Viapath 2018 Quality Account

Looking to the Future

Contents

A message from Viapath's CEO **Dougie Dryburgh**

Welcome to the 2018 Viapath Quality Account, which sets out our progress in delivering the highest quality pathology services. This is an important document which enables us to explain to customers and stakeholders how we keep a continued focus on providing safe, effective, responsive, caring and well-led services.

Scientists and clinicians are at the heart of our approach to delivery. The theme for the 2017 Quality Account was 'end to end pathology'. We continued with our focus on getting it right first time, from the point where the sample has been taken from the patient, to when the results are used by the clinical teams to deliver patient care. Additionally, Viapath's scientists and clinicians have driven assay development and successfully launched over 94 new tests.

Looking back over the last year, we commenced the laboratory information systems transformation programme and are rolling out projects across our London laboratories. This will enable faster, flexible and agile responses to all customers, irrespective of where the request for services is made. We are transforming our services to 'future fit', keeping focused on business-wide continuous quality improvement. This also provides opportunities to further strengthen collaborative working and alignment with all our customers and stakeholders.

We have reviewed what customers want, to ensure results are delivered in a clinically responsive time frame. We developed a customer strategy centred around a single point of contact. In addition, we now have an independent non-executive director leading the Viapath Operations and Quality Committee, which includes NHS partner membership as well as members of the Viapath Executive.

Viapath has responded robustly to the changes in NHS pathology delivery requirements and the emerging pathology networks. These are highlighted in the NHS long term plan (published January 2019) as key to driving effective high-quality services in the future, underpinned by new models for service delivery. Viapath is at the forefront of developing new technologies for future healthcare.

This year's report highlights what has been achieved, but also the areas in which we have challenges. I hope that the Quality Account demonstrates that we are working hard to achieve our ambition, to be a leader in transforming pathology services through our drive and relentless focus on continuous improvement, to shape future healthcare as a world-class pathology leader in innovation and research.

Finally, I would like to thank all our employees and teams for their continued focus and enthusiasm to innovate, learn and provide safe services for patients and customers.

Dougie Dryburgh
Chief Executive Officer

Innovation & Scientific Progress

Medical Director **Professor Jonathan Edgeworth**

Professor Jonathan Edgeworth
Medical Director
Caldicott Guardian

Each year we look back to prepare this Quality Account and reflect on the hundreds of Pathology contacts we have with front-line clinical services. Pathology supports every patient pathway across our healthcare community every day of the year: a cancer diagnosis, a serious infection, patients with multiple organ failure in the intensive care unit, a GP health-check, an A&E visit, monitoring of long-term conditions. Patients and clinicians need certainty of a safe, quality service on time, every time. This is monitored by Viapath and our customers separately and together; through performance indicators in the laboratories and across the whole pathway, feedback from customers with compliments or complaints, auditing of policies and practice, reporting of incidents and the review of risks. We focus on identifying and correcting laboratory analytical defects before they become incidents with a preventative mindset. But particularly we review the few hundred reported incidents that are likely to impact on patients each year from the 33 million tests we provide, to identify themes and factors that we can address to improve the service.

Bringing this together for the Quality Account we aim to balance reporting the improvements that have been made and the compliments received, alongside a description of incidents, errors and complaints that have occurred and how we have responded. Being part of or writing about things that go well is a positive experience, but it takes more effort to report an error, particularly if involving oneself, or to write about these adverse events. It requires determination to see learning through to sustainable improvement across the organisation. In recognition of the additional barrier to thinking about failings we constantly work on building an open transparent culture and a workplace that engenders a willingness to learn; supporting those employees involved in an incident by actively embedding a no-blame culture, and providing time in the working day to investigate, reflect, learn and share.

In addition to this 'business as usual' quality function, pathology services must have an intrinsic capability and capacity for change or 'Continuous Quality Improvement'. There are changes in patient expectations and pathways, in healthcare organisations and systems, and advances in science and technology to be embraced, all usually in many specialties and pathways at the same time. This is particularly true in South East London which has two of the UK's leading research-intensive teaching hospitals at the forefront of innovation. Pathology must therefore deliver and develop at the same time, evaluating new diagnostics in parallel with providing current services, and provide education and training for the next generation of scientists and healthcare professionals during the working day.

Taken together this high degree of expectation can stretch our workforce at all levels. We expect them to focus on improvements for tomorrow whilst not dropping the ball today – continuously looking out for and investigating the things that go wrong, whilst not diverting their attention from continuing to deliver the many things that go well. We try to make this tension a creative force for good and share that approach with our customers who we know themselves face the same demands. This is part of building a healthy team culture and partnership across multiple teams, bringing people with us on a shared journey. Moving away from a simple 'red-amber-green' view of the world to one of always getting better and moving forward. We have sought to present this throughout the Quality Account, whether it is in the Viapath Way, or describing our process for learning from errors, our Innovation Academy, our Learning & Development Fund and our performance.

I hope everyone who looks through this Account – patients, healthcare employees or commissioners alike – can find something useful and that it helps to explain something about who we are and what we do. If anyone wants to know more or has a comment on what we have written please do contact me on jonathan.edgeworth@viapath.co.uk.

Chief Scientific Officer **Dr Dominic Harrington**

Dr Dominic Harrington
Chief Scientific Officer

Throughout 2018 the Innovation Academy continued to promote innovation, quality and the professional development of our scientists. The eighth annual scientific symposium, which we hosted in December, provided an opportunity to share recent achievements and for us to explore the theme 'Stretch and Hold Forth', a theme selected to highlight how scientists at Viapath use their expertise to deliver novel diagnostics that support patient care.

This year saw Viapath's Clinical Genomics laboratory at Guy's Hospital become the first pathology provider in the world to gain ISO 15189:2012 accreditation for the use of MinION DNA sequencing devices made by Oxford Nanopore. This technology is capable of reading long fragments of DNA and has been applied to speed up the diagnosis of complex cases of Huntington's disease. Our Infection Sciences laboratories at St. Thomas' Hospital plan to extend the application of this technology during 2019 to include 16S rRNA gene sequencing to aid the rapid identification of bacterial species.

Another novel analytical technique successfully adopted by Viapath during 2018, was Ultra Performance Convergence Chromatography (UPC2). The Nutristasis Unit at St. Thomas' Hospital became the first pathology laboratory to explore the clinical utility of this platform, when they developed novel assays for the evaluation of fat-soluble vitamin status. Benefits include extremely rapid analysis times and a reduction in the use of toxic reagents.

To promote the identification and dissemination of healthcare innovations, we continued to sponsor the UK Advancing Healthcare Award for Innovation in Healthcare Science. The award provides us with a platform to celebrate the success of our peers. It gave us great pleasure to present this year's award to Great Ormond Street Hospital (see photograph opposite), for their pioneering work to bring cell therapy for the treatment of cancer and genetic diseases into routine use.

Within Viapath our 'Innovation Fund' and 'Scientific Learning and Development Fund' continued to support our scientists. These two funds have facilitated translational research and helped employees to reach their full potential respectively. We were delighted to hold Viapath's fourth annual 'Excellence in Pathology' award in December and be able to congratulate our winner Rachel Mayhew, on her work on the functional characterisation of genetic variants using red blood cell ektacytometry. Ektacytometry is a method for measuring the ability of cells to change shape as they pass through narrow spaces. Rachel works in the Molecular Pathology laboratory at King's College Hospital, and with her colleagues has begun to use next generation ektacytometry to aid the interpretation of variants of uncertain clinical significance from a 46 Red Cell Gene Panel. This is a technique for multiple gene testing at the same time. Red blood cell membranopathies can cause increased red cell fragility and destruction that leads to anaemia.

In August 2018, the scientific leadership at Viapath was strengthened through the appointment of two new Scientific Directors. I wish Dr Rachel Carling (Guy's and St. Thomas' Hospital) and Dr Katharine Bates (King's College Hospital and Princess Royal University Hospital) every success in their new roles. Together we will continue to provide an environment where talent is nurtured, supported and novel ideas are brought to life.

Quality Director **Liz Adair**

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Liz Adair
Quality Director

The journey so far

2019 marks the tenth anniversary of the creation of the pathology joint venture (GSTS rebranding to Viapath in 2014). This is an important landmark in our history, which presents an opportunity to pause and reflect on our governance journey so far.

