Issue 13 July 2018

Quality Matters Special

Welcome

Welcome to our Special Edition of Quality Matters, where we launch the Viapath 2017 Quality Account. All healthcare providers who offer a service to NHS funded patients, publish an account annually.

In our Quality Account we demonstrate progress with important governance, quality and risk issues, with a particular focus on lessons learnt from incidents.

We also recognise the excellent progress made with laboratory transition from CPA to ISO15189 over 2017, in addition to over 33 million units of activity being processed - a very busy year!

We hope you enjoy reading about our progress and welcome feedback on the Quality Account which can be found on the Viapath website and NHS Choices.

LINKS:

Viapath 2017 Quality Account Viapath website:

http://www.viapath.co.uk/annual-quality-report-and-account

NHS Choices:

https://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Documents/2018/Viapath-qa-2018.pdf

Let's Talk Quality... Quality Account

Quality Account 2017

Pioneers in Pathology

The quality theme for 2018 is 'end-to-end pathology', which will see Viapath respond to the anticipated changes in NHS pathology networks, and focus on the Viapath growth strategy – direct to consumers. It will also see the appointment of two independent non-exec directors strengthening the Viapath board: we are pleased to welcome Sir Jonathan Michael and Dr Sneh Khemka, both of whom have a strong track record in entrepreneurial and commercial leadership as well as leading complex healthcare organisations.

2017 saw a very positive step-change in business activities, resulting in double-digit growth, significant investment in equipment and training, and importantly, employee contributions recognised through our new employee incentive scheme.

Dougie Dryburgh
Viapath Chief Operating Officer

Incidents

In 2017 there was a 38% increase in adverse incidents reported across all our laboratories compared with 2016 (from 646 to 891).

Incidents

Adverse Incident (AI) is 'an unintended event or circumstance which adversely affects patients, visitors, employees, or has the potential to do so.'

Never Event is 'a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.'

Serious Incident (SI) is 'an adverse incident which has caused moderate to serious patient harm or death and/or is likely to cause major disruption to services, significant financial or asset loss or reputational damage.'

	2015	2016	2017
NHS reported Never Events/ Serious Incidents	2	1	12*
Adverse Incidents	705	646	891
Total incidents	707	647	900

"Each of our sites has access to the electronic NHS reporting system and we work very closely with NHS patient safety teams to establish what happened and resolve."

It can be hard to know whether an increase in incidents is an encouraging sign of a healthy reporting culture whereby employees report incidents which may impact on patients, services and employees to help improve, or whether it represents a reduction in service quality. To place our reporting in context, NHS Improvement reported that between October 2016 and September 2017, 1,895,834 incidents were reported in England. They have reported a year-on-year increase in incident reporting, actively encouraging a reporting culture in healthcare.

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How we learnt from complaints

Princess Royal University Hospital *Eye Clinic 29/09/2017*

Complaint: An eye clinic required an eye swab from a patient. However, when the laboratory received the sample the request form had requested a microscopy, culture and sensitivity test for virology and not an eye swab. This sample was therefore rejected by the laboratory.

Response: The laboratory and the eye clinic discussed the problem and as a result, Viapath revised the request form specifically to enable the eye clinic to make the correct request.

Bedford Hospital *Patient 08/05/2017*

Complaint: A patient attended Viapath Central Specimen with a specimen for microbiology. This was sealed in the specimen bag but it was subsequently realised that the date and time the specimen was collected was not written on the bag. The patient asked Viapath for new bag, so that the information could be written on the specimen pot, but was informed this was not necessary. Later at the appointment with the consultant, the patient found out the specimen had been rejected due to not having a date and time of collection.

Response: An apology letter was sent to the patient. The procedure in central specimen reception was amended to reflect the correct process and all employees working in that department were trained on the new procedure.

King's College Hospital & Guy's Hospital *Referral Hospitals 28/02/2017 & 27/06/2017*

Complaint: A referring hospital informed Viapath that they were unable to locate the results for a test they had previously referred.

Response: The root cause was investigated and as a result a booking in error was identified. The standard operating procedure has now been amended and the entire team received training on the new procedure. An apology letter was sent to the requesters.

We would like to hear from you...

If you have any suggestions or feedback please contact Quality Director Liz Adair via telephone 020 7188 7188 (Ext. 54885) or email to **QualityMatters@viapath.co.uk**.