Buckshaw Hospital

Quality Account
2025/26

Ramsay Health Care

Contents

Welcome to Ramsay Health Care UK

Buckshaw Hospital is part of the Ramsay Health Care Group

Statement from Nick Costa, Chief Executive Officer, Ramsay Health Care UK

Founded in 1964 in Sydney, Australia, Ramsay Health Care is a leading global healthcare provider, recognised for outstanding patient care and integrated services across Australia, Europe and the United Kingdom.

Patients choose Ramsay UK because they trust us to deliver the highest standards of clinical quality and provide exceptional care. This year, we have achieved several significant milestones that recognise excellence in clinical care. Ramsay UK became the first independent provider to secure JAG accreditation across all our 25 endoscopy units; we were awarded Gold National Joint Registry (NJR) Quality Data Provider status across all hospitals, for the second consecutive year and we received consistently positive outcomes from Care Quality Commission (CQC) inspections. These achievements were further strengthened by the positive findings of the Getting It Right First Time (GIRFT) review of Ramsay's orthopaedic and spinal services.

Over the last 18 months, we have reinvested £55 million into diagnostic imaging, equipment upgrades, digital platforms, estates, and early intervention. These investments ensure our hospitals remain modern, high-performing and able to meet growing demand; alongside strengthening patient experience and doctor engagement.

With Net Promoter Scores above 90, we are prioritising patient care by launching the "It starts with me" customer service training to further improve the patient experience and uphold a patient-first culture.

Together, our achievements highlight Ramsay UK's commitment to healthcare excellence, patient experience and making a positive impact in our local communities.

I am proud to share these results with you.

Nick Costa

Chief Executive Officer

Ramsay Health Care

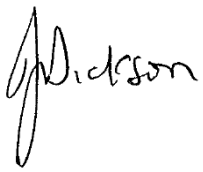
Statement from Jo Dickson, Chief Clinical and Quality Officer, Ramsay Health Care UK

At Ramsay Health Care UK, patient safety and the quality of care are paramount. As Chief Clinical and Quality Officer and Chief Nurse, I am immensely proud of the dedication and passion demonstrated by our clinical teams. Their unwavering commitment to delivering compassionate, evidence-based care ensures that patients always remain our foremost priority.

Across the UK group, I am continually inspired by the outstanding care provided by both our clinical and operational teams. Every day, they deliver exceptional service that embodies our core value of "People Caring for People." This dedication is clearly reflected in our impressive patient feedback scores, as well as the positive engagement received from colleagues and doctors. The contribution of every team member is vital, and we remain steadfast in our commitment to recognising, supporting, and championing their efforts.

This year, I have been particularly proud of the achievement of our first ‘Outstanding’ rating from the Care Quality Commission for one of our hospitals. This recognition was not easily attained, but it is a well-earned reflection of the exceptional practice and service that are consistently delivered. As we look to the future, our focus is on sharing best practice and learning so that this recognition may be more widely achieved throughout our organisation.

I am eager to continue this journey, building on our unwavering commitment to providing high-quality healthcare. With sustained investment and a dedication to innovation, we will further strengthen our promise to patients and the communities we serve.



Jo Dickson

Chief Clinical and Quality Officer

Ramsay Health Care

Introduction to our Quality Account

This Quality Account is Buckshaw Hospital's annual report to the public and other stakeholders about the quality of the services we provide. It presents our achievements in terms of clinical excellence, effectiveness, safety and patient experience and demonstrates that our managers, clinicians and staff are all committed to providing continuous, evidence based, quality care to those people we treat. It will also show that we regularly scrutinise every service we provide with a view to improving it and ensuring that our patient's treatment outcomes are the best they can be. It will give a balanced view of what we are good at and what we need to improve on.

Each site within the Ramsay Group develops its own Quality Account, which includes some Group wide initiatives, but also describes the many excellent local achievements and quality plans that we would like to share.

Part 1

1.1 Statement on quality from the Hospital Director

Mrs Helene Delaney, Hospital Director

Over the past year, the hospital has continued to build on its commitment to delivering safe, effective and patient-centred care. We have remained focused on maintaining high standards of clinical quality, strengthening engagement across our teams and ensuring that patient experience continues to inform how we develop and improve our services.

Our vision remains to be a leading healthcare provider where clinical excellence, safety, care and quality are central to everything we do. This Quality Account provides an overview of our performance during the past year and sets out our broad priorities for continued improvement in the year ahead.

I am pleased to report that we have continued to place patient safety, clinical effectiveness and patient experience at the centre of our approach. By listening to patients, colleagues and stakeholders, and by reviewing feedback alongside a range of quality and governance measures, we are able to recognise areas of good practice and identify opportunities for further improvement. These measures provide assurance that care is evidence-based and delivered by appropriately qualified and experienced healthcare professionals. Further detail on our performance, outcomes and improvement work is set out throughout this Quality Account. As Hospital Director, ensuring the delivery of consistently high standards of clinical care for our patients remains my highest priority.

This Quality Account is an accurate reflection of the hospital's performance and demonstrates our ongoing commitment to continuous improvement. We remain focused on delivering compassionate, high-quality, patient-centred care and on further strengthening the services we provide for our patients, colleagues and wider stakeholders.

Mrs Helene Delaney

Hospital Director
Buckshaw and Euxton Hall Hospitals
Ramsay Health Care UK

1.2 Hospital Accountability Statement

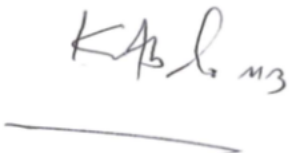
To the best of my knowledge, as requested by the regulations governing the publication of this document, the information in this report is accurate.

Hospital Director Euxton Hall & Buckshaw Hospitals

Mrs Helene Delaney

This report has been reviewed and approved by:

MAC Chair Euxton Hall & Buckshaw Hospitals
Mr Khalil Abdo



Clinical Governance Committee Chair Euxton Hall & Buckshaw Hospitals

Mr Hamed

Head of Clinical Services Buckshaw Hospital

Mrs Sarah Wakefield

Welcome to Buckshaw Hospital

Buckshaw Hospital, established in 2021, is a private rapid diagnostic and day surgery centre situated in Buckshaw Village, near Leyland and conveniently accessible from Chorley and Preston. The hospital caters to a diverse patient base, including individuals with private medical insurance, self-paying patients, and those referred through the NHS Patient Choice Scheme.

The facility comprises 12 ambulatory bays, two operating theatres, a treatment room, physiotherapy services, and a comprehensive diagnostic suite featuring CT, ultrasound, mammography, and MRI capabilities. Buckshaw Hospital is registered with the Care Quality Commission (CQC) to provide care and treatment for adults aged 18 and above. The hospital offers a full spectrum of high-quality services, encompassing outpatient consultations, pre-assessment, outpatient procedures, investigations, diagnostics, surgery, and follow-up care.

To optimise operational efficiency, Buckshaw Hospital collaborates closely with Euxton Hall and Fulwood Hospitals, sharing core functions such as the Hospital Director, Operations Manager, Finance Manager, Private Patient Manager, Business Relations Manager, Medical Records and Secretarial Teams, IT and Bookings Team, Training and Development Coordinator, and HR Administrator.

During the las 12 months the hospital has treated 7042 patients, 92.12% of which were treated under the care of the NHS.

Clinical services at Buckshaw Hospital are consultant-led, with consultants operating under approved Practising Privileges in accordance with Ramsay Health Care UK policy. The hospital maintains rigorous compliance standards, and consultants are encouraged to contribute to the Private Healthcare Information Network (PHIN), providing publicly accessible performance data to support patient decision-making.

An on-site Resident Doctor (RD) is available to support consultants and work collaboratively with the nursing team, ensuring the provision of continuous medical care. Buckshaw Hospital has established strong, collaborative relationships with key local commissioners, including the Lancashire and South Cumbria Integrated Care Board (ICB), Lancashire Teaching Hospitals NHS Foundation Trust, and Wigan, Wrightington and Leigh Hospitals NHS Trust. These partnerships underpin a coordinated approach to patient care across the wider healthcare system.

The hospital delivers a broad range of day case surgical and allied health services across multiple specialties, including general surgery, endoscopy, ear, nose and throat (ENT), urology, gynaecology and orthopaedic surgery. Allied health services feature physiotherapy (electrotherapy, acupuncture, continence support, back pain and chest clinics, pilates/personal training sessions) and advanced diagnostic imaging (MRI, CT, ultrasound, and 3D breast tomosynthesis). The well-equipped outpatient department supports pre-operative assessments and phlebotomy, facilitating comprehensive evaluation and preparation for treatment.

To uphold exemplary clinical standards and ensure compliance with national healthcare regulations, Buckshaw Hospital is supported by a team of specialist clinical leads, each responsible for crucial aspects of patient safety and care quality:

- **Infection Prevention and Control Lead Nurse:** Oversees the implementation of the Infection Prevention and Control Annual Plan, ensuring compliance with the Health and Social Care Act 2008 and CQC Regulation 12 on cleanliness and infection control.
- **Resuscitation Lead:** Ensures adherence to Resuscitation Council (UK) standards, manages training programmes (BLS, ILS, ALS, AIMS), audits equipment, and coordinates scenario-based simulations to maintain emergency preparedness.

- **Training and Development Coordinator:** Designs and delivers bespoke in-house training programmes, monitors mandatory training compliance, and audits clinical competency documentation to uphold safe and skilled patient care standards.
- **Blood Transfusion Lead:** Ensures compliance with MHRA regulations for blood product management, supported by a Consultant Haematologist. Annual staff training and simulation testing and prepare the hospital for scenarios such as massive haemorrhage.
- **Dementia Champion:** A registered nurse trained to support patients with dementia, supported by staff trained as ‘Dementia Friends’ via the Alzheimer’s Society. Dementia and disability aids are available to patients as needed.
- **Safeguarding Lead and Champions:** A Level 4 trained lead physiotherapist, supported by Level 3 safeguarding champions, ensures safeguarding policies are upheld. All staff receive annual mandatory safeguarding training, including e-learning modules.
- **Occupational Health Lead:** Promotes staff wellbeing through vaccination programmes, skin surveillance for clinical staff, and participation in flu campaigns. In winter 2025, 74% of staff received a flu vaccine.
- **Mental Health First Aiders:** Twelve team members are trained to provide immediate peer support, raise awareness, and offer guidance to colleagues experiencing mental health challenges, fostering a positive and resilient workplace culture.

Together, these roles reinforce Buckshaw Hospital's commitment to delivering high-quality, safe, and patient-centred care. The hospital continues to maintain close partnerships with local healthcare providers and invests in the ongoing development of its clinical staff through education, training, and a culture of continuous improvement.

Working with the Local Community

Buckshaw Hospital continues to focus on delivering high standards of patient care in a friendly and approachable manner. Working with our partners, which include local GPs, consultants, and other specialists, we deliver an individual personal service to all our patients, tailored to meet their needs.

The Business Relations Manager plays a pivotal role in developing and sustaining strong, effective relationships with local General Practitioners (GPs), referral management teams, and other key referrers across both private and NHS services. Through proactive engagement and regular communication, these partnerships enable the continuous review, development, and

streamlining of referral processes, ensuring they remain efficient, responsive, and aligned to the needs of both patients and healthcare professionals.

A core element of the role is to engage with healthcare professionals across the local community, building trust and maintaining a visible presence. This ensures that referrers are fully informed about the breadth of services available within our hospitals, including new and developing specialties. The Business Relations Manager also ensures that GPs and clinical teams have timely access to relevant information, guidance, and support to facilitate smooth and appropriate referrals into secondary care, ultimately enhancing patient experience and outcomes.

In addition, the Business Relations Manager works closely with consultants and hospital leadership teams to ensure appropriate clinic capacity and availability are maintained in line with demand. This includes identifying gaps in service provision, supporting business planning, and contributing to the recruitment of new Consultants. By doing so, the role helps to expand and strengthen the hospital's clinical offering, ensuring a diverse and comprehensive range of services is available to meet the needs of the local population.

The coordination and delivery of a bespoke educational programme for GP practices is another key responsibility. These sessions are designed to support continuous professional development, strengthen relationships with referrers, and provide valuable clinical insights. Delivered on a regular basis, the programme covers a wide range of relevant and topical subjects, tailored to the needs and interests of attendees. While these sessions were historically delivered within GP surgery settings, they have successfully transitioned to a virtual format, enhancing accessibility and attendance for busy clinical colleagues, while remaining entirely free of charge.

Furthermore, the educational offering has expanded to include sessions for both healthcare professionals and patients, supporting greater awareness, early intervention, and informed decision-making. Between April 2025 and March 2026, a series of highly successful educational events were delivered by Consultants from Buckshaw and Euxton Hall Hospitals, demonstrating strong engagement from both local referrers and the wider community, and reinforcing the hospital's commitment to education, collaboration, and high-quality patient care

During the reporting period Buckshaw Hospital continued to raise money for local charities, most recently raising almost £1349.07 for Best Foot Forward for Georgie. In the coming year, our chosen hospital charity is Rosemere.

Part 2

2.1 Quality priorities for 2026/27

Plan for 2026/27

On an annual cycle, Buckshaw Hospital develops an operational plan to set objectives for the year ahead.

We have a clear commitment to our private patients as well as working in partnership with the NHS ensuring that those services commissioned to us, result in safe, quality treatment for all NHS patients whilst they are in our care. We constantly strive to improve clinical safety and standards by a systematic process of governance including audit and feedback from all those experiencing our services.

To meet these aims, we have various initiatives on going at any one time. The priorities are determined by the hospitals Senior Management Team taking into account patient feedback, audit results, national guidance, and the recommendations from various hospital committees which represent all professional and management levels.

Most importantly, we believe our priorities must drive patient safety, clinical effectiveness and improve the experience of all people visiting our hospital.

At Buckshaw Hospital, the Ramsay Values most prominently "people caring for people" are woven into every aspect of our operations, forming the foundation for our commitment to outstanding patient care. This ethos shapes our culture, guiding staff to treat every patient, visitor, and colleague with empathy, dignity, and respect. Our multidisciplinary teams consistently strive to exceed expectations, ensuring that compassionate care is delivered alongside clinical excellence throughout all services. Rigorous training, continuous professional development, and robust safety protocols are implemented to uphold the highest standards of service quality. The hospital actively promotes open communication and shared decision-making, empowering both patients and staff to participate fully in their healthcare journeys. Patient safety is paramount: our clinical leads oversee comprehensive risk assessments, infection control initiatives, and incident reporting, fostering a proactive environment where harm is prevented and wellbeing safeguarded. By encouraging innovation, teamwork, and an unwavering dedication to ethical practice, Buckshaw Hospital ensures that the Ramsay Values remain at the heart of everything we do creating a safe, supportive, and trusted setting where patients' needs are always prioritised.

Priorities for improvement

2.1.1 A review of clinical priorities 2025/26 (looking back)

As we reflect on the progress made over the past year, we are pleased to confirm that we have successfully delivered against our 2025/26 priorities across patient safety, clinical effectiveness and patient experience. This work has strengthened our culture of safety, improved the quality and consistency of care and enhanced the experience of patients and their families. Collectively, these achievements demonstrate our continued commitment to delivering safe, effective and compassionate services across Buckshaw Hospital, while also providing a strong foundation for further improvement in the year ahead.

Patient Safety

During 2025/26, we made significant progress in strengthening staff understanding and use of Speaking Up for Safety and the RADAR reporting system. Over the course of the year, we focused on increasing staff awareness, confidence and engagement in recognising and reporting incidents, near misses and concerns across both clinical and non-clinical teams. Through a combination of focused education, practical training and visible leadership support, reporting has become more consistent, timely and meaningful, supporting earlier identification of issues and a more responsive approach to risk management and organisational learning.

Importantly, this work has not been limited to increasing reporting activity alone. We have also worked to improve the quality of feedback provided to staff so that teams can more clearly understand the outcomes of their reporting, what action has been taken as a result and how their contribution has supported wider improvement. This has helped reinforce the value of reporting, strengthen trust in the process and promote a more open and accountable culture in which staff feel encouraged to raise concerns and share learning. As a result, incident reporting is increasingly understood not simply as a procedural requirement, but as a key mechanism for improving safety, preventing recurrence and strengthening assurance across the organisation.

