HOD meetings. Risks were also reported to the Board on a monthly basis.
The Risk Committee reviewed the whole register in January 2023 and as a result a number of risks were closed or amalgamated. The committee also addressed the balance between Corporate (34) and Departmental (44) Risks.

Reported Incidents – Clinical, Near Miss, Non-clinical Incidents and Staff Accidents

The Hospital operates an online reporting system (Datix) which staff are encouraged to use to report all incidents and accidents. Staff receive incident reporting training on induction and attendance for an update is mandatory every three years.

Incidents were reviewed at the IGRM, EMT and MAC meetings. The H&S committee reviewed non-clinical incidents and staff accidents.

There were 439 reported clinical and non-clinical incidents during this period:

- 229 clinical incidents or near misses were reported covering both inpatient and outpatient activity. (A total of 238 were reported in 2021/22).
- 210 non-clinical incidents (A total of 198 were reported in 2021/22).

Clinical incidents: There were 57 Pathology related incidents in comparison 55 in the previous year. This continues to be the highest category of incidents and 39 of these were reported to SWLP for their internal review.

There were 27 incidents graded as Moderate:

- Twelve of these were related to medical devices or equipment.
- Ten were pathology related.

There were 6 incidents resulting in serious injury to a patient:

- Fracture pelvis following a fall
- Incompatible combination of implants in a Total Hip Replacement
- Management of sepsis following discharge from an NHS Hospital
- Loss of phallus following a Radial Artery Phalloplasty
- Missed breast lesion on three CT scans
- Lost histology sample

All these incidents resulted in a root cause analysis investigation being carried out and lessons learned, and recommendations disseminated to relevant staff.

In addition, the Duty of Candour process was invoked in the following incidents:

- Incompatible combination of Implants in a Total Hip Replacement.
- Missed breast lesion on three CT scans.
- Lost histology sample.

Non-clinical incidents: The largest category was Appointments, Admissions, Transfers and Discharges, which included the reporting of overrunning or failed clinics in Outpatients; a total of 22 incidents. These were monitored to identify trends and remedial action was taken to extended appointment times where necessary.
The second biggest category was Staffing, Facilities and Environment, which included 18 reports of failed or delayed waste collections by the service provider.

There were 14 moderate non-clinical incidents recorded:

- One was a flood that caused a power outage resulting in the closure of the Hospital for 24 hours.
- One was a car fire in the car park.
- Seven due to the regular failure of waste collections.
- One water leak affecting the 1st floor Outpatient department.

All incidents were investigated thoroughly, and learning shared across the Hospital. Some policies and processes were amended, and some training instigated as a result.
Key themes for incidents were interrogated in an attempt to identify trends or weaknesses in practice.

Adverse Outcomes

103 Adverse outcomes were reported via the Datix system. These are broken down as;

Type	Number of Reports	KPI (% of total admissions)
Extended stays due to complications or deviations from original planned surgery	34	0.6%
Unplanned readmissions within 29 days	15	0.3%
Cancelled procedures (for non-clinical reason)	14	0.2%
Surgical site infections (includes 4 x infected hematoma)	13	0.2%
Unplanned returns to theatre with the same admission	10	0.2%
Unplanned 2nd operation within 29 days	10	0.2%
Emergency transfers to another healthcare provider	7	0.1%
Venous Thromboembolism (VTE)	0	0.0%
Pulmonary Embolism (PE)	0	0.0%
Pressure Ulcers	0	0.0%
Hospital acquired Covid-19 infections	0	0.0%
Mortality	0	0.0%

Adverse outcome data is recorded based on criteria defined by PHIN and the CQC, including but not limited to; returns to theatre; emergency transfers out; and readmissions within 29 days of discharge.
This data was reviewed at the IGRM, Board and MAC meetings.

Individual consultant governance data was provided on request to assist with evidence for appraisal and GMC revalidation purposes.