I have reviewed the Viapath Quality Accounts published on NHS Choices over the last five years, to present key milestones. Quality Accounts are important, because they demonstrate our open and transparent approach to patient safety and quality and how we discharge our statutory obligations for delivering services to NHS funded patients. They have been crafted with a clear focus on patients and customers, in order to engage in important conversations.

GSTS Quality Account 2013

The Account was published against a backdrop of national inquiries into patient safety.

The **Pathology Quality Assurance Report** led by Dr Ian Barnes, is a review of pathology quality assurance which presented recommendations to improve structures, process and governance, with the aim of improving patient outcomes.

The **Francis Inquiry Report** which examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009, with 290 recommendations to address issues of patient safety, quality of care and leadership.

GSTS responded by strengthening the GSTS Board assurance/ governance framework. This included establishing the GSTS Governance, Risk and Quality Assurance Committee, with a 'Bench to Board' approach for patient safety.

Our focus and ambition for innovation took an important step forward with the launch of the Viapath Innovation Academy.

Viapath Quality Account 2014 – Advancing Together

2014 was a period of accelerated change. GSTS rebranded to Viapath and quickly established Viapath's core values of innovation, expertise and collaboration.

We embarked on a strategic shift from transition to stability, building robust foundations and infrastructure. This included the development of the Viapath Governance Risk and Quality (GRQ) Framework, which operates from Board to Bench, clinically led by senior leaders.

All laboratories prepared for transition from Clinical Pathology Accreditation (CPA), to the international ISO15189:2012 standards.

Across Viapath, the Service Improvement Team (SIT) was set up to support tackling complex process problems.

We advanced our innovation ambition, by establishing the Viapath Innovation Fund.

Viapath Quality Account 2015 – Improving Patients' Lives

In 2015, a key focus was quality improvement. We acknowledged that governance and operations required a joined up approach to tackling complex issues. So, not accepting the status quo, we made changes to ensure that the GRQ framework and operations meeting structure, operating jointly and firmly embedded 'Bench to Board'.

In July, we celebrated the Immunodermatology and Dermatopathology laboratory service at Guy's & St Thomas' NHS Foundation Trust , being the first in Viapath to receive accreditation to ISO15189:2012.

Our focus on patients and customers included welcoming Pat Roberts, patient advocate, from the charity Save Babies through Screening Foundation, to open the 2015 Innovation Academy symposium. We also recruited Daniel, our first member of Harvey's Gang, who spent a day as a junior scientist, at the King's College Hospital Denmark Hill site Blood Transfusion laboratory.

Viapath Quality Account 2016 – Pioneers in Pathology

In July 2016, we welcomed laboratory service colleagues from the Princess Royal University Hospital (PRUH) one of the King's College Hospital (KCH) sites. This was a successful transition, with TUPE transfer of over 100 PRUH employees into Viapath, who set to work on aligning laboratory processes and infrastructure. This enabled us, for the first time, to provide laboratory services for all KCH patients and local Clinical Commissioning Group (CCG) populations.

The Viapath Innovation Academy went from strength to strength, winning the Academy for Healthcare Science Award for Innovation. The NHS England Chief Scientific Officer hosted a Hackathon in Liverpool and invited scientists to join, to help solve (or hack!) complex issues affecting healthcare. Dr Katherine Bates from KCH, was a member of the winning team, working to 'Collaborate to Improve Care' in care homes.

Viapath Quality 2017 – End to End Pathology

In the year when the NHS celebrated its 70-year anniversary, Viapath laboratories, including Blood Transfusion services, made an unprecedented response to two terrorist attacks in London; at Westminster Bridge and London Bridge. The teams received accolades and commendations for their response which enabled clinicians to give life-saving care.

The executive team and clinical leadership were strengthened, by the appointment of the first Viapath Chief Scientific Officer, Dr Dominic Harrington.

Key drivers for change in 2017 included the learning following review of a small cluster of NHS Serious Incidents. This included improvements to laboratory processes, and governance assurance arrangements across the patient pathway, both in Viapath and NHS partners.

We developed a novel approach to identifying, escalating and managing incidents wherever they occur, the Viapath Complex Incident policy. It was launched October 2017, after consultation with NHS partners (hospitals and CCG).

2018 – Looking to the future

A relatively young organisation, Viapath is developing an organisational memory for governance and patient safety. We have learnt from the last decade and our governance arrangements have evolved; in part, as a result of national drivers and local customer requirements, but primarily because we have acted on and taken forward learning.

A summary of our continuous improvement journey over 2018 is summarised in the table below.

Month	Key governance events/themes in 2018
JAN	• Viapath launches Central Alert System (CAS) – focus on MHRA Field Notices/Safety Alerts
FEB	• Alignment of clinical governance framework and operations – Medical Director/Chief Scientific Officer/Clinical & Scientific Directors join executive operational team meetings, chaired by the Chief Operating Office
MAR	• Major projects methodology and management aligned with UKAS accreditation assessment process
APR	• Viapath-commissioned review of governance and quality arrangements commences
MAY	• Clinical & Scientific Control Board launched – Viapath-coordinated partnership Board established to support new tests/services
JUN	• Viapath Services/Group established GRQ governance meeting (focus patient safety)
JUL	• Customer transition governance arrangements aligned with Viapath GRQ framework
AUG	• Information Governance Committee terms of reference review
SEP	• Viapath Operations and Quality Board Committee chaired by Independent Non-Executive Director launched
OCT	• Head of Clinical Governance & Patient Safety appointed, reporting to Quality Director
NOV DEC	• Celebration of World Quality Day and eighth Viapath Innovation Academy symposium

> “Patient safety is dynamic, not static.”

In a technically complex field such as pathology services, a number of factors are at work at any one time, which can influence the likelihood of an incident. This can require a system-wide, end-to-end appreciation of the approach in preventing, analysing and learning from errors and in particular, examining the human factors involved without creating a blame culture. This is a key theme that we are taking forward over 2019.

Chief Operating Officer Richard Rolt

Richard Rolt
Chief Operating Officer

In 2018, the growing demand on our pathology service from across the healthcare sector continued. Yet again, the operational team rose to the challenge in a professional, efficient and agile way, ensuring the highest quality was maintained. This was reflected in our key performance indicators (KPIs) and achievement and maintenance of accreditation by external bodies, all whilst keeping the focus on sustaining turnaround times to meet the needs of the customer. We had a record-breaking year with a total of 34 million units of activity processed and a record first, in exceeding three million units of activity in a month for the first time, in October. We responded to this increased demand with an increase in overall workforce resource provision of 12.3% total labour hours, compared to 2017.

In my report last year, I announced a new senior operational structure that was implemented at the end of 2017, beginning of 2018. The new posts created were those of Director of Operations (DOO) for Viapath and three Divisional Operations Directors (DODs). These new and revised positions were put in place to bolster the cross-site and collaborative functioning of Viapath's operational leadership team. Now a year on, I can reflect on those changes and see the benefits that have been gained. I can now say confidently that tangible benefits have been felt across the business. These include closer working between the teams, resulting in greater improvements and support.

The DOO leads on operational performance, Service Improvement and Transformation functions, later in the year also taking on the leadership of Health & Safety and Customer Services. The Customer Services team has now been centralised, benefiting the operation by releasing time for science and giving the customer a single of point of contact. We have also achieved 10 improvement initiatives in 2018, the highest number of Service Improvement Team projects implemented and completed in any year so far. A new Head of Portfolio was put in place who has implemented a project assurance framework and ensures all portfolio projects are delivered to agreed quality standards.

The three DODs are responsible for Core, References and Support Services (also covering Bedford and Princess Royal University Hospital sites). This has resulted in an expert, cohesive collaborative senior team. Their focus is to work closely to lead on major projects whilst strategic planning for the future innovative Target Operating Model.

Many quality and service improvements can be seen in Reference services, in areas that support Minimum Residual Disease (MRD) monitoring, developing and refining processes with improved collaborative working with stakeholders. Innovation and planned improvements in service provision in complex and challenged areas such as Toxicology and Immunology services, building strong foundations for future robustness. Core services have responded to the increased pressure of workload with maintenance of service whilst supporting development of innovative testing that moved rapidly into service to support the patient pathway, whilst answering the needs of the customers required expansion and demands.