Clinical Effectiveness

We have successfully enhanced and expanded the One-Stop Breast Clinic at Buckshaw Hospital, delivering a significant improvement in both the efficiency of the patient pathway and the overall patient experience. The service now offers a more streamlined diagnostic journey, enabling patients to access assessment, imaging and, where required, biopsy within a single visit. This has reduced delays, improved coordination of care and helped to minimise anxiety at what is often a highly stressful and uncertain time for patients and their families.

A key part of this achievement has been the strengthening of the clinical team through the introduction of a dedicated Breast Care Nurse, the appointment of two Breast Consultants and

the addition of a new Radiologist. Together, these developments have increased clinical capacity, improved continuity of care, enhanced access to specialist advice and diagnostics and ensured that patients receive timely, coordinated and compassionate support throughout their pathway. The dedicated Breast Care Nurse has been particularly important in providing consistent clinical and emotional support, acting as a key point of contact for patients, helping to improve communication and contributing to a more personalised, reassuring and holistic experience. This service development represents a meaningful improvement in clinical effectiveness by ensuring that diagnostic assessment is delivered more efficiently, with greater specialist input and a stronger emphasis on continuity, responsiveness and patient-centred care.

Patient Experience

We have made strong progress in improving patient experience by placing the views of patients, families and carers more firmly at the centre of service improvement. Over the past year, we have strengthened the use of feedback mechanisms, including the Friends and Family Test, digital surveys and direct engagement channels, to gather richer and more meaningful insight into what matters most to those using our services. This information has been reviewed regularly through governance structures and patient-focused forums, helping to ensure that feedback directly informs decision-making, service development and local improvement activity.

Alongside this, we have taken important steps towards a more co-productive approach to improvement by encouraging greater involvement of patients in shaping solutions and by supporting staff to deliver more person-centred care through communication and compassionate care initiatives. This has contributed to a culture in which dignity, respect, responsiveness and continuous listening are recognised as essential elements of high-quality care. By strengthening how feedback is gathered, reviewed and acted upon, we have continued to build an environment in which patient experience is not viewed as a separate workstream, but as an integral part of how services are designed, evaluated and improved.

2.1.2 Clinical Priorities for 2026/27 (looking forward)

As we look ahead, our clinical priorities must remain firmly centred on delivering safe, effective, compassionate and consistently high-quality care. The priorities set out for 2026/27 focus on the areas most likely to improve patient outcomes, strengthen staff experience and provide robust organisational assurance. In particular, four priorities will be central to our improvement work: achieving and sustaining ANTT Gold Award standards; strengthening staff engagement with a clear emphasis on mental health and wellbeing; revisiting the Patient Safety Incident Response Framework (PSIRF) to ensure robust investigation, meaningful learning and effective closure of actions; and improving capacity and patient flow within the Ambulatory Unit. Together, these priorities provide a practical and strategic framework for enhancing

clinical standards, strengthening organisational culture and ensuring that learning and improvement are translated into measurable impact.

Achieving and Sustaining ANTT Gold Award Standards

Achieving ANTT Gold Award status is more than an accreditation milestone; it is a visible demonstration of clinical excellence, strong infection prevention practice and organisational commitment to patient safety. Aseptic Non-Touch Technique is designed to minimise avoidable infection risk during invasive procedures by protecting key parts and key sites, standardising safe practice and reducing unwarranted variation. Gold-level accreditation reflects maturity in governance and assurance, supported by clear policy, effective staff education, reliable competency assessment and ongoing monitoring of standards in practice.

For patients, this means greater confidence that care is delivered safely and consistently. For staff, it provides a clear and standardised framework that reduces ambiguity, supports professional accountability and reinforces the importance of getting the fundamentals right every time. For the organisation, it offers assurance that infection prevention is embedded not only in policy but also in day-to-day clinical practice, audit activity and leadership oversight.

To achieve and sustain ANTT Gold standards, several actions will be essential. Policies and procedures must remain current, clear and fully aligned to recognised ANTT principles. Education and training must be strengthened so that staff understand both the technical requirements of ANTT and the reasons why these standards matter. Competency assessment must be regular, meaningful and evidence-based, providing assurance that practice is being demonstrated consistently rather than assumed. Monitoring arrangements must also be visible and continuous, using audit, observational practice review and local feedback mechanisms to identify good practice and respond promptly where standards require improvement.

Equally important is the wider cultural message that this work sends across the organisation. Achieving Gold Award status should not be viewed simply as a compliance exercise, but as part of a broader patient safety ambition. It is about creating a culture in which safe aseptic practice is understood to be everyone’s responsibility, where unwarranted variation is challenged appropriately and where teams take pride in delivering care to the highest possible standard. Sustaining this priority will require visible leadership, local champions, consistent communication of expectations and recognition of progress made.

During 2026/27, this work will be supported through a review of current compliance levels, identification of training and competency gaps across services, standardisation of audit tools, increased observational assurance in clinical areas and clear accountability at site and service level. We will also make better use of triangulated data, including incidents, infection trends,

audit findings and staff feedback, so that we can better understand where standards are strongest and where additional support or intervention is needed. In this way, ANTT Gold will become not only an award to achieve, but a mechanism for driving safer care, stronger governance and greater confidence in the quality of our clinical practice.

- Review current compliance levels and identify gaps in training and competency.
- Ensure policies and procedures remain current and aligned to recognised ANTT principles.
- Strengthen competency assessment, audit and observational assurance in clinical areas.
- Use incident trends, infection data, audit findings and staff feedback to target improvement.
- Promote leadership visibility and local champions to sustain standards over time.

Strengthening Staff Engagement, Mental Health and Wellbeing

A high-performing clinical service depends on an engaged, supported and psychologically safe workforce. Staff engagement is not separate from quality and safety; it is fundamental to it. When staff feel valued, listened to and supported, they are more likely to speak up, contribute ideas, follow standards, support colleagues and deliver compassionate care. Conversely, when staff feel overwhelmed, disconnected or unsupported, the effects can be seen in morale, retention, sickness absence, team functioning and ultimately patient experience.
A renewed focus on mental health and wellbeing must therefore remain a central clinical priority. This means moving beyond broad statements of support and taking practical, visible steps that improve the day-to-day working experience of our teams. Mental health and wellbeing in the workplace is shaped by workload, staffing levels, leadership behaviour, communication, access to support, team culture and the extent to which staff feel able to raise concerns without fear. Any meaningful response must therefore combine organisational commitment with local action.
During 2026/27, we will strengthen staff engagement through regular and structured listening mechanisms, including team conversations, pulse feedback, leadership walk-rounds and meaningful follow-up on the issues raised. Staff need to see clearly that their voice leads to action. Visible and consistent leadership presence in clinical areas will be essential to this approach. Leaders must be approachable, engaged and actively listening to staff concerns, ideas and experiences. This visibility builds trust, improves communication and demonstrates commitment to the realities of frontline care delivery.

We will also ensure that line managers and leaders are equipped to have supportive conversations, recognise signs of stress and direct staff to appropriate support. Leadership capability in this area is critical, as wellbeing is often shaped most powerfully by immediate

local culture and daily experience. Alongside this, we will review workload pressures and operational pinch points honestly. Wellbeing cannot be improved through messaging alone if staffing gaps, excessive pressure or inefficient processes remain unresolved. Tackling avoidable inefficiencies, improving rostering approaches where possible, ensuring fair distribution of workload and reducing unnecessary administrative burden are all practical interventions that contribute directly to staff wellbeing.

Accessible support arrangements, including occupational health, employee assistance, psychological support, on site Mental Health First Aiders, peer support and wider wellbeing resources, must also be promoted in a way that is trusted, visible and easy to access. At the same time, we will continue to strengthen psychological safety so that staff feel able to raise concerns, report incidents, contribute learning and challenge poor practice in a constructive and respectful environment. Creating a culture of recognition will also be important, as engagement is strengthened when staff feel that their professionalism, effort and contribution are genuinely noticed and valued.

Progress against this priority will be monitored through a range of qualitative and quantitative indicators, including staff survey themes, local feedback, turnover, sickness absence, uptake of wellbeing support, speaking-up data, appraisal quality and training completion. The aim is to create an environment in which staff feel seen, heard and supported to perform at their best, and where mental health and wellbeing are understood as essential components of safe, high-quality care rather than as separate initiatives.

- Maintain regular leadership walk-rounds and structured staff listening opportunities.
- Act on staff feedback and communicate clearly what has changed as a result.
- Equip line managers to support wellbeing conversations confidently and consistently.
- Promote psychological safety so staff feel able to speak up without fear.
- Monitor survey themes, turnover, sickness absence and uptake of support services.

Revisiting PSIRF: Robust Investigation, Learning and Closure

The Patient Safety Incident Response Framework provides an important opportunity to strengthen how we respond to patient safety incidents by focusing on learning, systems thinking and improvement rather than process alone. To realise the full benefit of PSIRF, we must revisit our current arrangements and ensure that they are robust, timely, proportionate and consistently applied. This requires clarity around governance, roles, triage, oversight, methodology and the expected quality of investigation outputs.

A core priority for 2026/27 will be to ensure that investigations are comprehensive and of

consistently high quality. Effective investigations do more than describe what happened; they explore contributory factors in depth, consider human factors and wider system issues, examine where barriers failed and assess the broader context in which care was delivered. This requires trained investigators, clear terms of reference, effective quality assurance and leadership oversight that remains focused on learning and improvement rather than blame.

We will therefore review and strengthen the end-to-end incident response process to ensure that incidents are identified, escalated and triaged appropriately, and that the right level of response is triggered in a timely and proportionate way. Investigation timescales must be realistic but actively managed, and patients, families and staff must be supported throughout the process with openness, compassion and effective communication. Governance arrangements will need to provide sufficient scrutiny to ensure that themes are recognised, recommendations are meaningful and actions are proportionate, achievable and clearly linked to improvement.

Learning must also be shared more effectively. Too often, learning remains confined to an individual report, committee or single team. Under a stronger PSIRF approach, learning should be translated into practical messages and disseminated across services in ways that support reflection, discussion and change. This may include safety briefings, thematic reviews, governance meetings, training sessions, newsletters, team huddles and cross-site learning forums. The emphasis should be on making learning accessible, relevant and actionable rather than simply recording that it has been circulated.

Closing the loop is equally important. One of the most common weaknesses in incident management is not the identification of actions, but the failure to ensure that those actions are implemented, embedded and evaluated. To address this, each investigation must result in clearly assigned actions, named leads, realistic deadlines and a defined governance process for tracking completion. Importantly, there must also be follow-up to test whether changes have been embedded in practice and whether they have delivered the intended improvement. Closure should therefore mean more than sign-off; it should demonstrate that learning has been shared, actions have been completed, impact has been reviewed and those involved understand the outcome.

A stronger PSIRF approach should also help the organisation identify recurring themes and system-wide risks more effectively. By triangulating investigation findings with incident trends, complaints, audit data and staff concerns, we can build a richer understanding of where vulnerabilities exist and where proactive improvement work is required. This supports a shift from reactive response to preventative learning.

During 2026/27, we will review current PSIRF governance arrangements, refresh investigator training, standardise expectations for investigation quality, improve action-tracking processes, strengthen thematic review mechanisms and ensure there is a clear route for sharing learning across all relevant teams and sites. If implemented well, this renewed focus on PSIRF will support a more mature safety culture, improve organisational insight and provide more credible assurance that incidents are responded to in a way that is thorough, compassionate and genuinely improvement-focused.

- Ensure incidents are identified, escalated and triaged appropriately.
- Provide trained investigators, clear terms of reference and effective quality assurance.
- Share learning across teams and sites through practical and accessible mechanisms.
- Assign actions to named leads with deadlines and track them through governance processes.
- Review whether actions have been embedded and whether they have delivered improvement.

Improving Capacity and Patient Flow within the Ambulatory Unit

This priority is focused on strengthening the capacity, flow and operational effectiveness of the Ambulatory Unit in order to support the safe and timely assessment, treatment and discharge of patients who can be managed without admission. Ambulatory care enables patients to receive appropriate clinical intervention on the same day, reducing unnecessary inpatient admissions and ensuring that care is delivered in the most appropriate setting. Improving capacity within the Ambulatory Unit is therefore essential to maintaining responsive, efficient and patient-centred services in the context of increasing demand.

This priority has been identified through review of service demand, patient flow, operational performance and engagement with clinical and operational stakeholders. Ongoing pressure on urgent and same-day care pathways has reinforced the need to maximise the effective use of ambulatory services, reduce avoidable delays and improve patient throughput where clinically appropriate. It also aligns with wider NHS and system objectives relating to admission avoidance, timely access to care, effective use of available capacity and the delivery of high-quality care closer to patients' needs.

During 2026/27, the hospital will aim to increase the number of patients managed safely through the Ambulatory Unit, while reducing delays in assessment, treatment and discharge and improving patient feedback in relation to timeliness, coordination and overall experience of care. To support this, we will undertake a review of current Ambulatory Unit activity, patient pathways, referral criteria and operational capacity in order to identify opportunities to increase throughput safely and effectively.

This work will include consideration of staffing models, utilisation of clinic capacity, access to diagnostics, internal processes and opening arrangements where appropriate. We will work collaboratively across clinical and operational teams to improve the timely identification of patients suitable for ambulatory care, reduce avoidable delays and strengthen coordination between services involved in the patient pathway. Escalation arrangements during periods of increased demand will also be reviewed to support safe and effective patient flow.

Progress will be monitored through routine performance and quality metrics, including the number of patients managed through the Ambulatory Unit, same-day discharge rates, conversion to inpatient admission, length of stay within the unit, turnaround times and reasons for delay. This will be supported by review of patient feedback, incident data and service utilisation information to ensure that increased capacity is delivered in a safe, sustainable and patient-centred way. Progress against this priority will be reported through relevant operational performance meetings, clinical governance forums and quality committees, with regular review of performance, risks and improvement actions and updates provided through routine quality and performance reporting, including the annual Quality Account.

- Review current activity, referral criteria and patient pathways to identify opportunities for safe increase in throughput.
- Optimise staffing models, clinic capacity, diagnostics access and internal processes.
- Improve timely identification of patients suitable for ambulatory care.
- Reduce avoidable delays and strengthen coordination across the patient pathway.
- Monitor performance through flow, discharge, admission conversion and patient feedback metrics.

Across all priorities, progress will be overseen through the organisation's established governance framework, with involvement from clinical teams, operational leaders and relevant stakeholders. This will help ensure that improvement activity remains focused, measurable and aligned to both local needs and national expectations throughout 2026/27. By maintaining clear oversight, strong leadership and regular review of impact, the organisation will be well placed to demonstrate meaningful progress against its clinical priorities and continued commitment to safe, effective and compassionate care.

2.2 Mandatory Statements

The following section contains the mandatory statements common to all Quality Accounts as required by the regulations set out by the Department of Health.

2.2.1 Review of Services

During 2025/26 Buckshaw Hospital provided 9 ERS NHS Services and 5 subcontracted services.

Buckshaw Hospital has reviewed all the data available to them on the quality of care in all 9 of these NHS services.

The income generated by the NHS services reviewed in 1 April 2025 to 31st March 2026 represents 112.39% per cent of the total income generated from the provision of NHS services by Buckshaw Hospital for 1 April 2025 to 31st March 2026.

Ramsay uses a balanced scorecard approach to give an overview of audit results across the critical areas of patient care. The indicators on the Ramsay scorecard are reviewed each year. The scorecard is reviewed each quarter by the hospital's Senior Leadership Team together with Corporate Senior Managers and Directors. The balanced scorecard approach has been an extremely successful tool in helping us benchmark against other hospitals and identifying key areas for improvement.

In the period for 2025/26, the indicators on the scorecard which affect patient safety and quality were:

Indicator	**2025-26**
Staff Cost % Net Revenue	38.86%
HCA Hours as % of Total Nursing	29%
Agency Cost as % of Total Staff Cost	4.64%
Ward Hours PPD	1.52
% Staff Turnover	14.29%

% Sickness	7.3%
% Lost Time	13.01%
Appraisal %	82%
Mandatory Training	95%
Number of Significant Staff Injuries	0
Formal Complaints per 1000 HPD's	1.62
Patient Satisfaction Score	72%
Significant Clinical Events per 1000 Admissions	0.27
Readmission per 1000 Admissions	0.13
Workplace Health & Safety Score	96.1%
Infection Control Audit Score	96.4%
Consultant Satisfaction Score	73%

2.2.2 Participation in clinical audit

During 1 April 2025 to 31st March 2026 Buckshaw Hospital participated in a number of national clinical audits, these audits are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of Audit	Participation	% of Cases Submitted
Elective Surgery (National PROMs Programme)Septoplasty	YES	Over 70%
Serious Hazards of Transfusion Scheme (SHOT)	YES	0
JAG Census Quarterly	YES	100%

The Clinical Governance Committee has conducted an in-depth review of the national clinical audit reports for the period from 1 April 2025 to 31 March 2026. This thorough evaluation has enabled the hospital to identify specific areas for improvement and to formulate targeted action plans aimed at enhancing the quality of healthcare services provided to our patients.