Complaints

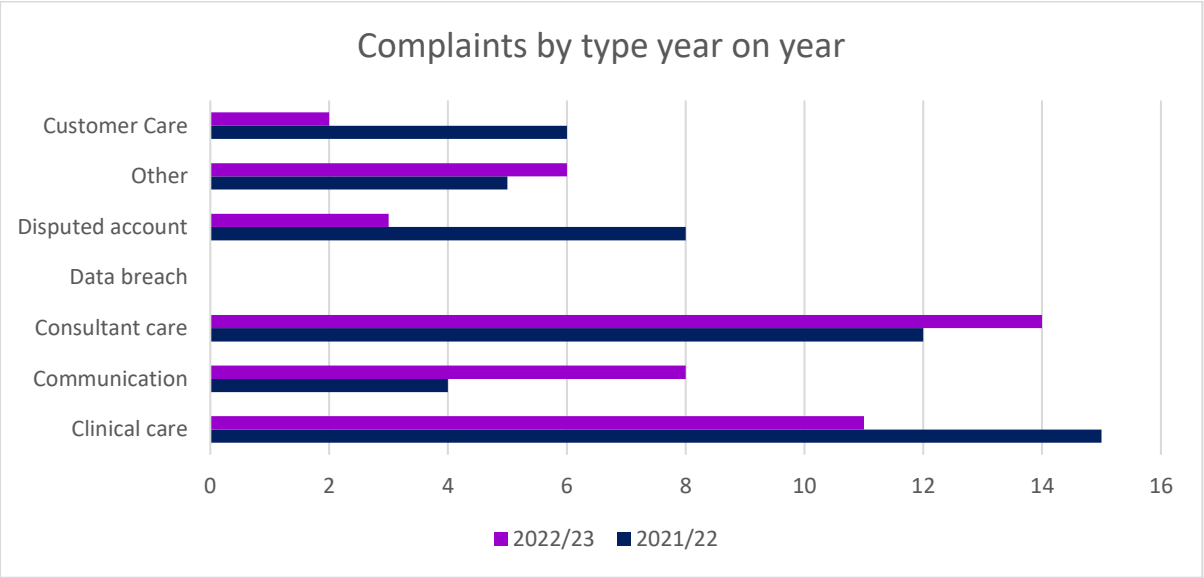
The Hospital takes complaints very seriously and adheres to the Independent Sector Complaints Adjudication Service (ISCAS) Code of Practice for Complaints Management, January 2022, and is a subscriber to the Independent Sector Complaints Adjudication Service.

All complaints were handled in accordance with the Complaints Policy which mirrors the ISCAS framework and learning outcomes shared as a part of the process.

35 (33 Stage 1 & 2 Stage 2) complaints were received in this period, as opposed to 40 (37 Stage 1, 3 Stage 2 & 1 Stage 3) received in the previous 12 months.
The chart below compares the stage of resolution of complaints against the previous year. One Stage 2 remains open, and none have progressed to Stage 3 thus far.

No. of Complaints 2022/23			No. of Complaints 2021/22		
Resolved at Stage 1	Progressed to Stage 2	Progressed to Stage 3	Resolved at Stage 1	Progressed to Stage 2	Progressed to Stage 3
33	2	0	37	3	1
94.3%	5.7%	0.0%	92.5%	7.5%	2.5%

The table below describes the main concerns raised; note, some complaints raised more than one concern thus explaining the difference in total numbers:



Outcome:	21-22	22-23
Substantiated	13	8
Partially substantiated	12	6
Unsubstantiated	14	12
Unable to substantiate	1	9

Safeguarding Children and Vulnerable Adults

There were three safeguarding incidents this year, two of which were formally reported.

- Concerns raised by the Outpatient Physio regarding a patient's carer. The patient and family had already raised a concern about this carer to the agency supplying her.
- Patient disclosed a personal matter regarding her husband who was in attendance with her in the Outpatients Department. A contact number was provided for a helpline and a GP appointment was made free of charge. This was not escalated on the patient's request.
- The carer of the husband of an elderly couple raised concerns for the husband regarding his wife's behaviour towards him. No immediate threat or danger identified.

Safeguarding training at Levels 1 & 2 continued as e-learning. Level 3 training continued face to face.