Support Services saw the benefits of cross-site leadership and sharing of processes, continuing to provide an accurate and responsive Central Specimen Reception service, supporting the business and patient sample pathway in a timely manner. We saw our ever-expanding Phlebotomy service, a market leader in training, maintaining waiting times for patients, of an average 10.6 minutes for the Guy's & St Thomas' and 17.3 minutes for King's College Hospital site, whilst delivering great patient experience – evidenced by a high number of patient compliments. We also saw the Princess Royal University Hospital pathology service provision to King's improve month on month, with its best ever performance achieved in October, Viapath's busiest month.

Across our business, our aim is to deliver against laboratory Key Performance Indicators (KPIs) that are reviewed by every service at monthly Performance Review Meetings (PRMs). At the PRMs, exceptions, trends and action plans are agreed. This includes reviewing and making enhancements to staffing, equipment and processes. Progress on sixty KPIs are reported monthly, in order to manage our overall performance and address any challenges. We are both proactive and reactive in responding to these by adding resources or equipment capacity where needed, or by developing longer-term service improvement plans for deeper issues.

In 2018 our productivity, measured by the total units of activity processed per hour, remained steady at 20.6. Employee sickness absence was 2.7% across 2018, a sustained figure from the previous year.

The Viapath Complex Incident Response management process, introduced in 2017, has now been embedded. It is the standard process to respond to incidents, ensuring prompt response and investigation into all root causes, with appropriate tracking of corrective, remedial and preventive actions. The increased controls around equipment that processes precious, irreplaceable patient samples are in place and we have begun the roll-out of exposure to human factors thinking and sharing of lessons learned.

It was a very successful year for UKAS (ISO 15189:2012) accreditations with a total of 18 laboratories now accredited and a busy UKAS calendar of 20 visits across Viapath. We have experience and understanding of the pace required to maintain accreditation: Therefore, in 2019 we are working with laboratory services to raise our standards and ensure that we see accreditation as an output of attention to detail and quality management systems – not the goal.

As pioneers and leaders in pathology we are seen to be setting the industry standards and not depending on external standards to set our goals.

I look forward in 2019 to the challenges of our planned major service redesign and moving towards a new Target Operating Model. I was pleased to see that our recent Pulse employee survey demonstrated that 98% of Viapath employees felt that patients were at the heart of the decisions that we all make. We will continue our commitment to scientific and clinical service excellence, in the knowledge that our teams have patients at the forefront of their minds.

34m
units of activity processed

12.3%
increase in total labour hours

20.6
total units/activity processed/hour

2.7%
Employee sickness

2018 Quality Performance Report

Accreditation & Regulation

There are a number of external inspection, regulation and accreditation agencies that regularly visit Viapath sites. They include:

- **CQC** Care Quality Commission
- **MHRA** Medicines & Healthcare products Regulatory Agency
- **UKAS** United Kingdom Accreditation Service
- **HTA** Human Tissue Authority
- **PHE** Public Health England
- **HSE** Health & Safety Executive

You can read more about them and the way they inspect healthcare organisations in the Viapath 2014 Quality Account in the Key Assurance and Regulatory Bodies section.

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

The CQC did not visit any sites in Viapath in 2018. You can access the reports from their last visits in 2013 on their website link. http://www.cqc.org.uk/provider/1-126775137

In 2018 UKAS completed all their assessments of Viapath laboratories transitioning from Clinical Pathology Accreditation (CPA), to the international ISO15189: 2012 standards. We are delighted that all our services have had a successful transition. In 2019, two will have reached the beginning of the next four-year accreditation assessment cycle.

As the Chief Scientific Officer described in his report, Viapath's Clinical Genomics laboratory at Guy's Hospital became the first pathology provider in the world to gain ISO 15189:2012 accreditation for the use of MinION DNA sequencing devices made by Oxford Nanopore.

No critical findings have been raised by the MHRA in 2018.

Viapath laboratory services site	Date CQC report issued
Bedford Hospital, Bedfordshire	16 January 2013
Guy's Hospital, London	11 April 2013
St Thomas' Hospital, London	11 April 2013
King's College Hospital – Denmark Hill site, London	29 March 2013
King's College Hospital – Princess Royal University Hospital site, Kent	Not inspected yet

Incidents

Adverse Incident/Patient Safety Incident Notification

As a provider of services to NHS funded patients, Viapath has a responsibility to report and review any adverse incident /patient safety incidents and review those reported by customers on our services. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting supports Viapath and the wider NHS to learn from mistakes and to act to keep patients safe.

Adverse Incidents are reported on the electronic systems managed by NHS partner Trusts and subsequently uploaded to the statutory National Reporting Learning System (NRLS). All employees access the electronic reporting system from each site and work in partnership with each NHS patient safety and service team during the investigation. This approach has established an open and transparent way of working, to understand what happened, the actions required and to share the learning.

In 2018, there were 2,183,195 Adverse Incidents raised in England and of these, 74 % were raised in hospitals. The remainder were raised in mental health (13 %), community (11 %) and other settings (2 %). Unfortunately, it is not currently possible to identify how many Adverse Incidents raised are specifically in pathology – this is because all pathology incidents are collected in the clinical assessment subset. This category includes diagnostics, scans tests and assessments. The clinical assessment category accounts for 7 % of all reported adverse incidents.

However, NHS England is planning to significantly change the way the NHS reports adverse incidents commencing in late 2019, which will enable healthcare providers to have more detailed information so that we can work together to understand better, why incidents occur and how to prevent patient harm.

There were 922 reported Adverse Incidents attributable to Viapath in 2018 (Table 2), which represents a 3.8 % increase compared with 2017. It is important to ask whether this represents a deterioration in quality or safety of the service, but that is hard to confidently answer due to it partly being an actively encouraged activity, partly a self-reporting system with broad criteria. Comparisons may provide some answer: Viapath had a 3.8 % increase between 2017 and 2018 compared with a 4.1 % rise reported nationally across the NHS. 922 Adverse Incidents is less than 1 % of those reported in our partner NHS Trust AI reporting systems.

It is therefore probably not helpful to focus on actual numbers of Adverse Incidents beyond these simple comparators, but rather to focus on addressing the issues that arise, sharing learning and continuing to encourage all employees to report Adverse Incidents and near misses promptly.

We discuss and review all incidents raised in the hospitals with the hospital patient safety team. The most common Adverse Incident raised is when a sample has not reached or cannot be processed by the laboratory, which is a significant concern for patients and clinical teams. For blood tests on patients in hospital, they can often be repeated with only minor impact on clinical care. It is more problematic when from a child, a hard-to-bleed patient, a patient in the community or the result is required urgently. An inability to process blood samples is usually due to a number of reasons, such as the samples being requested but not taken or sent to the laboratory, sent to the wrong location or the wrong labels being attached to the tube, or the sample being incorrectly filled. In the service improvement section you can read more about how we have tackled some of these problems.

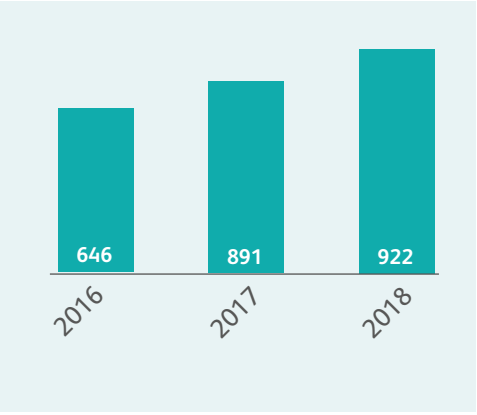


Table 2: Number of Viapath Adverse Incidents 2016-2018

> “Reporting supports Viapath and the wider NHS to learn from mistakes and to act to keep patients safe.”

Inability to report a result on a sample is a much greater concern if it cannot be repeated, such as a biopsy or a sample obtained during surgery. Fortunately these are rare events, but if this happens it would usually lead to the designation of a Serious Incident and lead to more detailed investigation and learning to improve the pathway.