Our hospital is unwavering their commitment to maintaining the highest standards of clinical governance. As part of this ongoing dedication, we will place a strong emphasis on refining the quality and completeness of our clinical data, recognising that robust and accurate information forms the foundation for effective decision-making and quality improvement initiatives.

Furthermore, over the coming year, we will continue to actively promote and facilitate increased participation in Patient Reported Outcome Measures (PROMs) across our hospitals. By systematically gathering and integrating patients' feedback and experiences, we will ensure that their perspectives directly inform the evolution and enhancement of surgical care and outcomes. This patient-centered approach will be complemented by regular monitoring, staff training, and collaborative efforts to drive continuous improvement. Through these initiatives, we aim to foster a culture of excellence, accountability, and transparency in all aspects of our healthcare provision.

Local Audits

Buckshaw Hospital participates in the Ramsay Corporate Audit Programme, as outlined in Appendix 2. This programme is developed and coordinated by the organisation's Corporate Clinical Governance Team and provides a structured framework for reviewing compliance, safety, quality, and effectiveness across Ramsay sites. The corporate audit schedule supports consistency in monitoring key standards and offers hospitals the opportunity to benchmark performance against other sites within the organisation. This enables the hospital to identify good practice, recognise areas requiring improvement, and implement actions to strengthen quality assurance and patient safety. Participation in the corporate programme also provides assurance that the hospital is meeting internal governance expectations, regulatory requirements, and nationally recognised standards of care.

Alongside the corporate programme, Buckshaw Hospital also undertakes a range of locally determined audits. These local audits are important in providing more focused assurance on specific areas of practice relevant to the services delivered within the hospital. They support the continuous monitoring of clinical processes, the identification of risks, and the evaluation of whether policies, procedures, and standards are followed consistently in everyday practice. Local audit findings also help to inform quality improvement of activity, support learning, and

ensure that actions can be implemented where any gaps or trends are identified. The outcomes of these audits are reported through the Clinical Governance Committee, where they are reviewed to provide oversight, monitor compliance, and agree on any further actions required.

Examples of local audits completed between April 2025 and March 2026 include:

Emergency Trolley Audit

This audit is undertaken to ensure that emergency trolleys are maintained in a state of immediate readiness for use in the event of a clinical emergency. It reviews whether required equipment and medications are present, correctly stored, within expiry date, and checked in accordance with local policy. The audit also provides assurance that emergency equipment is accessible, complete, and fit for purpose, thereby supporting a prompt and safe response to patient deterioration or resuscitation events.

Crash Bleep Response Audit

This audit assesses the effectiveness of the hospital's emergency response arrangements by reviewing the timeliness and appropriateness of staff attendance following activation of the crash bleep system. It helps determine whether escalation processes are functioning as intended and whether staff are responding in line with expected standards. The audit is important in providing assurance that emergency calls are managed efficiently and that there is an effective coordinated response to urgent clinical situations.

Blood Transfusion Audit

This audit reviews compliance with local policy and national best practice in relation to the transfusion process. It may include assessment of prescription, patient identification, consent where applicable, documentation, administration, monitoring, and traceability. The purpose of the audit is to ensure that blood transfusions are carried out safely, correctly, and consistently, minimising risks to patients and supporting compliance with clinical and regulatory standards. It also helps identify any learning or improvement actions required to strengthen transfusion safety practices.

2.2.3 Participation in Research

There were no patients recruited during 2025/26 to participate in research approved by a research ethics committee.

2.2.4 Goals agreed with our Commissioners using the CQUIN (Commissioning for Quality and Innovation) Framework

Buckshaw Hospital's income from 1 April 2025 to 31st March 2026 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

2.2.5 Statements from the Care Quality Commission (CQC)

Buckshaw Hospital is required to register with the Care Quality Commission and its current registration status on 31st March 2026 is registered without conditions.

Our current CQC rating of 'Good Overall' is derived from an inspection in April 2023.

In March 2026, the CQC carried out a comprehensive inspection at Buckshaw Hospital. As of the publication of this Quality Account, the updated rating resulting from this inspection has not yet been received. During the inspection, the following positive findings were observed:

- Strong organisational culture
- High levels of staff engagement
- Outstanding standards of cleanliness
- Favourable patient feedback
- Exemplary documentation practices

Throughout the reporting period, Buckshaw Hall Hospital has not been subject to any special reviews or investigations by CQC.

2.2.6 Data Quality

Statement on relevance of Data Quality and your actions to improve your Data Quality

At Buckshaw Hospital, we recognise that high-quality data is essential to safe, effective, and patient-centred care. Data is a vital tool in the clinical and operational decision-making process, which is why we place strong emphasis on ensuring that the information we gather, store, and share is reliable, accurate, and complete.

As an organisation, we are committed to achieving data that is complete, consistent, accurate, and timely. These principles underpin our efforts to support clinical teams in delivering informed care and enable us to measure performance, identify areas for improvement, and uphold regulatory compliance.

Our data validation processes help us maintain these high standards. Regular checks, audits, and staff training ensure that data entry and management are undertaken with accuracy and care. We work in line with GDPR principles, particularly the requirement for data to be accurate and up to date. Where inaccuracies are identified, swift steps are taken to correct or, if necessary, delete data to maintain compliance and protect patient safety.

Data quality directly supports our healthcare professionals, giving them confidence in the information they rely on to make clinical decisions. It also enhances patient trust, as we demonstrate our commitment to protecting both their personal and sensitive information.

Ultimately, better data quality contributes to better outcomes, for patients, for staff, and for the wider organisation. To support our commitment to maintaining and enhancing data quality, Buckshaw Hospital implements the following actions:

- Ongoing improvements to our electronic patient record system (Maxims): Continued updates to Maxims are enhancing the quality and completeness of digital records. While a small number of records remain paper-based, the increased use of electronic data collection ensures greater accuracy and mandatory field completion.
- Staff training and competency: Any employee responsible for scanning patient documents into Maxims undergoes structured training and completes a competency assessment to ensure consistent, high-quality data entry.
- Two-tier document accuracy checks: All scanned documentation is subject to a robust two-tier checking process, which has been externally audited, Buckshaw Hospital strives to meet compliance in these audits, reflecting the diligence and accuracy of our information governance processes.
- Leadership spot checks: Members of the Senior Leadership Team conduct regular spot checks to assess data accuracy and ensure compliance with documentation standards.
- Responsive incident management: Any data quality issues are escalated, investigated, and actioned promptly. Lessons learned are shared across departments, and processes are reviewed to prevent recurrence.
- Information security audits: We have undergone a full internal Information Security Audit, with a clear action plan in place to address any areas for improvement.
- Mandatory e-learning compliance: All staff have completed the Information Security e-learning module, achieving 100% compliance, reinforcing the importance of secure and accurate data handling across the organisation.

By embedding these measures into daily practice, Buckshaw Hospital continues to build a culture of accountability and excellence in data quality, supporting safer care and better outcomes for our patients.

NHS Number and General Medical Practice Code Validity

Buckshaw Hospital submitted records during 2025/26 to the Secondary

Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included:

The patient's valid NHS number:

- Admitted care - 99.69%
- Outpatient Care – 100%
- Accident and Emergency care N/A (not undertaken at our hospital).

The General Medical Practice Code:

- Admitted care – 100%
- Outpatient Care – 100%
- Accident and Emergency care N/A (not undertaken at our hospital).

Information Governance Toolkit attainment levels

Ramsay Health Care UK Operations Ltd status is 'Standards Met'. The 2025/2026 submission is due by 30th June 2026.

This information is publicly available on the DSP website at:
https://www.dsptoolkit.nhs.uk/

Clinical coding error rate

Buckshaw Hospital was subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Hospital Site	NHS Admitted Care Sample 50 Episodes of Care	Primary Diagnosis % Correct	Secondary Diagnosis % Correct	Primary Procedure % Correct	Secondary Procedure % Correct	DSPTK Attainment Level
Buckshaw Hospital	100%	100%	100%	100%	100%	Level 3

Ramsay Health Care DSPT IG Requirement 505 Attainment Levels as of April 2026

2.2.7 Stakeholders views on 2025/26 Quality Account

Re: Lancashire and South Cumbria ICB Response to Buckshaw Hospital Quality Account 2025/26

Lancashire and South Cumbria Integrated Care Board (LSCICB) welcomes the opportunity to review and comment on Buckshaw Hospital's Quality Account for 2026/27. We thank Ramsay Health Care UK for the development of this report and for its continued focus on reflecting on performance, improvement activity, and priorities for the year ahead. The ICB recognises the continued pressures across the healthcare system, including increasing demand, workforce challenges, and financial constraints. Within this context, maintaining a strong focus on quality, safety, and patient experience remains essential. The ICB is committed to working in partnership with providers to ensure the consistent delivery of safe, effective, and person-centred care.

The ICB acknowledges areas of positive performance outlined within the Quality Account. In particular, we recognise the organisation's continued commitment to strengthening safety culture, supporting staff wellbeing, and maintaining robust infection prevention and control practices. Ongoing investment in initiatives that promote openness, staff support, and learning is welcomed and remains fundamental to sustaining safe and effective care. It will be important to continue to evaluate the impact of these initiatives over time.

The organisation's priorities are broadly aligned with system-wide objectives, including improving patient experience, strengthening staff engagement, and enhancing safety processes. This alignment provides a strong basis for collaborative working. The ICB would, however, expect future reporting to more clearly demonstrate how these priorities are translating into measurable improvements in outcomes. Strengthening the link between identified priorities, actions taken, and the impact achieved will be important in providing assurance of progress.

The ICB welcomes the continued focus on capturing and responding to patient feedback, and acknowledges the positive sentiment reported. However, there remains an opportunity to strengthen the breadth and representativeness of patient feedback. Lower response rates can limit the extent to which feedback reflects the full patient cohort and may reduce the ability to identify areas for improvement. The ICB would encourage continued efforts to improve engagement with feedback mechanisms and to demonstrate more clearly how patient insight is influencing service development and improvement. Greater triangulation with other quality indicators would further strengthen assurance in this area.

The ICB notes the monitoring of key safety and clinical indicators and acknowledges the range of actions being taken to address areas of variation. Where increases or changes in performance are identified, it is important that these are supported by robust analysis and that the impact of improvement actions is clearly evidenced. While the interventions described are appropriate, further clarity is required in demonstrating whether these have led to sustained improvements in outcomes. The ICB will continue to seek assurance that:

• Emerging risks are identified and responded to in a timely way

• Improvement actions are clearly defined and monitored

• Progress is evidenced through measurable outcomes over time

Strengthening the focus on impact, rather than activity alone, will be important in this area.

The ICB expects a clear and comprehensive approach to reporting patient safety incidents, learning, and improvement. It is important that Quality Accounts provide a complete and transparent reflection of safety incidents, alongside clear articulation of investigation findings and learning. This supports both public accountability and system-wide learning. The ICB would encourage continued alignment with the Patient Safety Incident Response Framework (PSIRF), ensuring that:

• Reporting reflects current terminology and approaches

• Learning is clearly described

• Evidence is provided demonstrating how learning has been embedded into practice

Further strengthening this area will enhance assurance in the organisation’s governance arrangements.

The ICB recognises the central role of workforce stability, engagement, and wellbeing in delivering high quality care. Where workforce challenges are identified, including turnover or engagement, it is important that these are actively addressed and that the impact of improvement initiatives is clearly demonstrated. The ICB welcomes the focus on staff engagement and looks forward to understanding how this translates into improved workforce stability and experience over time.

The ICB supports the organisation’s focus on key priority areas, including patient experience, staff engagement, and safety. A key area for development in future Quality Accounts will be demonstrating the impact of improvement activity. This includes providing clearer evidence of:
• Measurable improvements in outcomes

• Sustained progress against identified risks

• The link between quality initiatives and patient benefit

This will be important in strengthening assurance and demonstrating continuous improvement.

The ICB values its ongoing partnership with Ramsay Health Care UK and Buckshaw Hospital and remains committed to supporting improvement through robust and constructive engagement. We acknowledge the work involved in producing this Quality Account and its role in supporting transparency, public accountability, and continuous improvement. The ICB looks forward to continuing to work collaboratively with the organisation to ensure the delivery of safe, effective, and high-quality care for all patients.

Yours sincerely

Claire Lewis

Associate Director - Quality Assurance

Part 3: Review of quality performance 2023/24

Head of Clinical Services (Matron), Buckshaw Hospital

Review of quality performance 1st April 2025 - 31st March 2026

As Head of Clinical Services at Buckshaw Hospital, I am proud to reflect on the dedication, professionalism, and compassion shown by our teams each day in delivering safe, effective, and patient-centred care. Patient safety remains at the heart of all we do and underpins every aspect of our clinical practice, decision-making, and service delivery. We are committed to ensuring that every patient receives care in an environment where safety, dignity, kindness, and respect are consistently promoted, and where high standards of clinical care are supported by strong leadership, clear accountability, and a culture of openness and learning.

We know that excellent patient care can only be delivered by colleagues who feel valued, supported, and empowered in their roles. For this reason, staff wellbeing remains a fundamental priority at Buckshaw Hospital. We are committed to fostering a positive, inclusive, and supportive working environment in which staff feel respected, listened to, and confident to speak up, raise concerns, and access help when needed. Through visible leadership, wellbeing initiatives, occupational health support, and access to mental health first aiders, we continue to promote both the physical and psychological wellbeing of our workforce, recognising that a healthy, engaged, and resilient team is essential to the delivery of safe and compassionate care.

We also place significant importance on staff development, education, and continuous professional growth. Ensuring that colleagues have access to the right training, competency assessment, supervision, and development opportunities is essential to maintaining safe, effective, and responsive services. By investing in our people and encouraging reflective practice, shared learning, and continuous improvement, we strengthen both individual capability and the resilience of our services. Patient experience and patient feedback continue to play a vital role in this work, helping us to understand what matters most to those who use our services and informing changes that improve both quality and experience of care. Alongside this, our governance arrangements, including incident reporting, structured review processes, and the development of our Patient Safety Incident Response Framework (PSIRF) approach, support a culture in which learning is embedded and improvement is ongoing. Learning from incidents, audits, patient feedback, and quality improvement activity remains

central to how we review performance, respond to risk, and continue to enhance the care we provide.

I remain continually encouraged by the commitment and pride shown by colleagues across Buckshaw Hospital and by the difference they make to patients every day. Their dedication is the foundation of the high standards we strive to maintain. As we continue to develop our services, we remain focused on strengthening patient safety, improving patient experience, supporting the wellbeing and development of our staff, and fostering a culture of learning, accountability, and continuous improvement. Together, we will continue to ensure that Buckshaw Hospital provides care that is safe, effective, responsive, and centred on the needs of our patients, while also being a place where staff feel supported to thrive and succeed.