At the end of the FY compliance was as follows:
Adult Safeguarding Levels 1&2 – **94%**
Adult Safeguarding Level 3 – **100%**
Paediatric Safeguarding Levels 1&2 – **95%**
Paediatric Safeguarding Level 3 – **83%**

Policy Ratification/ Document Management

The process for ratifying new or significantly amended policies has proved efficient and effective. Policies were mostly ratified and published within the required four-week timeframe. Progress was reviewed at the IGRM.

Robust management of documents ensured that policies, procedures, and forms were reviewed within 3 years. The number of documents under review at the end of the year was 45 documents representing 1.2% of all controlled documents.

Training

Staff were supported in delivering high-quality care through provision of a robust in-house mandatory training programme. Additionally, continuous professional development was facilitated and supported financially, to meet the needs of the individual and bridge any skills shortages required for developing services.

For continuous support of the GDSS all new staff were expected to attend Diversity training specifically targeted at improving understanding of the transgender population and their experience with transitioning.

Departmental Training Champions continued to facilitate the booking of their colleague's mandatory training at the required intervals. The Champions have access to allocate e-learning for staff directly on the e-learning portals.

Heads of Department were required to ensure their staff were fully trained and competent to carry out their individual roles.

The Training Administrator monitored mandatory training and overall compliance started the financial year at 90% attendance and this was maintained throughout the year. The Training Administrator maintained a live report which was available for all staff to view; training needs and compliance were regularly discussed at the HoDs meetings.

Any additional training requirements were identified in the annual appraisal process, which has been improved to better capture training needs.

In order to improve understanding of individual mandatory training requirements, the Human Resources team is developing a training passport for new staff which will be rolled out during the next quarter.

Quality Improvement Initiatives

The following initiatives were implemented:

- Embed the recommendations from the Paterson Enquiry:
    - Practising Privileges policy updated to reflect the recommendations.
    - Standard process implemented to ensure compliance with the Top 4 documents
- Reduce patient fasting times and actively encourage hydration:
    - 3 audits were undertaken during the reporting period.
- Introduced an online assessment tool to streamline pre-operative assessments for patients and improve efficiencies within the team.
- Implemented a new Wound Care Assessment form in the Outpatients Department.
- Reviewed and updated the Standardised Vasectomy Consent Form.
- Strengthened the provision of Chaperones in all outpatient departments.
- Introduced a Physiotherapy MDT with input from Consultants, Physiotherapists, Radiologists, Ward, and Day Unit staff.

Objectives for the forthcoming year

- To maintain the Hospital's good rating with CQC and work towards improving to Outstanding in at least one domain.
- To implement the organisational Integrated Governance and Risk training plan to support compliance.
- To integrate and continue to embed the Hospital Values with the CQC Domains across the Organisation.
- To implement a quarterly organisational governance newsletter to improve communication and continued learning.
- To complete any outstanding the actions from the mock CQC inspection (conducted by Elsiarc).
- To continue to build on the relationship with PHIN and support the exchange of information in a timely fashion.

- To strengthen the Patient Reported Outcome Measures (PROMS) reporting process and returns.
- To implement a process for storing the outpatient documentation for minor procedures electronically.
- To continue to develop a programme for implementing digitised patient records.
- To reintroduce the Patient Led Assessments of the Care Environment (PLACE).
- To implement the Patients Safety Incident Response Framework (PSIRF) for the management of patient safety incidents.
- To implement Learn From Patients Safety Events (LFPSE) within Datix incident reporting.
- To continue to work towards achieving Joint Advisory Group (JAG) for Gastrointestinal Endoscopy accreditation.
- To continue to engage with CHKS for ISO 9001:2015 standards accreditation.

Conclusion
2022/23 was a hugely successful year for the Hospital, with patient activity and revenue exceeding its highest level ever. Patient care and clinical outcomes continued to be of the highest standard, with consultant feedback on care being exemplary, without exception.

Gill Welch
Director of Clinical Services

Antti Kivimaki
Integrated Governance and Risk Director