Duty of Candour

The Duty of Candour is our legal duty to be open and honest with patients and their families, when things go wrong.

Viapath continues to discharge its Duty of Candour and Being Open as appropriate with all patients and their families. We do this in partnership with the designated clinical lead Consultant/GP.

Serious Incidents and Never Events

The NHS Serious Incident Framework (2015) defines a Serious Incident requiring investigation as an adverse:
'incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death, harm or injury to patient, carer, staff or visitor'.

A Never Event is defined as a:
'serious incident that is wholly preventable since guidance or safety recommendations provide strong systemic barriers and are available at a national level and should be in place within all healthcare providers'.

Reporting of both is a statutory requirement in line with the Health and Social Care Act 2008 and Care Quality Commission regulated activities.

During 2017 there were 12 reported Serious Incidents of which one was a Never Event and this prompted an external review commissioned by our partner NHS Trusts, as reported in last year's Quality Account. Sometimes, when there is a cluster of less serious incidents, and a trend or potential for serious harm has been identified, the Trust may decide that this constitutes an NHS Serious Incident. In 2017, there were a very small number of Serious Incidents which were categorised in this way (two), but this was not the case in 2018.

In 2018 there were six Serious Incidents, with one being downgraded by the respective NHS Trust and Commissioner, and none were Never Events. The main themes were: patient results not being issued or reported promptly due to delays between pathology, hospital and GP electronic systems, and processing issues including equipment failure, which resulted in precious samples being affected or lost.

	2015	2016	2017	2018
NHS Reported Never Events/ Serious Incidents	2	1	12*	6**

Table 1: Summary of total Viapath reported Never Events/ Serious Incidents (*includes one Never Event,**includes one third party event)

Viapath Complex Incidents

Viapath recognises that occasionally, incidents occur which can be very complex but do not impact on NHS funded patients in a way that partner NHS Trusts call them a Serious Incident. Consequently, Viapath introduced the Complex Incident Reporting Policy which was described in the Viapath 2017 Quality Account. http://www.viapath.co.uk/annual-quality-report-and-account.

All Serious Incidents are defined as Viapath Complex Incidents but not all Complex Incidents are NHS Serious Incidents.

Four Complex Incidents were reported in 2018 with two examples and learning points described below.

1. The central specimen reception team at the PRUH spotted that a sample pot had been issued in which the transport medium had expired, resulting in the sample not being able to be processed. It is important that samples are transported in the right conditions, in order for the laboratory to be able to prepare and analyse the sample correctly. Immediately, an investigation and review of the quality control processes for issuing sample pots was undertaken, to ensure that pots are not issued which have expired. Quality controls, Standing Operational Procedures (SOP) and training were updated, with the learning communicated to primary care and GP practice colleagues.

2. During the investigation of a Serious Incident at GSTT, it was suggested that some laboratory supplies were being delayed, due to the complexity of procurement and finance processing procedures. Any delay can impact on patients receiving the results of their tests. The Service Improvement Team were asked to undertake a review of all the processes involved and to support the team in taking recommendations forward. The team identified a highly complex set of processes which were simplified, the procedures and policies were reviewed and the head of finance communicated regularly with the laboratories with progress updates. This joint working initiative has been welcomed across Viapath and with NHS partners.

   As a result of the learning, Viapath set up and launched a patient safety governance meeting, where colleagues from Viapath Services and Group share learning, highlight issues and good practice. This underpins a key principle at Viapath, which is that everyone has a key role to play in delivering safe services for patients.

“Everyone has a key role to play in delivering safe services for patients.”

Update on actions resulting from the 2017 external reviews commissioned by partner NHS Trusts

In response to the NHS Serious Incidents (SIs) in 2017, Guy's, St Thomas' and King's College Hospitals commissioned two independent reviews, one for histopathology across Viapath and one for a specialist haematology laboratory on the Guy's Hospital site.

The reports did not identify any systemic issue impacting on the safety of the service and did not find an explanation for why 2018 saw 12 SIs compared with only one or two in the preceding years. Indeed they noted that these SIs had all occurred in laboratories that had recently received favourable external accreditation assessments that focus on the quality management system in place. Nevertheless these reports provided a source of targeted action and ongoing learning to support service improvement. They made a number of formal and informal recommendations, many of which were not directly related to the SIs but rather reflected the experience of the assessors and their sharing of best practice. We broadly grouped the subsequent actions in the following categories.

Partnership working with NHS customers

Improving partnership working with NHS Trusts for delivery of pathology services, for example during sample transport to the laboratory as highlighted above, and the process for introducing new tests into service from research laboratories.

Quality and governance functions

Recommendations to improve the quality management structure, particularly strengthening the roles and responsibilities of quality managers and disseminating Viapath-wide learning and service improvement.

Operational activities

The process for purchasing equipment and supplies and the need for laboratory refurbishment.

IT systems

Recommendations for investment in the laboratory computer system to include removal of any manual entry and setting up of common Key Performance Indicators across all sites.

These recommendations have been very helpful in setting our direction of quality improvement and resulted in a detailed programme of work with action plans that are monitored at monthly governance meeting, chaired by our Medical Director. Some of the completed actions include:

- Improved performance indicators to determine specific quality markers for early warning, to prevent a problem or event occurring
- Review of clinical governance roles and responsibilities for service delivery and leadership, including the appointment of a Head of Clinical Governance & Patient Safety reporting to the Quality Director
- Review and update of standard operating procedures for identifying and prioritising equipment in need of repair or replacement
- Improvements in the processes for logging samples into laboratories
- Introduction of Human Factors training to employees to assist in thinking about and redesigning the way we do things, to minimise or stop a mistake being made. We have delivered face -to-face workshops to over 600 employees already.

> "Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings."

A focus on human factors learning

Our primary purpose is to provide safe high quality care for patients. However, it is becoming increasingly recognised across healthcare services globally that delivering services to patients can place individuals, teams and organisations under pressure. This may have an impact on the quality of care or service potentially causing harm to patients. A definition which NHS England use to describe human factors is as follows:

"Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings".

Catchpole (2010), cited in Department of Health Human Factors Reference Group Interim Report, 1 March 2012, National Quality Board, March 2012. Available at: http://www.england.nhs.uk/ourwork/part-rel/nqb/ag-min

Viapath has established a range of quality and service improvement science techniques. You can read about some of techniques used by the Viapath Service Improvement Team to improve the design of processes and procedures, in the service improvement section. Through 2019, we are taking forward our learning from incidents and events, to minimise risk to patients, with a particular focus on the human factors identified and how we can optimise those factors to deliver safe care.

Risk

Risk management

Reflecting on the 2017 external reviews, Viapath has begun a process of strengthening the risk management framework. Actively looking ahead to manage risks and taking a more preventative mindset by mitigating as best we can the risks pathology faces to delivery of excellent, safe, efficient and effective care. Risk can occur in a variety of ways, for example as a result of changes in how or where we deliver services. The aim of risk management is to ensure these risks are identified early, assessed as to the best way to manage or control them and to reduce their effect.

At the heart of our services are patients. Therefore, the risk management process ensures that any factors that might compromise patient safety are prioritised. To do this, all laboratory teams and corporate areas identify their risks and potential threats, by working to the Viapath risk management arrangements and escalation flow process. Details can be found in the Viapath 2017 Quality Account. http://www.viapath.co.uk/annual-quality-report-and-account

Risk Assessment, Escalation and Monitoring

When a risk has been identified, an assessment is undertaken in accordance with the Viapath Risk Management Policy. Risk assessment is the overall process of identification, analysis and evaluation. The process facilitates the ongoing management, reduction or eradication of the risk to protect the safety of patients, employees, visitors, and the organisation as a whole. The identification of risk takes many forms and involves both a pro-active approach and retrospective review of an event. Where identified, we carry out a risk assessment of what the impact will be and what the likelihood is of recurrence.

Risks requiring escalation and senior review are escalated to senior operational managers immediately and monitored at the monthly site GRQ meeting. Should the risk require further escalation this is via the executive team, to ensure Director oversight.