Sarah Wakefield

Head of Clinical Services

Buckshaw Hospital

Ramsay Clinical Governance Framework 2025/26

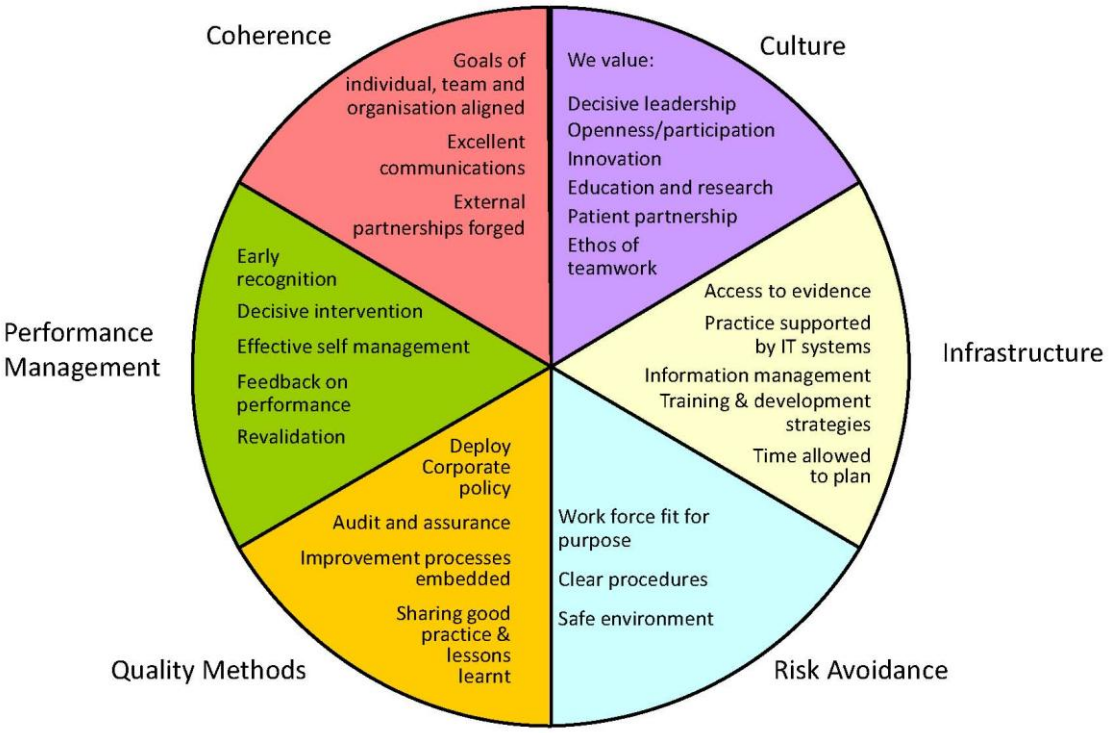
The aim of clinical governance is to ensure that Ramsay develop ways of working which assure that the quality of patient care is central to the business of the organisation.

The emphasis is on providing an environment and culture to support continuous clinical quality improvement so that patients receive safe and effective care, clinicians are enabled to provide that care and the organisation can satisfy itself that we are doing the right things in the right way. It is important that Clinical Governance is integrated into other governance systems in the organisation and should not be seen as a “stand-alone” activity. All management systems, clinical, financial, estates etc, are inter-dependent with actions in one area impacting on others.

Several models have been devised to include all the elements of Clinical Governance to provide a framework for ensuring that it is embedded, implemented and can be monitored in an organisation. In developing this framework for Ramsay Health Care UK we have gone back to the original Scally and Donaldson paper (1998) as we believe that it is a model that allows coverage and inclusion of all the necessary strategies, policies, systems and processes for effective Clinical Governance. The domains of this model are:

- Infrastructure
- Culture
- Quality methods
- Poor performance
- Risk avoidance
- Coherence

Ramsay Health Care Clinical Governance Framework



National Guidance

Ramsay also complies with the recommendations contained in technology appraisals issued by the National Institute for Health and Clinical Excellence (NICE) and Safety Alerts as issued by the NHS Commissioning Board Special Health Authority.

Ramsay has systems in place for scrutinising all national clinical guidance and selecting those that are applicable to our business and thereafter monitoring their implementation.

3.1 The Core Quality Account indicators

Mortality

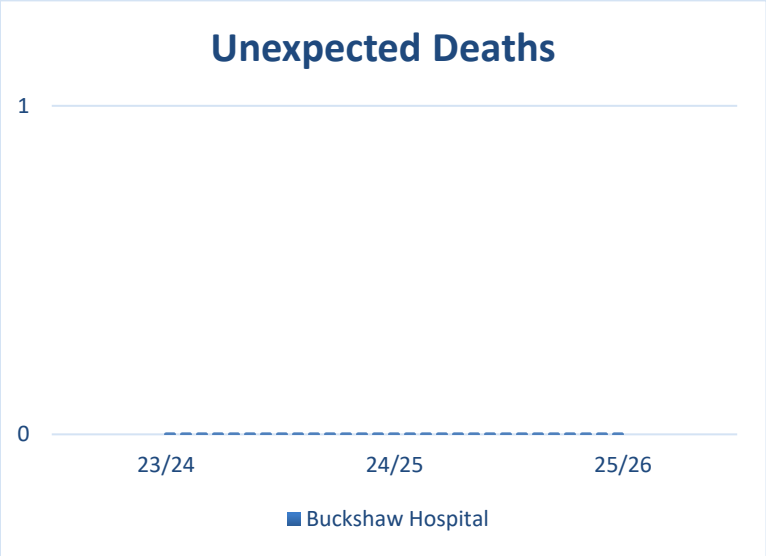
Mortality:	Period	Best		Worst		Average		Period	Buckshaw	
	Nov22 - Oct23	RQM	0.7215	RXP	1.2065	Average	1.0021	23/24	A4M8P	0.0000
	Nov23 - Oct24	RQM	0.6967	RXR	1.2985	Average	1.0036	24/25	A4M8P	0.0000
	Nov24 - Oct25	RYJ	0.7194	RXL	1.3183	Average	1.0092	25/26	A4M8P	0.0000

SHMI Figures are not available for Independent Sector Hospitals

Publication Date: 14 Mar 2024

Publication Date: 13 Mar 2025

Publication Date: 9 Apr 2026



Rate per 100 discharges.

Buckshaw Hospital considers the data reported during this period to be accurate for the following reasons:

There have been no unexpected deaths at Buckshaw Hospital within this reporting period.

National PROMs

Buckshaw Hospital actively participates in the Department of Health's Patient Reported Outcome Measures (PROMs) survey for Septoplasty procedures, encompassing both NHS and private patients. PROMs assess a patient's health status or health-related quality of life from the patient's own perspective. This is achieved through questionnaires completed both before and after surgery, providing valuable insight into the effectiveness of the care received. By measuring outcomes that matter most to patients, PROMs serve as a vital tool in evaluating the extent of health improvement following illness or injury. The hospital's engagement in this national programme reflects its ongoing commitment to quality assurance, transparency, and continuous improvement in patient care.

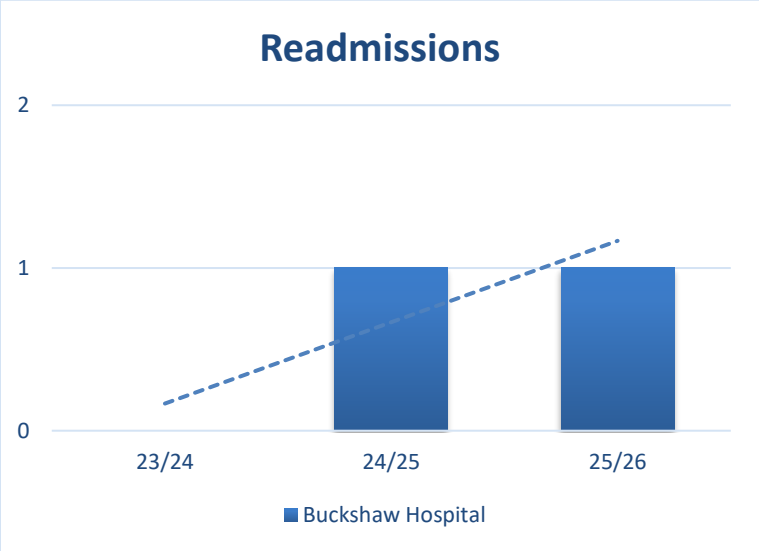
Readmissions within 28 days

Readmissions:	Period	Best		Worst		Average		Period	Buckshaw	
	20/21	N/A	N/A	N/A	N/A	Eng	15.5	23/24	A4M8P	0.00000
	23/24	N/A	N/A	N/A	N/A	Eng	14.2	24/25	A4M8P	0.00015
	24/25	N/A	N/A	N/A	N/A	Eng	14.7	25/26	A4M8P	0.00015

Publication Date: 17 Mar 2022

Publication date: 26 November 2024

Publication Date: 27 Nov 2025

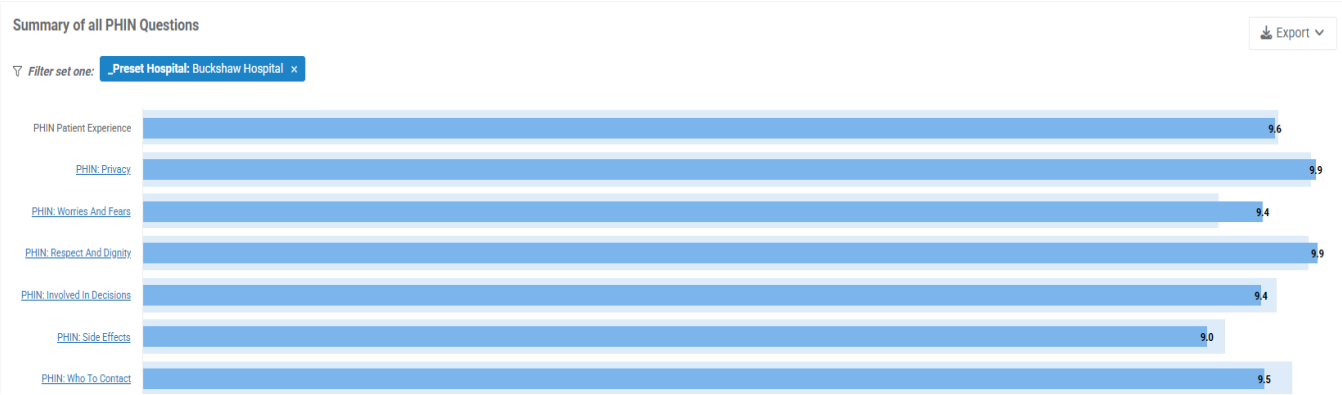


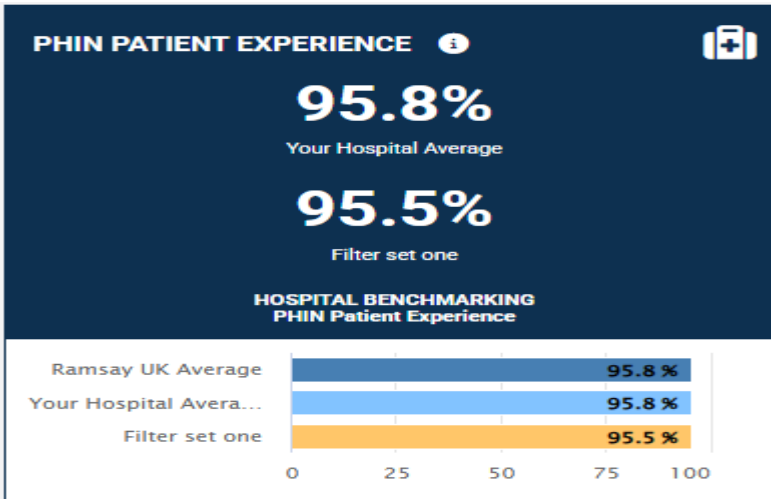
Rate per 100 discharges.

Upon review, it is confirmed that there has been no increase in the rate over the past 12 months, and the rate remains unchanged for this period. However, during the 2024/2025

reporting period, Buckshaw Hospital recorded a rise in hospital readmissions. Although readmissions are typically seen as a negative indicator, in this instance the increase is attributed to heightened clinical vigilance and the introduction of targeted initiatives designed to improve patient care, discharge planning, and post-operative follow-up. These measures have enabled the earlier detection of potential complications, resulting in prompt and appropriate readmissions as needed to support patient recovery and safety. The hospital continues to monitor and analyse readmission data, using the insights gained to refine care pathways and ensure the highest standards of continuity and quality in patient care.

Responsiveness to Personal Needs





F&F Test:	Period	Best		Worst		Average		Period	Buckshaw	
	Jan-24	Several	100%	RTK	74.0%	Eng	94.0%	Jan-24	A4M8P	*
	Jan-25	Several	100%	RL4	71.0%	Eng	95.0%	Jan-25	A4M8P	100.0%
	Jan-26	Several	100%	RTK	74.0%	Eng	95.0%	Jan-26	A4M8P	100.0%

Buckshaw Hospital considers that the data presented is accurate and reflective of patient feedback for the following reasons:

In addition to delivering safe and effective care, overall patient experience remains a core measure of quality at Buckshaw Hospital. Feedback received through the Friends and Family Test (FFT) plays a vital role in shaping the development of our services, ensuring they are responsive to the needs and expectations of our patients.

We actively use insights gained from patient surveys to inform service improvements and enhance the quality of care delivered. Patient comments and ratings are regularly reviewed and discussed as part of our governance processes, with changes implemented where necessary to support continuous improvement.

Buckshaw Hospital continues to score above the UK average, as shown in the table above, where patients were asked whether they would recommend the care and treatment received at the hospital. Our commitment to delivering a high standard of care is reflected in these results, with Buckshaw Hospital achieving a score of 100% for two consecutive years.

VTE Risk Assessment

VTE Assessment:	Period	Best		Worst		Average		Period	Buckshaw	
	Q1 to Q3 19/20	Several	100%	RXL	71.8%	Eng	95.5%	Q1 to Q3 19/20	A4M8P	N/A
	Q3 24/25	Several	100%	RCB	13.7%	Eng	90.3%	Q3 24/25	A4M8P	45.8%
	Q1 to Q3 25/26	Several	100%	NVC0Y	3.08%	Eng	91.3%	Q1 to Q3 25/26	A4M8P	88.3%

Due to Covid this submission was paused. There is no data published after Q3 19/20

VTE risk assessment 2024/25 has been reinstated and is ongoing until further notice. The latest published quarters provide the most accurate and current position

Buckshaw Hospital considers that this data demonstrates VTE performance has improved significantly, increasing from 45.8% last year to 88.3% this year. This is a substantial improvement of 42.5 percentage points, which shows that the actions already taken are having a positive impact. However, despite this progress, performance remains below the average of 91.3%, leaving a further gap to close.

Improving VTE compliance is essential because it is directly linked to patient safety and quality of care. Consistently completing VTE assessments helps ensure that patients at risk of thrombosis are identified early and receive appropriate preventative treatment. Performance below the benchmark suggests that some patients may not be assessed in a timely or consistent way, which increases clinical risk and may also affect compliance with national standards and internal quality targets.

The rise from 45.8% to 88.3% reflects:

- Greater staff awareness of the importance of VTE assessment
- Improved oversight and monitoring
- Better compliance with admission and documentation processes
- Increased focus from clinical leaders and ward teams

To close the remaining gap and move above the average, the following actions could help:

- Strengthen real-time monitoring so missed assessments are identified and acted on promptly
- Provide targeted feedback to wards, teams, or individuals where compliance is lower
- Embed VTE checks into daily safety huddles or handovers
- Review patient pathways to identify where assessments are being missed or delayed
- Ensure staff training and reminders are ongoing, particularly for new starters or rotating staff
- Use audits and spot checks to reinforce accountability and track progress
- Share good practice from areas that are consistently achieving strong compliance

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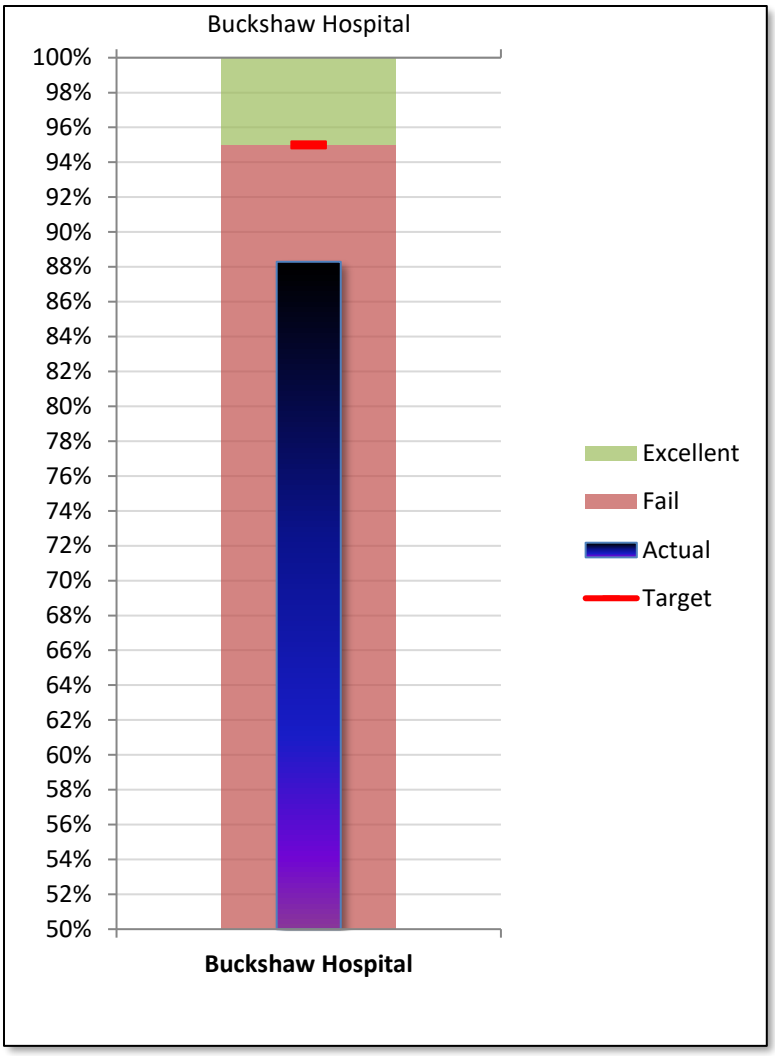


Source: https://www.england.nhs.uk/statistics/statistical-work-areas/vte/
The mandatory data collection started in June 2010; it was paused during the pandemic and following a consultation process, has been reinstated and is ongoing until further notice.

C difficile infection

C. Diff rate:	Period	Best		Worst		Average		Period	Buckshaw	
	2021/22	Several	0	RPY	54.0	Eng	16.0	2023/24	A4M8P	0.0000
	2023/24	Several	0	RPY	56.6	Eng	18.8	2024/25	A4M8P	0.0000
	2024/25	RQ3	2	RPY	81.0	Eng	23.0	2025/26	A4M8P	0.0000

Buckshaw Hospital considers that this data is as described for the following

reasons:
There has been no incidence of C. Diff infections at Buckshaw Hospital during this period. The absence of any C. difficile incidents within our hospital is a positive reflection of the strength of our infection prevention and control arrangements. This has been supported by the presence of a dedicated Infection Prevention and Control Lead Nurse (IPCLN), regular local IPC committee meetings with oversight and challenge from a Consultant Microbiologist, and clear governance processes that ensure risks are identified and addressed promptly. In addition, staff are supported to undertake mandatory and NMAHP training, with effective systems in place for education, auditing, and monitoring compliance. Clear roles and responsibilities across teams help to maintain high standards of practice and reduce the risk of lapses in care, all of which contribute to sustaining a safe environment for patients and staff.

Patient Safety Incidents with Harm

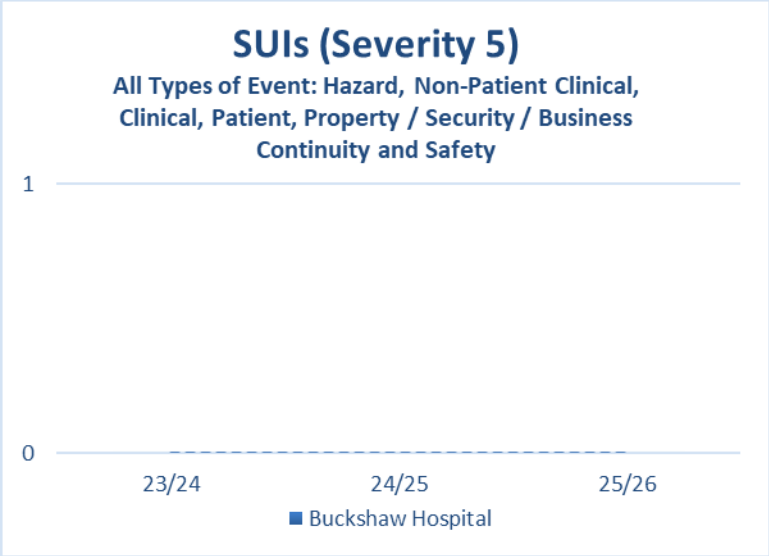
SUIs:	Period	Best		Worst		Average	
	2022/23	N/A	N/A	N/A	N/A	N/A	N/A
	2023/24	N/A	N/A	N/A	N/A	N/A	N/A
	2024/25	N/A	N/A	N/A	N/A	N/A	N/A

Period	Buckshaw	
2023/24	A4M8P	0.0000
2024/25	A4M8P	0.0000
2025/26	A4M8P	0.0000

September 2023 update: We have paused the annual publishing of this data while we consider future publications

There is no nationally published data for LFPSE at present (Ramsay went live in November 23)

There is no nationally published data for LFPSE at present (Ramsay went live in November 23)



The number of Serious Untoward Incidents (SUIs) categorised as Severity 5 has remained unchanged for Buckshaw Hospital during the reporting period. The data indicates that

Buckshaw Hospital continues to demonstrate strong standards in patient safety and staff protection, with no serious untoward incidents reported between April 2025 and March 2026. This reflects the effectiveness of the hospital's governance, risk management, and safety processes, as well as the ongoing commitment of staff to maintaining a safe clinical environment. Sustaining this position will require continued vigilance, robust reporting arrangements, and a proactive approach to identifying and mitigating potential risks.

3.2 Patient safety

We are a progressive hospital and are focussed on stretching our performance every year in all performance respects, and certainly in regard to our track record for patient safety.

Risks to patient safety come to light through several routes including routine audit, complaints, litigation, adverse incident reporting and raising concerns but more routinely from tracking trends in performance indicators.

Buckshaw Hospital holds bi-weekly Patient Safety Incident Review Group (PSIRG) meetings as part of its commitment to maintaining a strong patient safety culture and ensuring robust oversight of incidents, concerns, and emerging risks. These meetings provide a formal forum for the timely review of patient safety events, enabling themes, trends, and individual incidents to be considered in a structured and multidisciplinary way. The purpose of the PSIRG is to ensure that incidents are reviewed proportionately, that the level of investigation is appropriate, and that learning is identified and translated into meaningful improvement. Discussion within the meeting typically includes reported incidents, harm grading, potential Serious Untoward Incidents, Duty of Candour requirements, investigation progress, contributory factors, immediate actions taken, and opportunities for wider organisational learning. The group also considers whether further escalation, specialist input, or support is required, and monitors the completion of actions to ensure that recommendations are implemented and sustained. Holding these meetings on a bi-weekly basis supports prompt scrutiny of incidents, strengthens governance arrangements, and helps ensure that concerns are not only responded to quickly but also used proactively to reduce recurrence and improve the quality and safety of care. Learning and outcomes from the PSIRG are shared through established governance routes, including feedback to relevant clinical teams, divisional or departmental meetings, safety briefings, and escalation through quality and governance committees where required. This process helps to ensure that learning is disseminated appropriately, staff remain informed of key issues and actions, and the organisation continues to build an open, transparent, and improvement-focused approach to patient safety.

Our focus on patient safety has resulted in a marked improvement in several key indicators as illustrated in the graphs below.

3.2.1 Infection prevention and control

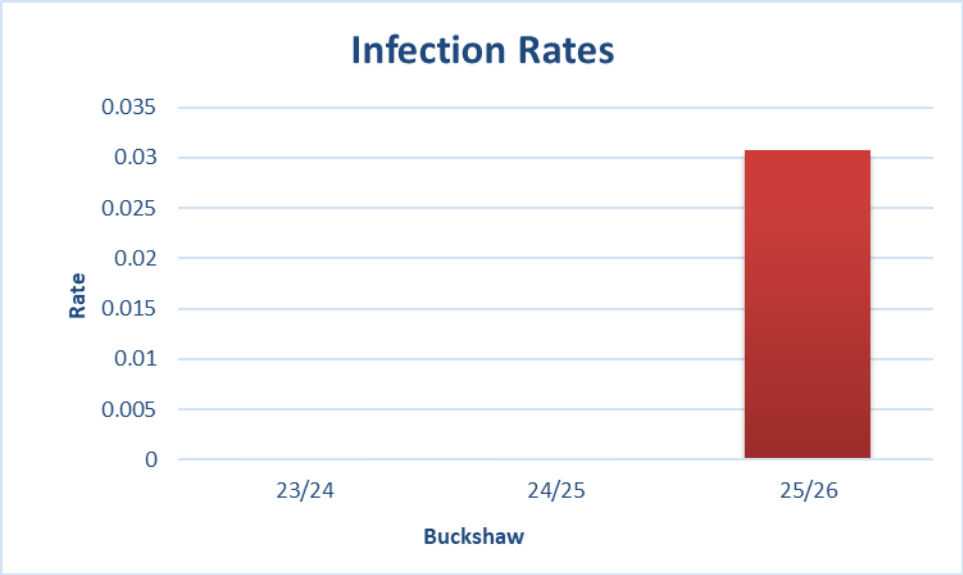
Buckshaw Hospital has a very low rate of hospital acquired infection and has had no reported MRSA Bacteraemia over the years.

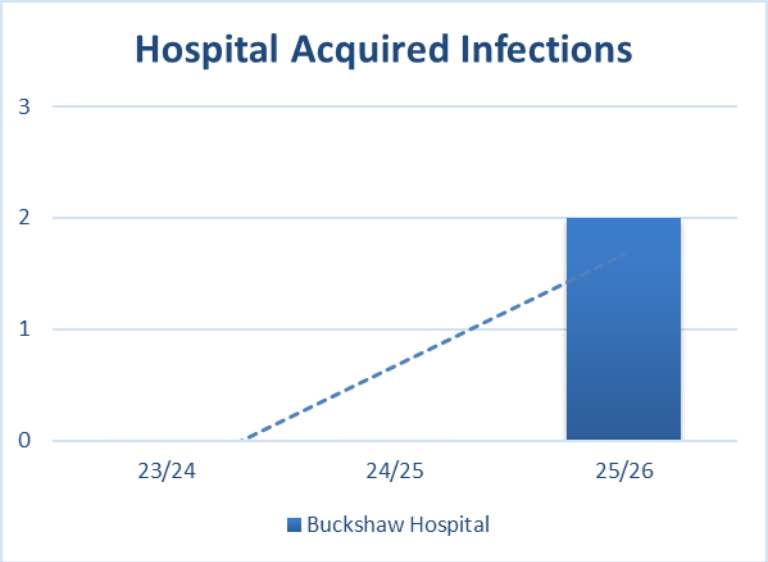
We comply with mandatory reporting of all Alert organisms including MSSA/MRSA Bacteraemia and Clostridium Difficile infections with a programme to reduce incidents year on year.

Ramsay participates in mandatory surveillance of surgical site infections for orthopaedic joint surgery and these are also monitored.

Infection Prevention and Control management is very active within our hospital. An annual strategy is developed by a Corporate level Infection Prevention and Control (IPC) Committee and group policy is revised and re-deployed every two years. Our IPC programmes are designed to bring about improvements in performance and in practice year on year.

A network of specialist nurses and infection control link nurses operate across the Ramsay organisation to support good networking and clinical practice.





Rate per 100 discharges.

Buckshaw Hospital has identified an increase in infection rates during 2025/26 and has strengthened its Infection Prevention and Control (IPC) arrangements through a focused programme of enhanced audit, visible leadership, staff education, and continuous improvement in clinical practice.

A key focus has been the introduction of more targeted and structured IPC audits, enabling us to monitor compliance more effectively, identify areas for improvement, and provide greater assurance around standards of cleanliness, aseptic practice, hand hygiene, and environmental safety. These audits have supported earlier identification of risks and have helped teams take timely action to improve compliance and embed best practice.
We have also strengthened local IPC leadership through dedicated Infection Prevention and Control Link Nurse (IPCLN), who provides visible support within clinical areas and help promote good practice at ward and departmental level. The IPCLN plays an important role in reinforcing standards, supporting peer-to-peer learning, escalating concerns, and acting as a champion for IPC within the clinical teams. This has helped improve engagement and ownership of infection prevention measures across the hospital.
In addition, new wound care pathways have been introduced to support a more consistent and evidence-based approach to wound management. These pathways have helped standardise practice, improve documentation, support timely intervention, and reduce variation in care. By

strengthening wound care processes, we have further supported the prevention of avoidable infection and improved the overall quality and safety of patient care.
Targeted IPC training has also been delivered to staff to address specific areas of risk and reinforce expected standards in practice. This has included focused education in key topics such as hand hygiene, aseptic technique, use of personal protective equipment, environmental cleaning, and the prevention and management of healthcare-associated infections. By providing training that is responsive to local need and informed by audit findings, incidents, and emerging priorities, we have continued to build staff knowledge, confidence, and accountability in relation to IPC.
Collectively, these improvements have strengthened our IPC framework and demonstrate our continued commitment to reducing infection risk, supporting staff to work safely, and ensuring that patients receive care in a clean, safe, and high-quality environment.

Programmes and activities within our hospital include:

During 2025/2026, Buckshaw Hospital has continued to prioritise infection prevention through active participation in the UK Health Security Agency's (formerly Public Health England) *Surveillance of Surgical Site Infections Programme*. In line with national requirements, data collection has focused on patients undergoing hip and knee replacement surgery, enabling continuous monitoring and targeted action to minimise post-operative wound infections.

Buckshaw Hospital recognises that infection prevention and control (IPC) is a fundamental component of effective risk management and high-quality healthcare delivery. A robust IPC programme not only enhances patient safety by preventing healthcare-associated infections (HCAIs) but also promotes staff well-being and ensures regulatory compliance.

A clearly defined team is responsible for infection prevention and control, with established lines of accountability across all departments. Oversight and governance are embedded at every level to ensure a consistent, proactive approach to infection risk reduction.

The Head of Clinical Services (Matron) holds overall responsibility for reporting infection outbreaks, Serious Untoward Incidents (SUIs), and progress against the annual IPC plan. These updates are formally reported to the Group Infection Prevention Lead for HCAIs, maintaining organisational transparency and alignment with national and group standards.

A Consultant Microbiologist, works in partnership with the Matron and the Infection Control Lead Nurse (ICLN) to support the implementation of the annual IPC plan. In addition to providing expert microbiological guidance, the Consultant Microbiologist contributes to staff education and ensures that microbiology services align with the hospital's infection prevention objectives.

The Infection Control Lead Nurse plays a central role in operationalising the IPC plan. Responsibilities include delivering training across all staff groups, conducting infection control audits, developing and reviewing standard operating procedures (SOPs), conducting surveillance of alert organisms, and performing root cause analyses (RCAs) following infection incidents. The ICLN also provides daily support and advice on infection prevention matters.

Departmental Infection Prevention Link Practitioners serve as frontline champions for IPC within their respective areas. These individuals conduct engagement audits (covering hand hygiene, medical devices, and environmental assurance), model best practice, and act as key liaisons between their teams and the central IPC leadership.

The hospital's Pharmacy Manager also serves as the Antimicrobial Pharmacist and Guardian. This role is pivotal to supporting antimicrobial stewardship across the hospital. Responsibilities include leading audits on antibiotic prescribing, training clinical teams on antimicrobial best practices, and working closely with the Consultant Microbiologist to develop and monitor antimicrobial policies in line with national guidance.

Together, this multi-disciplinary team ensures that infection prevention and control remains a visible, integral part of daily practice at Buckshaw Hospital. Continuous surveillance, staff engagement, education, and governance are cornerstones of the hospital's approach to minimising the risk of HCAIs and safeguarding both patients and staff.

As part of our commitment to maintaining best practice standards, we are proud to have achieved ANTT (Aseptic Non Touch Technique) Bronze Accreditation. This recognition reflects our adherence to nationally recognised aseptic technique protocols and demonstrates the high level of training, compliance, and clinical practice maintained by our staff.

These combined measures highlight Buckshaw Hospital's continued dedication to delivering safe, high-quality surgical care and upholding the highest standards in infection prevention and control.