The Viapath risk monitoring principles are:

- Risks are monitored through a consistent and integrated approach across Viapath, ensuring clinical, non-clinical and corporate risks are captured within the operational and corporate governance arrangements
- All general risks are assessed using a consistent grading tool which is in line with that of our NHS partner Trusts
- All identified risks are recorded on the local/site section of the risk register and shared with partner organisations via departmental and corporate governance forums
- Shared learning, led by the senior leadership teams, is supported by newsletters, general forums and daily patient safety laboratory huddles.

Risk Registers

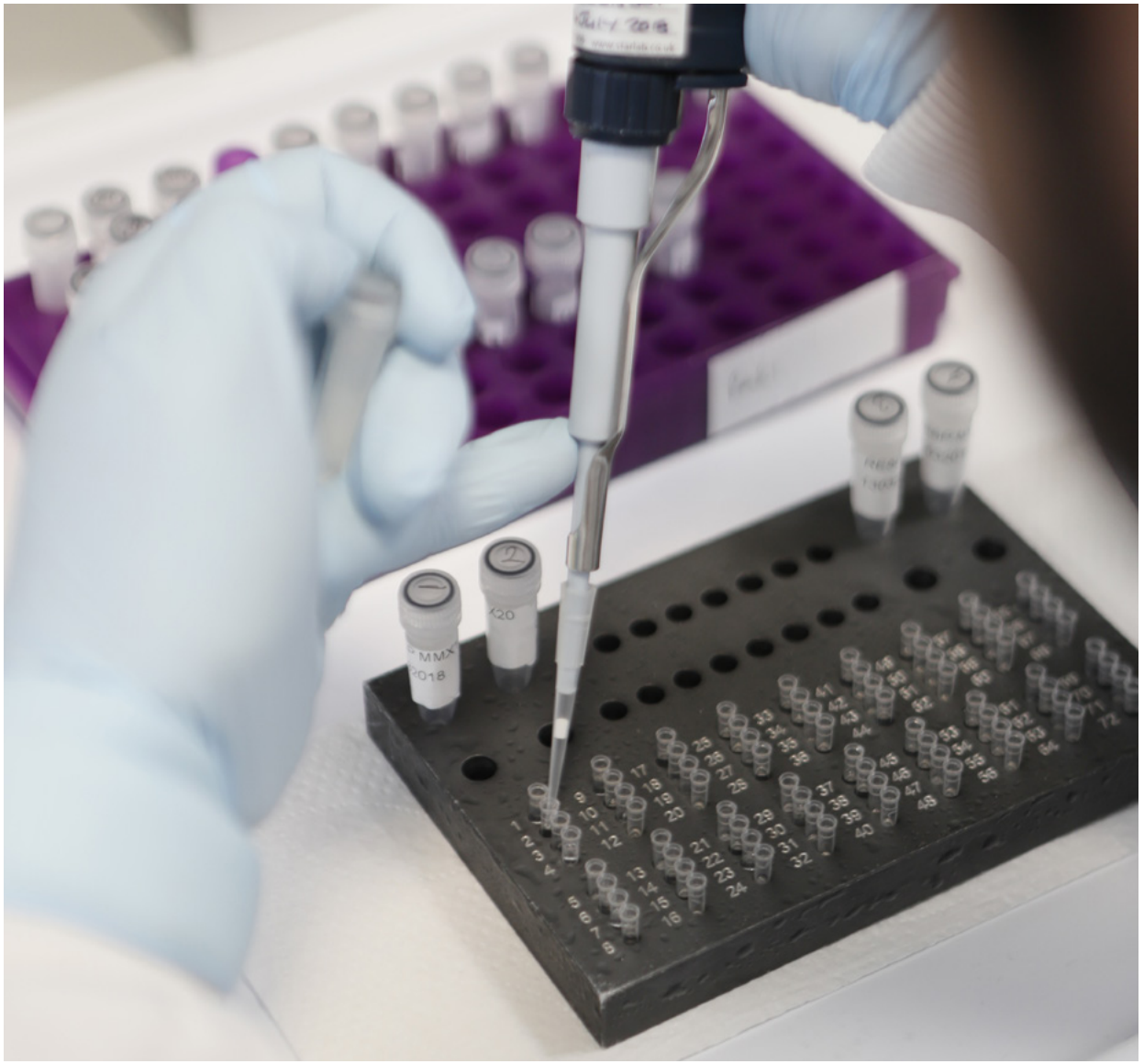
The Viapath risk register comprises a series of local, departmental and corporate sections and is essential to the successful management of risk. After identification, a risk is logged onto the appropriate section of the register. Actions are taken to respond, all of which are monitored by the responsible lead reporting into site governance GRQ meetings.

A red rating is attributed to the highest scoring risks and amber to those where unless action is taken promptly, it could become significant. Green ratings are when the risk has sufficient mitigation (action to prevent or minimise reoccurrence) in place, but requires

> “At the heart of our services are patients.”

ongoing monitoring until full assurance has been provided. Risks move off the register when mitigation plans have been fully implemented. Work is ongoing to standardise the risk assessment process at each hospital site to ensure consistency between Viapath and NHS partner Trusts. This will be completed in 2019.

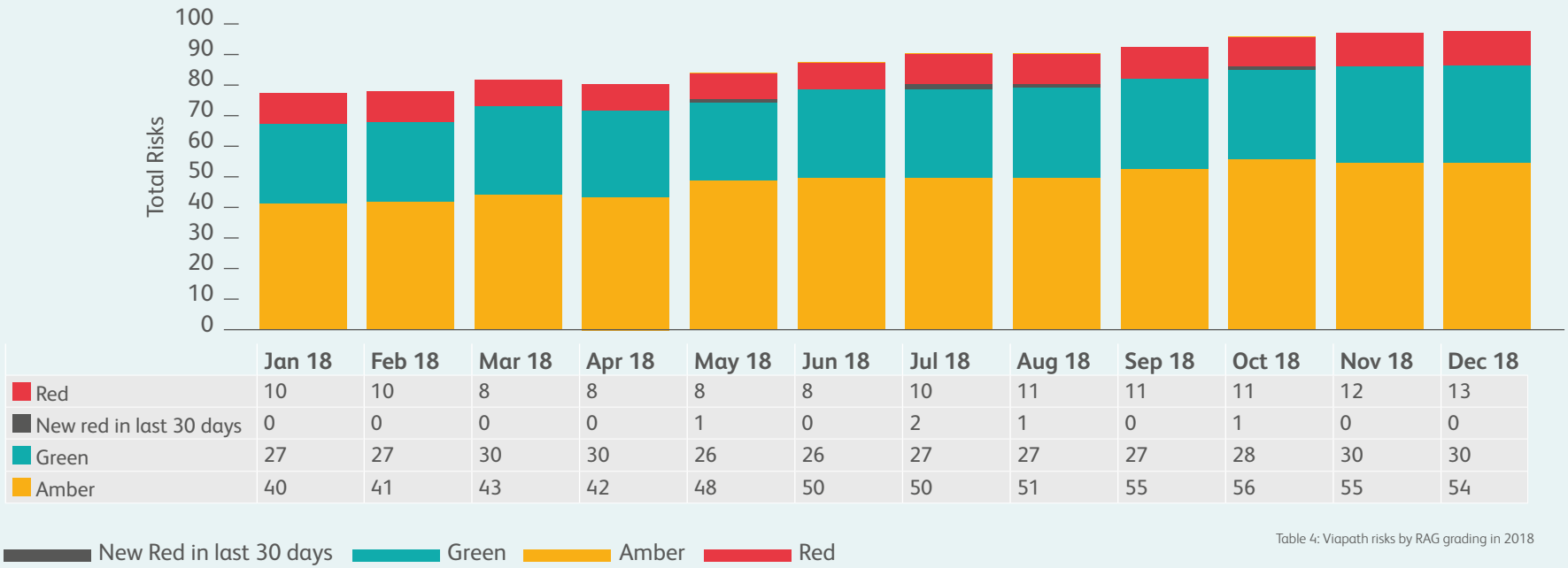
The risk register sections are formally reviewed at the appropriate management level at least quarterly. New risks are raised monthly at site GRQ meetings and the Viapath Board receive reports on any new red risks reported. Risk information is recorded and controlled so that lessons can be learnt.



Risks

Table four shows the numbers of active risks contained in the risk register each month. Red risks can be placed into the following groups:

- IT systems. Viapath inherited a complex set of IT systems ten years ago, many of which we continue to support. We have kept them identified as red risks for consistency, but the fact they have been maintained consistently over these ten years indicates that the mitigating factors have been largely effective.
- The old physical infrastructure in some of our 63 laboratories has resulted in occasionally having water leaks that have been dealt with by Trust estates, but remain a risk of recurrence. These water leaks have potential to damage valuable equipment and are likely to be a risk for a number of pathology organisations working in complex NHS buildings. While we are developing our strategy to move many laboratories into newer buildings, we have decided to highlight and accept this residual ongoing estate risk.



	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Red	10	10	8	8	8	8	10	11	11	11	12	13
New red in last 30 days	0	0	0	0	1	0	2	1	0	1	0	0
Green	27	27	30	30	26	26	27	27	27	28	30	30
Amber	40	41	43	42	48	50	50	51	55	56	55	54

Table 4: Viapath risks by RAG grading in 2018

Risk management

The overall trend for the number of risks being identified is upwards. We saw a step change increase over the summer, which has continued to rise over the rest of 2018. This largely follows from the 2017 external reviews that led to managers across the organisational reviewing their risks, and for example, where lessons had been learnt on one site, ensuring that all other sites undertook a risk review to assess if they too had similar potential risks.

We particularly prioritise areas where staffing levels present a potential risk to service continuity; for example in laboratories where there are national shortages of scientists such as blood transfusion services. The services affected have plans which are regularly monitored by the senior leadership team and are recorded as amber risks

However, the trend also suggests that although we have focused on raising risks, some areas have been slow at closing them. It is important that all risks have an active focus and that managing risk safely is part of day-to-day work practice. In response, the Medical Director and Chief Operating Officer have requested a review of our process and procedures for managing risk, which will be completed in 2019.

Health & Safety

In 2017 Viapath set an objective to accomplish 100% Personal Protective Equipment (PPE) compliance for example, using gloves and goggles. As a result, PPE related incidents in relation to inadequate use, decreased significantly with only six incidents reported in 2017 in comparison to 16 reported the year before (62% reduction). Incidents reduced further in 2018, with only four incidents occurring during this period, which is a further 33% reduction overall compared to 2017.

Throughout 2018, another focus was the introduction of Health & Safety (H&S) lessons learnt procedure. This process involves acting on findings of accidents, near-misses and organisational vulnerabilities identified by teams during monitoring, audit and review processes. Lessons learnt published during this period were identified through near-miss investigation and audit review.

We focused on two key issues:

- Ensuring that 'critical' equipment that required a continuous power supply was identified. Important because if, uncommonly, a power surge /ceasing of the power supply occurred, it could impact on its functioning and damage the tissue sample.
- Containment Level 3 annual sealability.

Viapath follows the Control of Substances Hazardous to Health [COSHH] Regulations. Biological agents are categorised by the Advisory Committee on Dangerous Pathogens (ACDP) according to risk and divided into Hazard Groups. These Hazard Groups (one is the lowest, four being the highest risk) are defined on the basis of how infectious substances/human tissue are and the consequences of such infection. Therefore the laboratory which handles hazardous substances is categorised by the level of containment required. (Containment Level three is required for Hazard Group 3 pathogens) The containment level reflects the increasing levels of health risk to those involved in, or who could be affected by, such work.

As a result of our focused work, we have reviewed and strengthened standard operating practices. Analysis identified some processes required attention on human factors and system design, to mitigate against reoccurrence. This learning has given assurance across the business, that critical processes are reviewed in real time, to mitigate any potential risk of reoccurrence.

Viapath's commitment to training and supporting the H&S teams in 2018 has been strengthened by our robust H&S training programme, in conjunction with the Viapath Learning & Development team. This will:

- Support employees in identifying hazards and adopt safe and healthy work practices
- Help avoid the personal and financial costs that accidents and ill health cause
- Build a positive culture in which unsafe and unhealthy working is not tolerated
- Enable employees to identify ways to improve H&S management
- Assist the business in meeting our legal duty to protect the health and safety of employees and others.

The training programme will incorporate all elements of health, safety and well-being including risk assessment, COSHH assessment, fire risk assessment, manual handling, Display Screen Equipment assessors, first aid training, Institution of Occupational Safety and Health (IOSH) managing and working safely and being open to conversations focusing specifically on employee mental health and well-being.

"Viapath follows the Control of Substances Hazardous to Health [COSHH] Regulations."

H&S incidents per level of harm in 2018

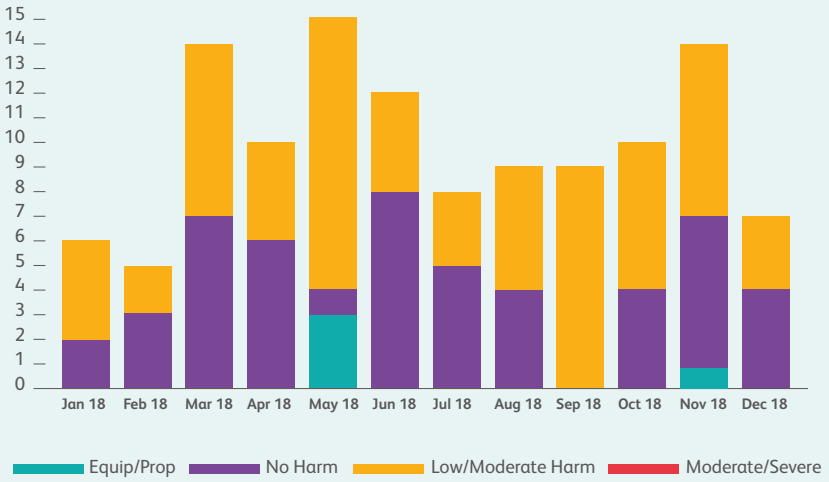


Table 5: Health & Safety incidents per level of harm in 2018

Total needle stick/sharps injuries and proportion out of total incidents

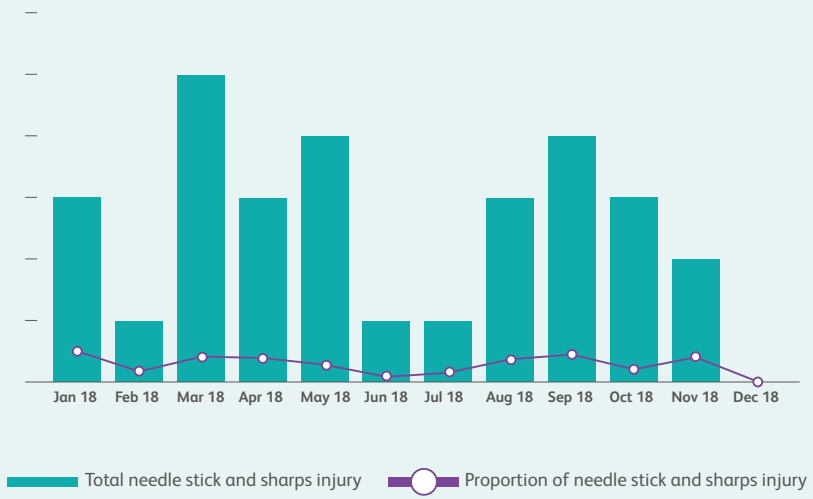


Table 6: Total needle stick/sharps injuries and proportion out of total incidents

In 2018 there were 118 H&S related incidents reported, a 10% increase from the year before. All H&S incidents reported in 2018 fell under the category of either no harm or low/moderate harm with four incidents occurring due to equipment/property damage. Overall, the H&S incidents trend is consistent but sharps injuries and exposure to hazardous substances continues to be the most commonly reported type of incident.

Health & Safety Needle Stick Incidents Trend

In 2018 Viapath reported 34 needle stick/sharps incidents which accounts for 29% of the overall reported incidents in 2018. The data is showing a consistent trend in comparison with 2017 and the business will be working with the departments to reduce levels throughout 2019. Tissue Sciences and Phlebotomy report the highest numbers of needle stick/sharps incidents, contributing to 38% and 29% respectively of the total.