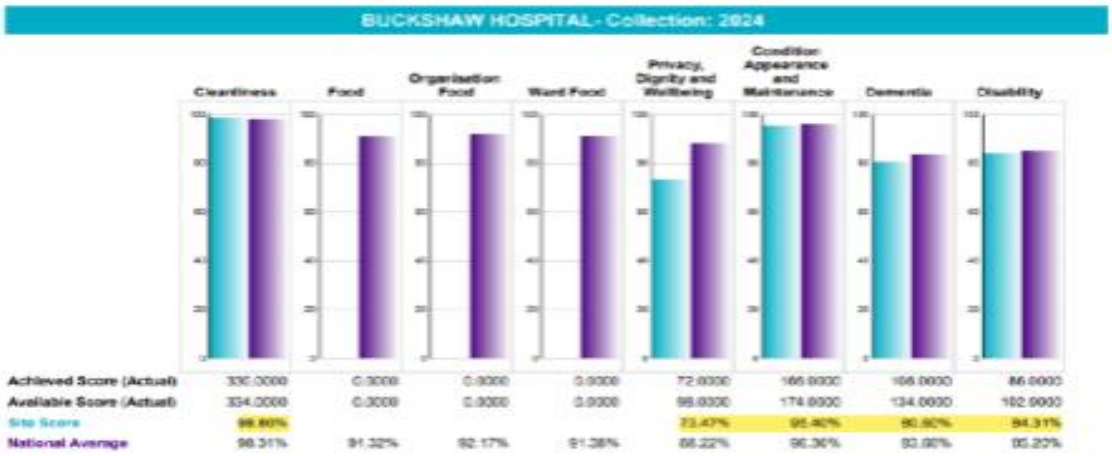
3.2.2 Cleanliness and hospital hygiene

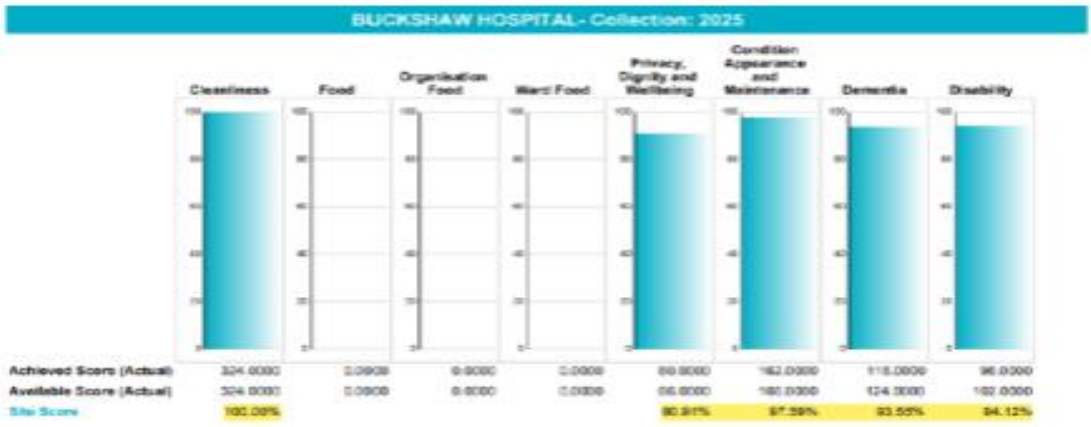
Assessments of safe healthcare environments also include **P**atient-**L**ed **A**ssessments of the **C**are **E**nvironment (**PLACE**)

PLACE assessments occur annually at Buckshaw Hospital, providing us with a patient's eye view of the buildings, facilities and food we offer, giving us a clear picture of how the people who use our hospital see it and how it can be improved.

The primary purpose of a PLACE assessment is to capture the patient perspective on the environment in which care is delivered, with a particular focus on aspects that matter most to patients, including cleanliness, privacy, dignity, food, disability access, and the suitability of the environment for those living with dementia. The PLACE Audit for Buckshaw Hospital was

completed in November 2025 and demonstrates a very positive outcome. Compared with the 2024 audit, the overall site score improved from 98.8% to 100%, reflecting continued commitment to maintaining a high-quality care environment. Notable improvements were also seen across a number of key domains, including a 23.8% increase in Privacy, Dignity and Wellbeing, a 7% improvement in the Dementia-friendly environment, and a 10% improvement in Disability Access. These results provide assurance that Buckshaw Hospital continues to respond positively to patient feedback and is committed to enhancing the care environment to ensure it is safe, inclusive, respectful, and supportive of patient needs.





During 2025/26, Buckshaw Hospital was also proud to receive Gold standard CAP accreditation for Housekeeping Services following an unannounced Continuous Advanced Programme assessment. This achievement provides important assurance that high standards of environmental cleanliness are being maintained consistently across the hospital and reflects the professionalism, attention to detail and commitment of the housekeeping team in supporting the delivery of safe care. The award is particularly significant from an infection prevention and patient safety perspective, as a clean and well-managed clinical environment is fundamental to reducing the risk of avoidable harm, preventing healthcare-associated infection and maintaining patient confidence in the safety and quality of services. It also demonstrates that the organisation recognises the vital contribution of non-clinical teams to patient safety and quality outcomes, and that standards of cleanliness, monitoring and operational discipline are embedded across the patient pathway. This accreditation is therefore not only a positive recognition of housekeeping excellence, but also an important reflection of the hospital's wider commitment to infection prevention, safety assurance and the delivery of high-quality care.

3.2.3 Safety in the workplace

Safety hazards in hospitals are diverse ranging from the risk of slip, trip or fall to incidents around sharps and needles. As a result, ensuring our staff have high awareness of safety has been a foundation for our overall risk management programme and this awareness then naturally extends to safeguarding patient safety. Our record in workplace safety as illustrated by Accidents per 1000 Admissions demonstrates the results of safety training and local safety initiatives.

Effective and ongoing communication of key safety messages is important in healthcare. Multiple updates relating to drugs and equipment are received every month and these are sent in a timely way via an electronic system called the Ramsay Central Alert System (CAS). Safety alerts, medicine / device recalls and new and revised policies are cascaded in this way to our Hospital Director which ensures we keep up to date with all safety issues.

At Buckshaw Hospital, ensuring a safe and supportive working environment is a core priority. A comprehensive range of structured measures is in place to promote workplace safety and to ensure that staff feel supported and confident in delivering care within a secure, well-governed, and professionally managed environment.

Health and Safety Committee:

The Health and Safety Committee provides formal oversight of all aspects of workplace safety across the hospital. It meets regularly to review incidents, monitor compliance, consider emerging risks, and oversee the implementation of actions designed to strengthen safety arrangements. Through this process, the committee supports continuous improvement and helps ensure that health and safety remains a visible and embedded priority throughout the organisation.

Governance Coordinator:

The Governance Coordinator plays an important role in supporting compliance, assurance, and oversight within the hospital's wider clinical governance framework. This includes coordinating reporting processes, supporting risk management systems, monitoring actions arising from incidents and audits, and helping to ensure that governance arrangements remain robust, effective, and responsive to organisational need.

Central Alerting System (CAS) Alerts Review Process:

A robust and clearly defined process is in place to review, action, and monitor safety alerts issued through the national Central Alerting System (CAS). Alerts are assessed promptly,

allocated to the appropriate leads, and tracked through to completion to ensure timely compliance with national safety requirements. This process supports assurance that critical safety information is acted upon effectively and embedded into practice where required.

Occupational Health Nurse:

The Occupational Health Nurse leads on a range of staff health and wellbeing initiatives that contribute directly to workplace safety. This includes monitoring immunisation compliance, supporting fitness for work, providing health advice, and coordinating the annual flu vaccination programme. These arrangements help to protect both staff and patients and support a healthy, resilient workforce.

Incident Reporting Tool:

RADAR is a secure, accessible, and well-established internal incident reporting system that enables all staff to report safety incidents, near misses, and concerns in a timely manner. The organisation actively promotes a positive reporting culture, encouraging openness, transparency, and shared learning rather than blame. This supports early identification of issues, prompt investigation, and meaningful action to reduce the risk of recurrence.

Risk Registers:

Live risk registers are maintained at both departmental and facility level, enabling risks to be identified, assessed, escalated, and monitored in real time. These registers support a proactive approach to risk management by ensuring that current and emerging concerns are clearly documented, reviewed regularly, and linked to mitigation plans and accountable leads.

Departmental Champions:

Designated departmental champions provide local leadership and support compliance with key safety requirements and regulatory standards. This includes areas such as Control of Substances Hazardous to Health (COSHH), Provision and Use of Work Equipment Regulations (PUWER), falls prevention, and Infection Prevention and Control (IPC). Champions help embed good practice within teams, reinforce standards, and act as an important link between policy requirements and day-to-day operational delivery.

Mental Health First Aiders:

Trained Mental Health First Aiders are available across the organisation to offer immediate support, signposting, and reassurance to colleagues who may be experiencing stress, anxiety, or other mental health concerns. This is an important resource, particularly during periods of increased operational pressure, and contributes to a supportive workplace culture in which staff wellbeing is recognised as an essential component of safe and effective care.

Policies and Standard Operating Procedures (SOPs):

A comprehensive suite of policies, procedures, and standard operating documents is in place to provide staff with clear, accessible guidance on how to work safely, consistently, and effectively. These documents set out expected standards, define responsibilities, and support compliance with legal, professional, and organisational requirements. Regular review and updating of this documentation helps ensure that guidance remains current and relevant.

Annual Mandatory Training:

All staff are required to complete annual mandatory training through a combination of face-to-face sessions and e-learning modules. This ensures that knowledge of core safety topics is regularly refreshed and that staff remain informed about current requirements, safe working practices, and organisational expectations. Mandatory training forms an essential part of maintaining a safe working environment and supporting high standards of care.

Annual Competency Reviews:

Clinical staff undertake regular competency assessments to ensure that they have the knowledge, practical skills, and professional capability required to deliver safe, effective, and high-quality care. Competency reviews provide assurance that standards are being maintained and help identify any additional support, supervision, or development needs at an early stage.

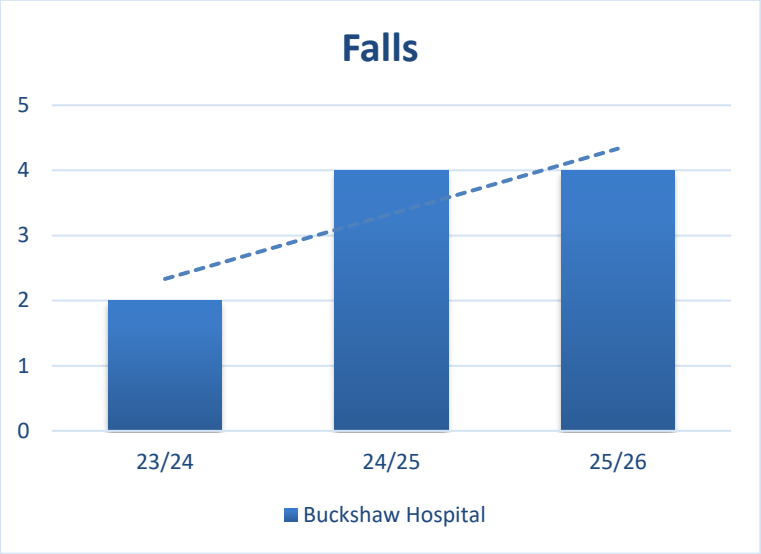
Learning from Incidents:

Whilst these measures provide a strong and well-established foundation for workplace safety, it is recognised that incidents may still occur. Whether incidents affect patients, staff, visitors, or contractors, timely reporting remains essential in order to support learning, improvement, and prevention. All employees are encouraged to report incidents, near misses, and concerns through the internal reporting system so that issues can be reviewed promptly and transparently.

Each reported incident is reviewed and investigated proportionately to identify contributory factors and root causes, determine corrective and preventative actions, and establish whether any additional training, support, or process change is required. Learning arising from incidents is shared through a range of internal communication channels, governance meetings, and team discussions to ensure that improvements are embedded in practice. Where appropriate, this learning is also escalated and shared more widely across the organisation to contribute to broader service development and improvement.

Collectively, these measures reflect the hospital’s ongoing commitment to fostering a culture of safety, openness, accountability, and continuous improvement, ensuring that workplace safety remains central to the delivery of high-quality patient care.

Falls:



Rate per 100 discharges.

As illustrated in the above graph, Buckshaw Hospital's inpatient falls rate remains the same as last year and is now below the national average.

In response to the falls rate increase, the hospital implemented several targeted measures aimed at reducing risk and enhancing the quality of care:

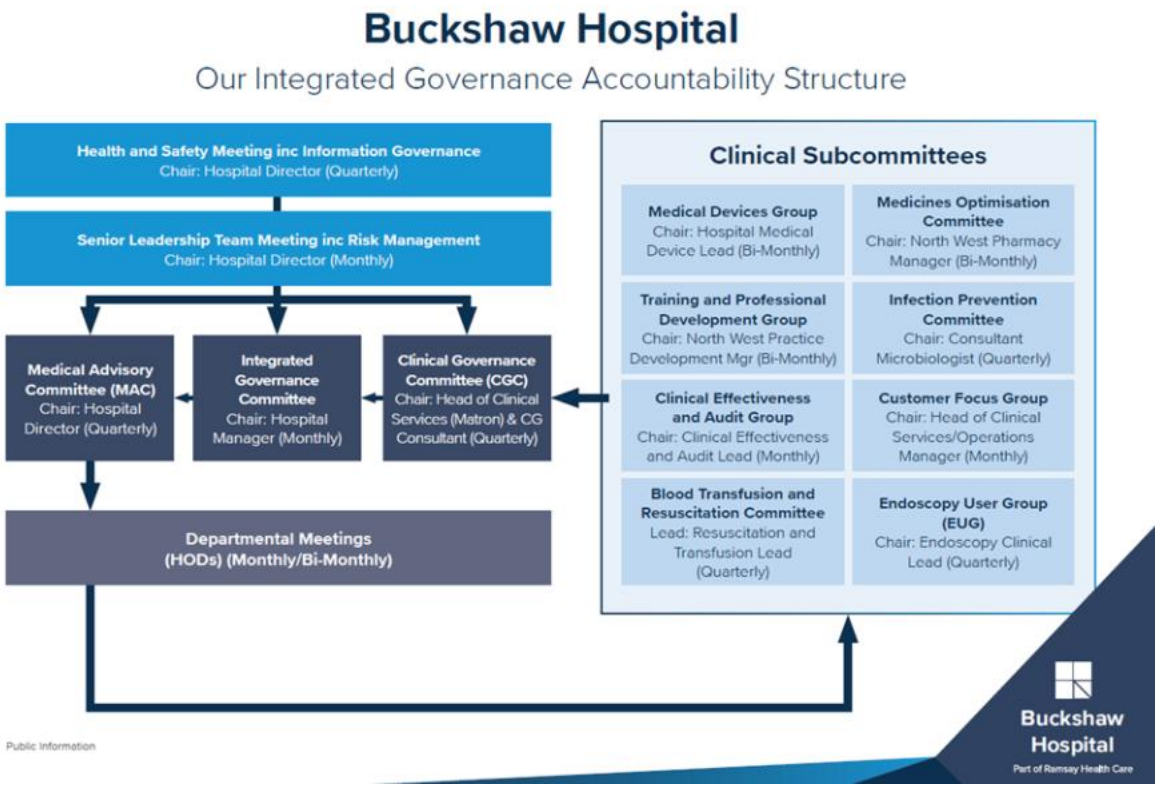
- **Introduction of Falls Mats:**
  Falls mats have been introduced as a preventative safety measure for at-risk patients, helping to minimise harm in the event of a fall.
- **Mandatory Falls Risk Assessments:**
  All patients on the ward now undergo a mandatory falls risk assessment on admission, ensuring early identification and management of potential risk factors.
- **Falls Champions:**
  Designated Falls Champions have been identified within the clinical teams to lead on falls prevention education, promote best practice, and support consistent implementation of safety measures.

In the event of a fall, each incident is reviewed in line with the Patient Safety Incident Response Framework (PSIRF). Where appropriate, a thematic review is conducted to identify common trends or contributing factors, informing further improvements and staff training. These initiatives demonstrate Buckshaw Hospital's commitment to continuous learning and safety improvement, ensuring that patient well-being remains at the heart of clinical practice.