2019 Health & Safety Objective

In 2019 Viapath will focus on the development of the Health & Safety Strategy. The strategy will be based on the continual improvement of the health, safety and protection of employees and visitors and achieving legal compliance. The aim of the strategy is to:

- To develop a culture and ownership of health and safety across the business
- To monitor and measure health and safety performance throughout the business
- Ensure the business remains legally compliant
- Ensure the safety and well-being of our people.

This will help Viapath manage health and safety and improve employee safety, reduce workplace risks and create better, safer working conditions.

Service Improvement

The bespoke Viapath Service Improvement Team (SIT) have expertise in helping services identify issues and change the way services are delivered, in order to be more efficient and effective. They encourage the removal of wasteful processes and help in reducing the unwanted variation of outcomes. This is achieved by utilising Lean Six Sigma methodology; a well-established technique that has been developed to challenge current practices and the status quo.

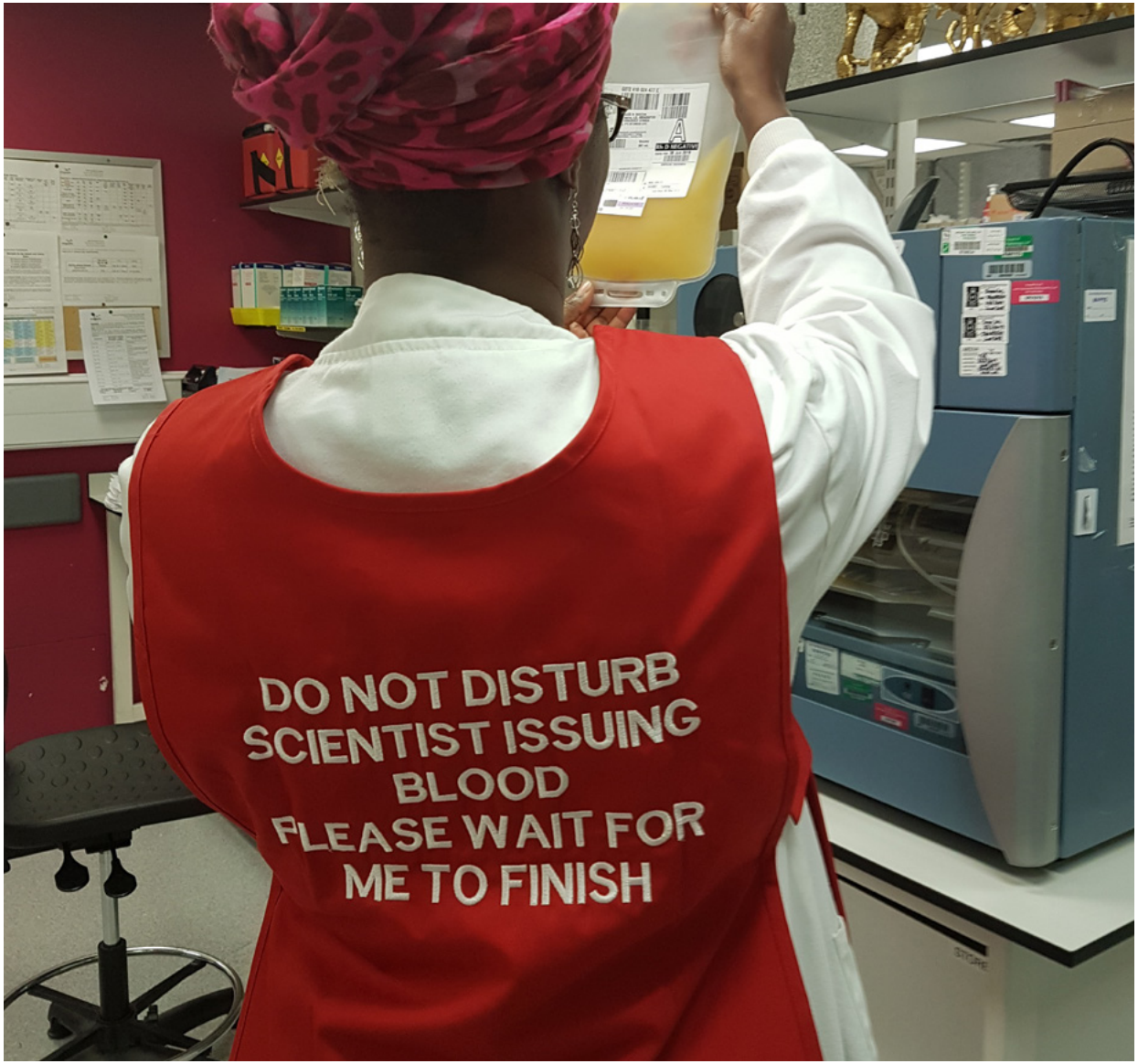
Improvement projects typically impact a number of processes and teams, so key people involved in each process will be engaged in improvement activities with the team. The activities could include process mapping by conducting observational assessments and process analysis, to understand how and why things are done the way they are; demand and capacity planning including best use of resources and best practice benchmarks. The team then analyse the data, making recommendations and plans with the team to improve the service. They then track progress and ensure the improvement project keeps to its schedule for delivery.

The team were involved in fifteen process improvement initiatives and projects in 2018, across multiple sites and departments within the business. Below are some examples of those initiatives that are already providing process improvements.

Blood transfusion service

Problem Statement:

The Never Event in October 2017, involved a patient being transfused with a blood product (plasma), of the wrong blood group. More detail can be found in the Viapath 2017 Quality Account. http://www.viapath.co.uk/annual-quality-report-and-account.



Following an investigation conducted jointly by Viapath and the Trust, a series of recommendations were made, including reviewing the workload/processes/staffing levels, as they may have impacted on the service at the time of the incident.

The SIT team spent time in the laboratory reviewing in detail all their work processes, demand, capacity and resource requirements. They then provided detailed process maps and spent time reviewing the workload and resources required, in order to meet demand. They concluded that a number of improvements should be made.

Improvement/Recommendations:

A key finding was that employees were constantly interrupted and therefore, increased the opportunity to make a mistake. Tabards were introduced to workers on the Front Bench, to reduce disruption – please see photograph. The use of tabards worn by nurses, whilst undertaking key patient safety tasks such as giving medication to patients, has been proven to work well and stop interruptions.

The team also created a video demonstration, which has been used across Viapath to introduce awareness of human factors and how to make services safer for patients. You can watch it on Youtube. https://www.youtube.com/watch?v=KgxEwdlUQII

They recommended changing location of employees to create a smooth work flow process and not having to disrupt or cross other workers' paths. In addition, it enabled the most experienced scientists to oversee and undertake the critical steps in the issuing of blood products.

The numbers and experience of employees was reviewed and the SIT provided a detailed staffing model to establish how best to deploy employees. The operational team worked with recruitment to recruit additional scientists.

In conclusion, the laboratory has sustained the changes made and is regularly reviewing and modifying its processes to ensure that they are safe and efficient. The lessons learnt have been rolled out across other laboratories.

Improvement of laboratory sample turnaround times

Problem statement:

The virology laboratory had not been consistently achieving its Turnaround Time (TAT) within three days from receipt of sample within Central Specimen Reception (CSR) at St Thomas' Hospital (STH), to reporting. A proposal was made for the sexual health clinic to have an analyser as part of their Point of Care (POC) testing, in an attempt to mitigate unsatisfactory TATs for chlamydia and gonorrhoea. The SIT were asked to investigate the issues raised in order to improve the service and efficiency for the patients and clinicians.

Here is an example of a spaghetti diagram which shows how the SIT map the different work processes all going on at the same time in a laboratory. These diagrams are very helpful in establishing the best layout and order of tasks needing to be done, to optimise the use of the instruments and employees.

Example of a spaghetti diagram

Improvements/Recommendations:

Following the SIT extensive review, using the same techniques as described in the previous example, they recommended that the laboratory changes its process for booking in and loading samples onto the analyser. Previously the process had been fragmented and therefore using a streamline approach reduced wasted time and improved the TAT.