3.3 Clinical effectiveness

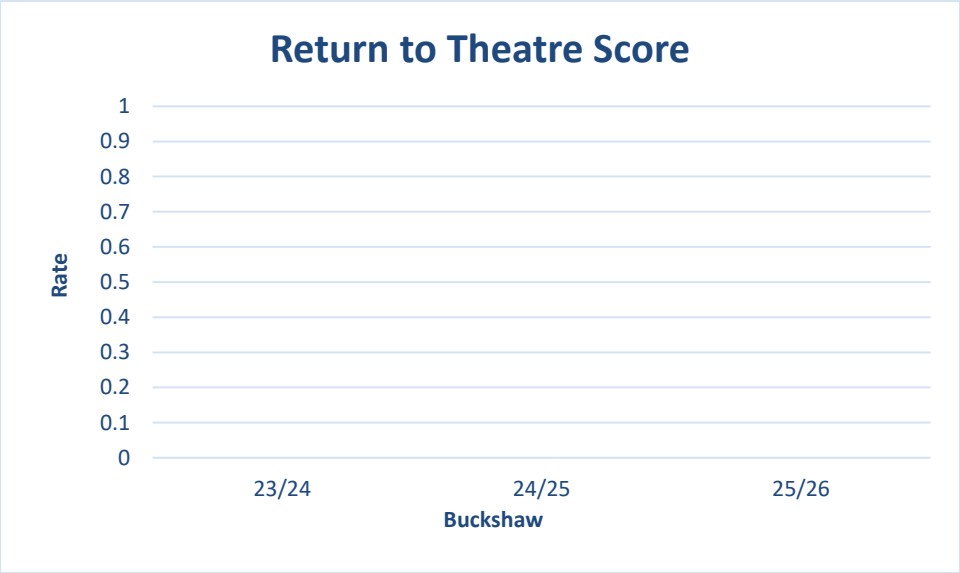
Buckshaw Hospital has a Clinical Governance committee that meet regularly through the year to monitor quality and effectiveness of care. Clinical incidents, patient and staff feedback are systematically reviewed to determine any trend that requires further analysis or investigation. More importantly, recommendations for action and improvement are presented to hospital management and medical advisory committees to ensure results are visible and tied into actions required by the organisation as a whole. The Clinical Governance framework below:

- Provides assurance that Buckshaw Hospital has an effective and responsive Clinical Governance structure in place, which supports the organisation's quality improvement programme and keeps the Board informed on quality and performance.
- Provides assurance that Buckshaw Hospital has effective processes in place to drive quality improvement across clinical services, with continuous monitoring of patient safety and the quality of care provided.
- Provides a clear focus on accountability arrangements, strategic planning, reporting, and communication, ensuring robust governance and oversight across the organisation.

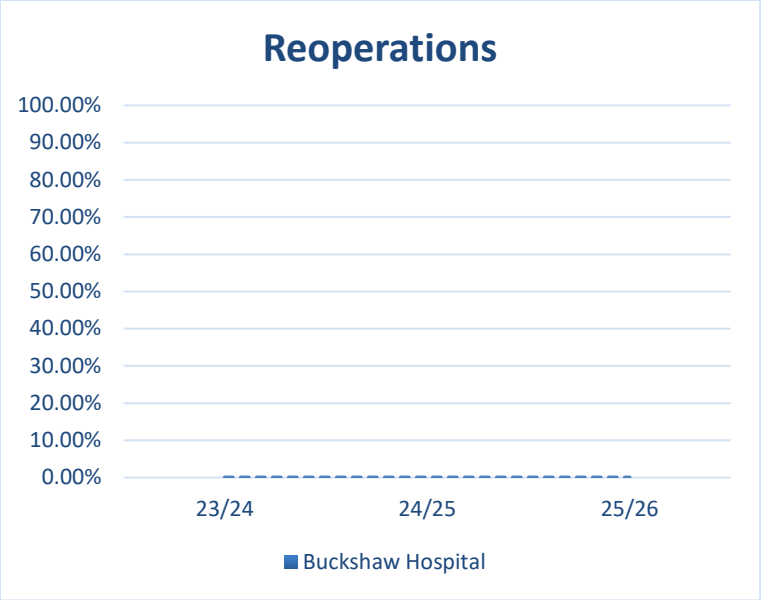


3.3.1 Return to theatre

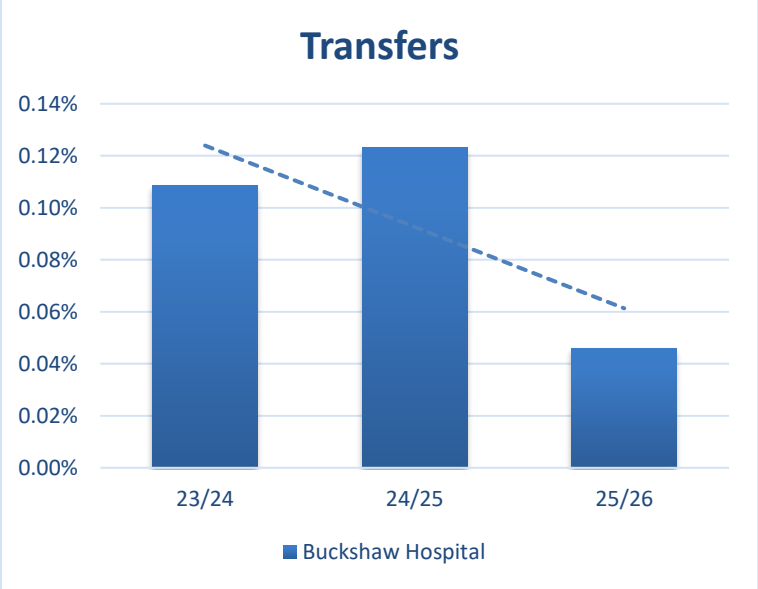
Ramsay is treating significantly higher numbers of patients every year as our services grow. The majority of our patients undergo planned surgical procedures and so monitoring numbers of patients that require a return to theatre for supplementary treatment is an important measure. Every surgical intervention carries a risk of complication so some incidence of returns to theatre is normal. The value of the measurement is to detect trends that emerge in relation to a specific operation or specific surgical team. Ramsay's rate of return is very low consistent with our track record of successful clinical outcomes.



Rate per 100 discharges.



Rate per 100 discharges.



Rate per 100 discharges.

During the reporting period, Buckshaw Hospital reported no return-to-theatre cases or unplanned re-operations, which provides positive assurance regarding the quality of surgical care, perioperative planning, and post-operative management delivered across the hospital. This outcome demonstrates that procedures continue to be undertaken safely and effectively,

with no requirement for surgical revision, and reflects the strength of the hospital's clinical pathways and consultant-led model of care.

During the same period, there was an increase in patient transfers to the hospital's sister site. Whilst any increase in transfers warrants careful review, it is important to note that the majority of these transfers were precautionary in nature and undertaken for observation and ongoing monitoring, rather than as a result of significant clinical deterioration or surgical complication. This indicates that clinical teams are identifying potential concerns at an early stage and escalating appropriately, thereby demonstrating a strong commitment to patient safety, clinical vigilance, and timely intervention. As a day surgery hospital, Buckshaw Hospital does not provide overnight inpatient care. Some transfers therefore represent appropriate escalation for extended monitoring where clinically indicated, rather than emergency intervention. All transfers continue to be subject to internal review to identify learning opportunities, support service development, and ensure that escalation pathways remain safe, effective, and proportionate to patient need.

Encouragingly, the hospital has also seen a reduction in the rate of patient transfers to the local NHS hospital. Where such transfers have occurred, they have generally been precautionary and have reflected an appropriately low threshold for escalation in circumstances where access to higher-acuity care may be required. Early recognition and timely clinical intervention have been central to avoiding deterioration and supporting positive patient outcomes.

This improvement has been supported by a range of quality improvement and workforce development initiatives. These include enhanced training in the recognition and management of the deteriorating patient, aligned to national standards and supported through the use of NEWS2 (National Early Warning Score), alongside simulation-based training and strengthened escalation processes to support multidisciplinary communication and timely response in higher-risk scenarios. In addition, the hospital has maintained a strong focus on clinical audit, incident review, and case analysis to promote shared learning and reinforce evidence-based practice.

Whilst there remains scope for further improvement, these findings are encouraging and demonstrate Buckshaw Hospital's continued commitment to delivering safe, effective, and high-quality surgical care, underpinned by a culture of continuous learning, early intervention, and quality improvement.

3.3.2 Learning from Deaths

There have been no patient deaths at Buckshaw Hospital in this reporting period.

3.3.3 Staff Who Speak up

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS Trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment by doing so. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

In 2018, Ramsay UK launched 'Speak Up for Safety', leading the way as the first healthcare provider in the UK to implement an initiative of this type and scale. The programme, which is being delivered in partnership with the Cognitive Institute, reinforces Ramsay's commitment to providing outstanding healthcare to our patients and safeguarding our staff against unsafe practice. The 'Safety C.O.D.E.' enables staff to break out of traditional models of healthcare hierarchy in the workplace, to challenge senior colleagues if they feel practice or behaviour is unsafe or inappropriate. This has already resulted in an environment of heightened team working, accountability and communication to produce high quality care, patient centred in the best interests of the patient.

Ramsay UK has an exceptionally robust integrated governance approach to clinical care and safety and continually measures performance and outcomes against internal and external benchmarks. However, following a CQC report in 2016 with an 'inadequate' rating, coupled with whistle-blower reports and internal provider reviews, evidence indicated that some staff may not be happy speaking up and identify risk and potentially poor practice in colleagues. Ramsay reviewed this and it appeared there was a potential issue in healthcare globally, and in response to this Ramsay introduced the 'Speaking Up for Safety' programme.

The Safety C.O.D.E. (which stands for Check, Option, Demand, Elevate) is a toolkit which consists of these four escalation steps for an employee to take if they feel something is unsafe. Sponsored by the Executive Board, the hospital Senior Leadership Team oversee the roll out and integration of the programme and training across all our Hospitals within Ramsay. The programme is employee led, with staff delivering the training to their colleagues, supporting the process for adoption of the Safety C.O.D.E through peer-to-peer communication. Training compliance for staff and consultants is monitored corporately; the company benchmark is 85%.

Since the programme was introduced serious incidents, transfers out and near misses related to patient safety have fallen; and lessons learnt are discussed more freely and shared across the organisation weekly. The programme is part of an ongoing transformational process to be embedded into our workplace and reinforces a culture of safety and transparency for our teams to operate within, and our patients to feel confident in. The tools the Safety C.O.D.E. use not only provide a framework for process, but they open a space of psychological safety where employees feel confident to speak up to more senior colleagues without fear of retribution.

Buckshaw Hospital currently has three trained 'Speak Up for Safety' trainers, who are actively supporting this important programme across the hospital. There is a focused drive in place to ensure that all members of staff receive this training, which is designed to empower individuals at every level to speak up confidently and constructively when they observe behaviours or situations that could compromise patient safety or staff wellbeing.

The initiative is a key part of our ongoing commitment to fostering a positive safety culture, where open communication and psychological safety are prioritised.

In addition, Buckshaw Hospital has recently appointed a Consultant Representative, who will act as a dedicated liaison between the Consultant body and hospital leadership. This role has been introduced to enhance engagement, address concerns, and strengthen collaborative working between senior clinicians and management, ensuring a unified approach to safety, quality, and service development.

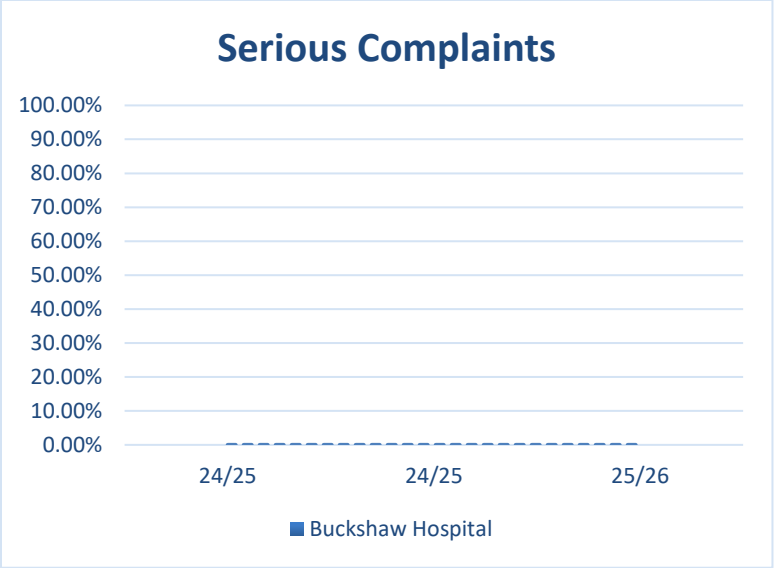
3.4 Patient experience

All feedback from patients regarding their experiences with Ramsay Health Care are welcomed and inform service development in various ways dependent on the type of experience (both positive and negative) and action required to address them.

All positive feedback is relayed to the relevant staff to reinforce good practice and behaviour letters and cards are displayed for staff to see in staff rooms and notice boards. Managers ensure that positive feedback from patients is recognised and any individuals mentioned are praised accordingly.

All negative feedback or suggestions for improvement are also feedback to the relevant staff using direct feedback. All staff are aware of our complaint's procedures should our patients be unhappy with any aspect of their care.

There have been no serious complaints at Buckshaw Hospital in the last three years.



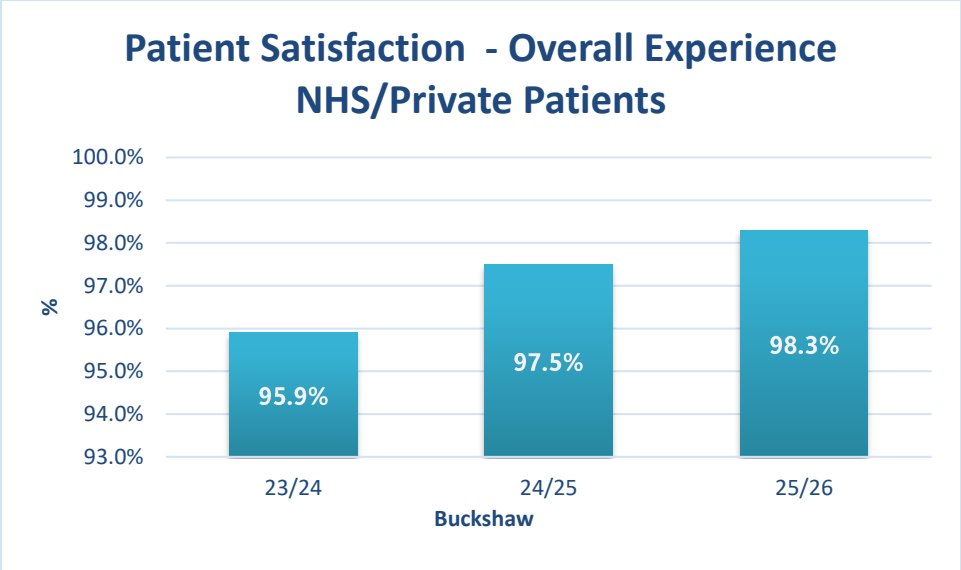
Patient experiences are fedback via the various methods below and are regular agenda items on Local Governance Committees for discussion, trend analysis and further action where necessary. Escalation and further reporting to Ramsay Corporate and DH bodies occurs as required and according to Ramsay and DH policy.

Feedback regarding the patient's experience is encouraged in various ways via:

- Continuous patient satisfaction feedback via a web based invitation
- Hot alerts received within 48hrs of a patient making a comment on their web survey
- Friends and family questions asked on patient discharge
- 'We value your opinion' leaflet
- Verbal feedback to Ramsay staff - including Consultants, Heads of Clinical Services / Hospital Directors whilst visiting patients and Provider/CQC visit feedback.
- Written feedback via letters/emails
- Patient focus groups
- PROMs surveys
- Care pathways – patients are encouraged to read and participate in their plan of care

3.4.1 Patient Satisfaction Surveys

Every patient is asked their consent to receive an electronic survey or phone call following their discharge from the hospital. The results from the questions asked are used to influence the way the hospital seeks to improve its services. Any text comments made by patients on their survey are sent as 'hot alerts' to the Hospital Manager within 48hrs of receiving them so that a response can be made to the patient as soon as possible.



The table above demonstrates that Buckshaw Hospital's Patient Satisfaction score for 2025/26 has increased by 0.8% when compared with 2024/25, reflecting a continued improvement in the overall patient experience. The results provide positive assurance that patients continue to report high levels of satisfaction with the care and treatment they receive at the hospital. They also show that Buckshaw Hospital has remained above the Ramsay UK average, demonstrating sustained strong performance in an important measure of quality and patient experience.

Patient feedback is highly valued at Buckshaw Hospital, as it provides an essential source of insight into what matters most to patients and where further improvements can be made. Feedback enables the hospital to listen, learn, and respond to patients' individual needs and expectations, while also helping to identify opportunities to strengthen the quality, responsiveness, and personalisation of care. This ongoing focus on patient voice supports a culture of continuous improvement and ensures that service development remains informed by the experiences of those who use our services.

Buckshaw Hospital continues to support its teams through Customer Service Excellence training, which places a strong emphasis on the patient experience and the importance of consistently going the extra mile in delivering care. This training reinforces the core principles of care, compassion, confidence, and competence, which underpin all interactions with patients. Every patient is treated as an individual, and staff are encouraged to provide care that is respectful, responsive, and tailored to personal needs and preferences. This commitment to compassionate, person-centred care remains central to the hospital's approach and contributes to the high levels of satisfaction reported by patients.

Buckshaw Hospital Case Study

Patient Story: How Physiotherapy Helped Me Regain My Confidence and Independence

Before I started physiotherapy, I felt as though my world had become much smaller. Pain and reduced mobility had slowly crept into my daily life, and things I had once taken for granted started to feel difficult. Walking short distances, using the stairs, getting out of the house, and completing everyday jobs all became tiring and, at times, quite overwhelming.

Before coming to physiotherapy, I had lost a lot of confidence. I was frightened of making my pain worse and unsure about what I should or should not be doing. I did not feel like myself, and I found it difficult having to rely on others more than I wanted to. It affected my independence, but it also affected how I felt emotionally.

From my very first appointment, I felt listened to. The physiotherapist took time to understand what life was like for me, what I was struggling with, and what I hoped to get back to. They did not just focus on my symptoms; they focused on me as a person. That made such a difference, because I felt reassured, understood and hopeful that things could improve.

My treatment plan was built around the things that mattered most to me. The physiotherapist explained everything in a way I could understand and made sure I felt safe and confident with each exercise. As I began to improve, the exercises were gently progressed, which helped me see that I was getting stronger. Having things I could continue with at home gave me a sense of control over my recovery.

The encouragement I received meant so much to me. The team were kind, patient and supportive, even on the days when I felt frustrated or doubted myself. They noticed the small improvements that I might not have seen on my own, and they helped me believe in my progress. I felt involved in my care, but more importantly, I felt cared for.

The Difference It Made

Over time, I started to notice changes that felt truly meaningful. I could walk further, move more easily, and do more of the everyday things I had been avoiding. My pain became easier to manage, but the biggest change was how I felt in myself. I began to feel more capable, more independent and more confident again.

Physiotherapy has genuinely changed my life. It helped me regain a sense of independence that I thought I had lost, and it gave me the confidence to start doing the things that matter to me again. I feel more positive about the future and more confident to keep active. The support I received did not just help me physically; it helped me feel like myself again.

To anyone who is struggling with pain, reduced mobility or a loss of confidence, I would say do not underestimate the difference physiotherapy can make. Progress does not always happen

overnight, and there can be difficult days, but with the right support and encouragement, things really can improve.

I am so grateful to the physiotherapy team for their patience, compassion and expertise. They helped me rebuild my confidence, improve my independence and return to daily life with hope and a much more positive outlook. For me, it has made all the difference.

Appendix 1

Services covered by this quality account

Regulated Activities – Buckshaw Hospital

	Services Provided	Peoples Needs Met for:
Treatment of Disease, Disorder Or injury	Physiotherapy, Dermatology, General Surgery, Orthopaedics, Urology, ENT, Gynaecology, Gastroenterology	All adults 18 yrs. and over
Surgical Procedures	Ambulatory and Day Surgery only General surgery including Laparoscopic inguinal hernia repair & breast surgery Orthopaedics Gynaecology Urology ENT Gastroenterology	All adults excluding: • Exclusion Criteria • Patient who have any of the following will not be a suitable for treatment at the unit : • Zero tolerance to abusive or aggressive patients. • No suitable support at home. . • Unstable ASA 3 and above. • Blood disorders (haemophilia, thalassemia). • On Renal dialysis. • A history of malignant hyperpyrexia/hyperthermia • A psychiatric history or have severe mental health • A need for ventilator support post operatively. • Any requirement for planned high dependency care. • Limited mobility due to breathlessness. • Poorly controlled asthma needing oral steroids or has had frequent hospital admissions with in the last three months. • Patients with a BMI 40 or above will not be considered for a General anaesthetic • An MI (heart attack) in the last 6 months. • Stents(cardiac) inserted in the last year • CVA (stroke) in the last 6 months. • Angina classification 3-4 (limitations on normal activity e.g. 1 flight of stairs or angina at rest). • However, all patients will be individually assessed and we will only exclude patients if we are unable to provide an appropriate and safe clinical environment All patients must meet social/clinical criteria for day surgery
Diagnostic and screening	GI physiology, Imaging services- static MRI, CT, Ultrasound, 3D Mammography & Breast screen, Phlebotomy, Urinary Screening and Specimen collection	All adults 18 yrs. and over
Family Planning Services	Gynaecology patient pathway, insertion and removal of inter uterine devices for medical as well as contraception purposes	All adults 18 years and over as clinically indicated

Appendix 2 – Clinical Audit Programme 2025/26.

The RHCUK clinical audit programme sets out a rolling schedule of assurance and improvement activity across RHCUK (July 2025 to June 2026). Audits span infection prevention and control (IPC) practice (e.g., hand hygiene, One Together elements, environmental infrastructure and linen management), medicines optimisation and pharmacy governance (e.g., medicines reconciliation, controlled drugs and prescribing processes), radiology governance and image quality (e.g., IR(ME)R, CT/MRI modality audits and reporting for BUPA), theatre safety and patient journey checks (including NatSSIPs elements and peri-operative observations), essential care standards (e.g., wound management, falls prevention, nutrition and hydration), and corporate/operational assurance (e.g., health & safety themes and occupational health record management and screening).

Each audit has a named owner to ensure accountability for data collection, analysis and reporting. Findings are reviewed through local governance structures (e.g., IPC, Pharmacy, Radiology, Theatres and SLT/Ops oversight as appropriate) to agree actions, assign leads and timescales, and assess risk. Where audits identify gaps in compliance or variation in practice, each site is responsible for implementing targeted quality improvement (QI) activity. Where organisational trends are identifies, QI initiatives may be lead by the corporate clinical team (for example: refresher training, process redesign, documentation changes, environmental or equipment controls, or focused observational re-checks). Progress and impact are monitored through repeat measurement at the next scheduled audit point (monthly/fortnightly cycles for high-frequency measures and seasonal blocks for specialty audits), with re-audit providing assurance that changes have been embedded and sustained.

AUDIT	Department Allocation / Ownership	QR Code Allocation	Frequency	Deadline for Submission
Hand Hygiene observation (5 moments)	Ward, Ambulatory Care, SACT Services, Theatres, IPC (all other areas)	Ward, Ambulatory Care, SACT Services, Theatres, Whole Hospital	Monthly	Month end
Hand Hygiene observation (5 moments)	RDUK	RDUK	Monthly	Month end
Surgical Site Infection (One Together)	Theatres	Theatres	October, April	Month end
IPC Governance and Assurance	IPC	Whole Hospital	July to September	End of September
IPC Environmental infrastructure	SLT	Whole Hospital	October to December	End of December
IPC Management of Linen	Ward	Ward	August, February	End of August End of February
Sharps	IPC	Whole Hospital	August, December, April	Month end
50 Steps Cleaning (Functional Risk 1)	HoCS, Theatres, SACT Services	Theatres, SACT Services	Weekly	Month end
50 Steps Cleaning (Functional Risk 1)	HoCS, Theatres	Theatres	Fortnightly	Month end
50 Steps Cleaning (FR2)	HoCS, Ward, Ambulatory Care, Outpatients, POA	Ward, Ambulatory Care, Outpatients, POA	Monthly	Month end
50 Steps Cleaning (FR4)	HoCS, Physio, Pharmacy, Radiology	Physio, Pharmacy, Radiology	July, October, January, April	Month end
50 Steps Cleaning (FR4)	RDUK	RDUK	July, October, January, April	Month end
50 Steps Cleaning (FR5)	SLT (Patient facing: reception, waiting rooms, corridors	Whole Hospital	July to September	End of September
50 Steps Cleaning (FR6)	SLT (Non-patient facing: Offices, Stores, Training Rooms)	Whole Hospital	July to September	End of September
Peripheral Venous Cannula Care Bundle	HoCS (to delegate)	Whole Hospital	July to September	End of October
Urinary Catheterisation Bundle	HoCS (to delegate)	Whole Hospital	October to December	End of December
Patient Journey: Safe Transfer of the Patient	Ward	Ward	August, February	Month end

Patient Journey: Intraoperative Observation	Theatres	Theatres	July to September January to March (if required)	End of September No March deadline
Patient Journey: Recovery Observation	Theatres	Theatres	October to December April to June (if required)	End of December No deadline
LSO and 5 Steps Safer Surgery	Theatres, Outpatients, Radiology	Theatres, Outpatients, Radiology	July to September January to March	End of September End of March
NatSSIPs Stop Before You Block	Theatres	Theatres	July to September January to March	End of September End of March
NatSSIPS Prosthesis	Theatres	Theatres	July to September January to March	End of September End of March
NatSSIPs Swab Count	Theatres	Theatres	July to September January to March	End of September End of March
NatSSIPs Instruments	Theatres, Outpatients, Radiology	Theatres, Outpatients, Radiology	October to December April to June	End of December End of June
NatSSIPs Histology	Theatres, Outpatients, Radiology	Theatres, Outpatients, Radiology	October to December April to June	End of December End of June
Blood Transfusion Compliance	Blood Transfusion	Whole Hospital	October to December	End of December
Blood Transfusion – Autologous	Blood Transfusion	Whole Hospital	July/September (where applicable)	No deadline
Blood Transfusion - Cold Chain	Blood Transfusion	Whole Hospital	As required	As required
Complaints	SLT	Whole Hospital	August/September February/March	End of September End of March
Duty of Candour	SLT	Whole Hospital	August/September February/March	End of September End of March
Practising Privileges - Non-consultant	HoCS	Whole Hospital	July, October, January, April	Month end
Practising Privileges - Consultants	HoCS	Whole Hospital	July, October, January, April	Month end
Practising Privileges - Doctors in Training	HoCS	Whole Hospital	July, January (where applicable)	No deadline
Privacy & Dignity	Ward	Ward	May/June (as required)	No deadline
Essential Care: Falls Prevention	HoCS (to delegate)	Whole Hospital	September / October (as requied)	No deadline

Essential Care: Nutrition & Hydration	HoCS (to delegate)	Whole Hospital	September / October	End of October
Essential Care: Wound Management (to be developed)	HoCS (to delegate)	Whole Hospital	TBC	TBC
Resuscitation & Emergency Response	HoCS (to delegate)	Whole Hospital	July, October, January, April	Month end
Medical Records - Therapy	Physio	Physio	July to September January to March	End of September End of March
Medical Records - Surgery	Theatres	Whole Hospital	July to September January to March	End of September End of March
Medical Records - Ward	Ward	Ward	July to September January to March	End of September End of March
Medical Records - Pre-operative Assessment	Outpatients, POA	Outpatients, POA	July to September January to March	End of September End of March
Medical Records - Radiology	Radiology, RDUK	Radiology, RDUK	July to September January to March	End of September End of March
Medical Records - Cosmetic Surgery	Outpatients	Whole Hospital	July to September January to March	End of September End of March
Medical Records - Paediatrics	Paediatrics	Paediatrics	July to September January to March	End of September End of March
Medical Records - NEWS2	Ward	Whole Hospital	July to September January to March	End of September End of March
Medical Records - VTE	Ward	Whole Hospital	July to September January to March	End of September End of March
Medical Records - Patient Consent	HoCS	Whole Hospital	October to December April to June	End of December End of June
Medical Records - MDT Compliance	HoCS	Whole Hospital	July to September January to March	End of September End of March
Non-Medical Referrer Documentation and Records	Radiology	Radiology	July, January	Month end
MRI Reporting for BUPA	MRI	Radiology	July, November, March	Month end
CT Reporting for BUPA	Radiology	Radiology	August, December, April	Month end
No Report Required	Radiology	Radiology	August, February	Month end
MRI Safety	MRI, RDUK	Radiology, RDUK	January, July	Month end

CT Last Menstrual Period	Radiology, RDUK	Radiology, RDUK	July, October, January, April	Month end
RDUK - Referral Forms - MRI	RDUK	RDUK	August, October, December, February, April, June	Month end
RDUK - Referral Forms - CT	RDUK	RDUK	July, September, November, January, March, May	Month end
RDUK - Medicines Optimisation	RDUK	RDUK	October, March	Month end
RDUK - PVCCB	RDUK	RDUK	July, January	Month end
Bariatric Services	Bariatric Services	Whole Hospital	July to September January to March (if required)	End of September No deadline
Paediatric Services	Paediatric	Paediatric	July, January	Month end
Paediatric Outpatients	Paediatric	Paediatric	September	Month end
Paediatric Radiology	Paediatric	Paediatric	October	Month end
Safe & Secure	Pharmacy	Outpatients, SACT Services, Radiology, Theatres, Ward, Ambulatory Care, Pharmacy	July to September January to March	End of September End of March
Prescribing, Supply & Administration'	Pharmacy	Pharmacy	October to December April to June	End of December End of June
Medicines Reconciliation	Pharmacy	Pharmacy	July, October, January, April	Month end
Controlled Drugs	Pharmacy	Pharmacy	September, December, March, June	Month end
Pain Management	Pharmacy	Pharmacy	October, April	Month end
Medicines Governance	Pharmacy	Pharmacy	January to March	End of March
Medicines Governance	Pharmacy	RDUK	January to March	End of March
SACT Services	Pharmacy, SACT Services	Pharmacy, SACT Services	September/October	End of October
Departmental Governance	Ward, Ambulatory Care, Theatre, Physio, Outpatients, Radiology	Ward, Ambulatory Care, Theatre, Physio, Outpatients, Radiology	October to December	End of December
Departmental Governance (RDUK)	RDUK	RDUK	October to December	End of December
Safeguarding	SLT	Whole Hospital	December	Month end

IPC Environmental infrastructure (RDUK)	RDUK	RDUK	August, February	Month end
Decontamination - Sterile Services (Corporate)	Decontamination (Corp)	Decontamination	As required (by corporate team)	No deadline
Decontamination - Endoscopy	Decontamination (Corp)	Decontamination	As required (by corporate team)	No deadline
Medical Records - SACT consent	SACT Services	SACT Services	May	Month end
Occupational Delivery On-site	HoCS, RDUK	Whole Hospital, RDUK	November to January	End of January
Managing Health Risks On-site	Corporate OH	Whole Hospital	As required	No deadline
Catering (Kitchen)	Ops Managers	Health & Safety	July, October, January, April	End of month
Catering (Ward)	Ops Managers	Health & Safety	July, October, January, April	End of month
Health & Safety and Facilities	SLT	Health & Safety	January/February	End of February

Appendix 3

Glossary of Abbreviations

ACCP	American College of Clinical Pharmacology
AIM	Acute Illness Management
ALS	Advanced Life Support
CAS	Central Alert System
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DDA	Disability Discrimination Audit
DH	Department of Health
EVLT	Endovenous Laser Treatment
GP	General Practitioner
GRS	Global Rating Scale
HCA	Health Care Assistant
HPD	Hospital Patient Days
H&S	Health and Safety
IHAS	Independent Healthcare Advisory Services
IPC	Infection Prevention and Control
ISB	Information Standards Board
JAG	Joint Advisory Group
LINk	Local Involvement Network
MAC	Medical Advisory Committee
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NCCAC	National Collaborating Centre for Acute Care
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
A4M8P	Code for Buckshaw Hospital used on the data information websites
ODP	Operating Department Practitioner
OSC	Overview and Scrutiny Committee
PLACE	Patient-Led Assessment of the Care Environment
PPE	Personal Protective Equipment
PROM	Patient Related Outcome Measures
RIMS	Risk Information Management System
SUS	Secondary Uses Service
SAC	Standard Acute Contract
SLT	Senior Leadership Team
STF	Slips, Trips and Falls
SUI	Serious Untoward Incident
VTE	Venous Thromboembolism

Buckshaw Hospital

Ramsay Health Care UK

We would welcome any comments on the format, content or purpose of this Quality Account.

If you would like to comment or make any suggestions for the content of future reports, please telephone or write to the Hospital Director using the contact details below.

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