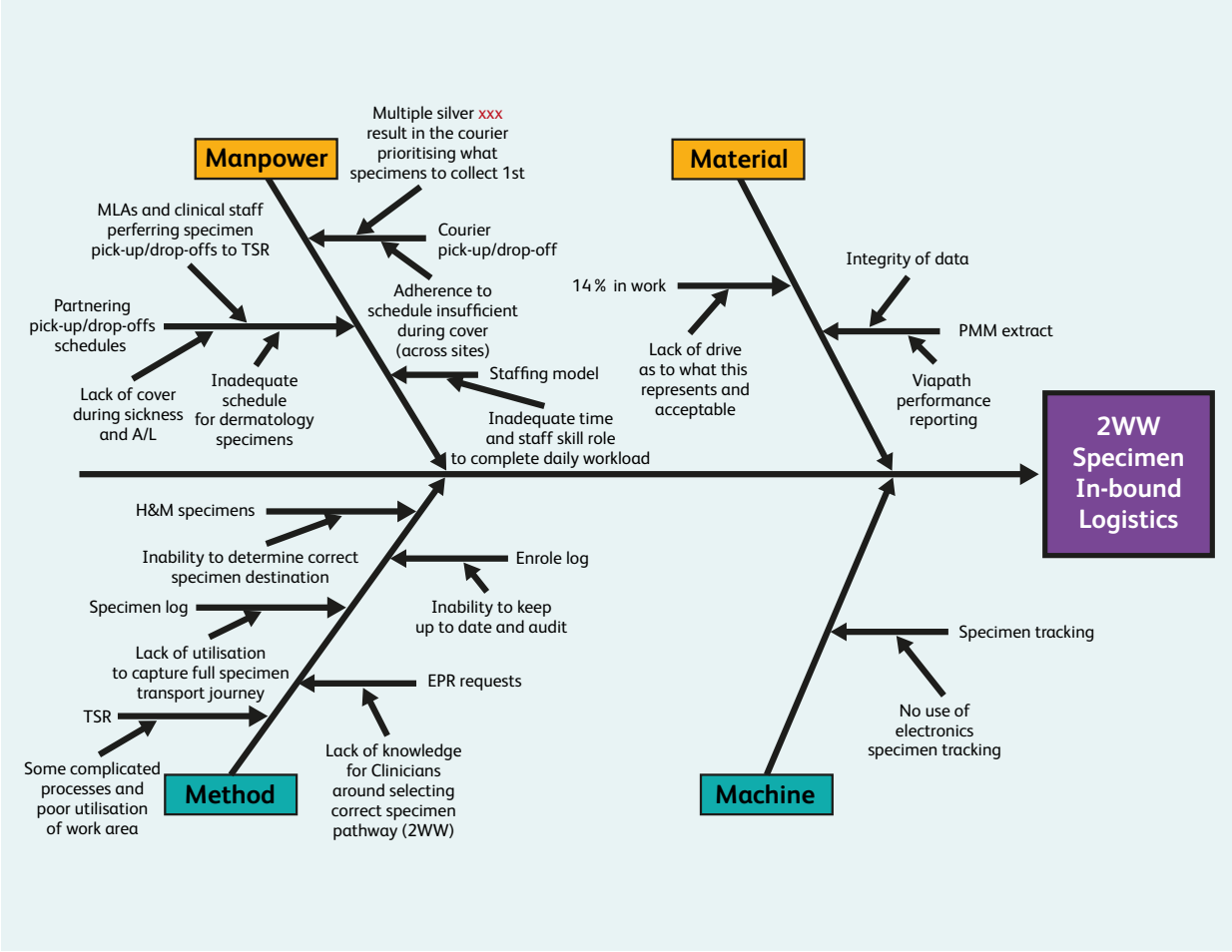
The SIT reviewed the workflow and equipment in the laboratory and made a number of recommendations including the removal of some equipment, so freeing up space for the laboratory team to work. They also supported the laboratory to optimise the use of the analysers to ensure maximum efficiency by running three together.

Finally, the SIT team devised an improved process for booking in samples day and night, with a service level agreement between all parties involved in the process. As a result of their work, the TAT rose from 70.5 % to 97.1 %, far exceeding the TAT standard and has been maintained.

Tissue sample logistics

Problem statement:

Following a review into a cluster of incidents in tissue sciences laboratories, it was identified that further investigation was required around the inbound logistics of samples across the Trust. The internal and external transportation methods of samples are quite complex and therefore contribute to the failure to achieve the turnaround time (TAT) of 2 Week Wait Cancer Pathway cases (2WWCP). Samples could take up to 3–4 days to reach the laboratory. The SIT undertook a detailed observational analysis and investigation. They developed a fishbone diagram to help them and the team understand what the issues were and how best to tackle them.



Example of Fishbone diagram to illustrate investigation root causes

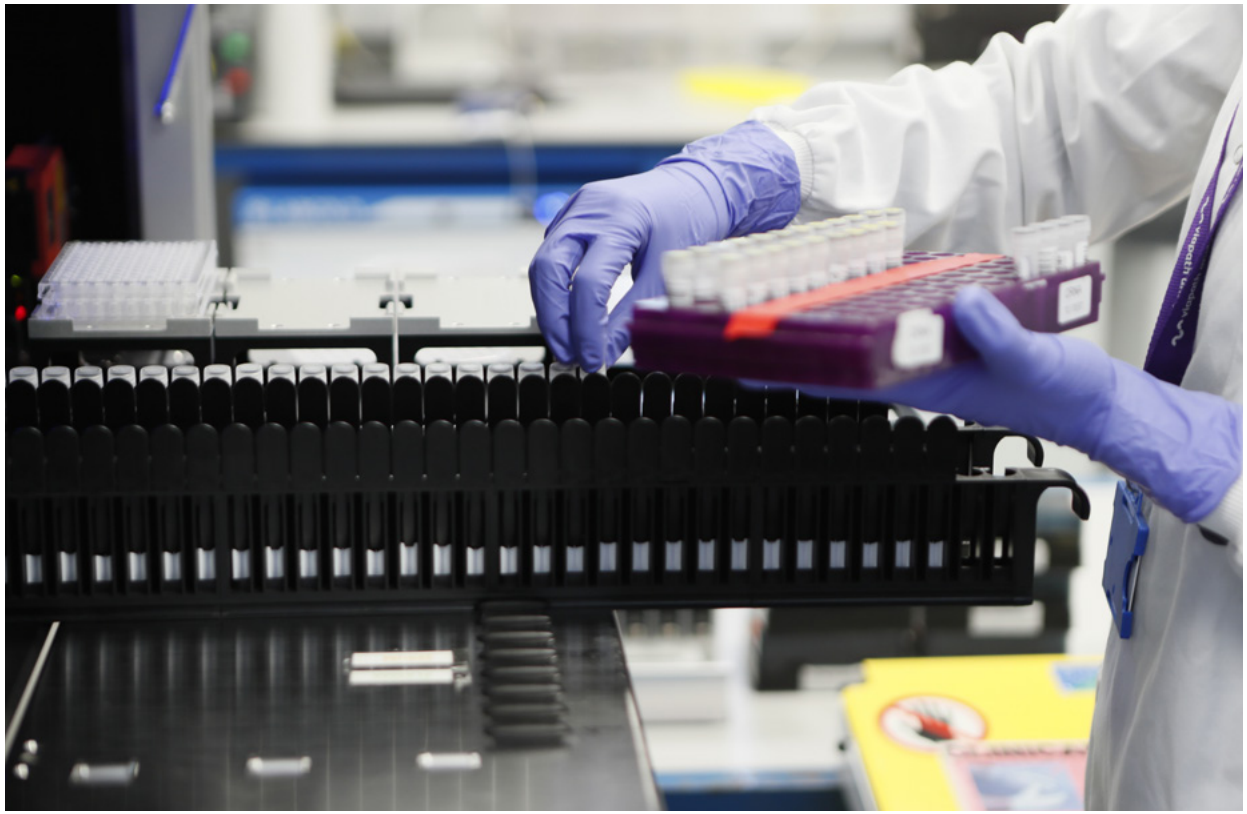
Improvements/Recommendations:

Hospital porters are a key team for ensuring that samples reach laboratories promptly. However, the SIT identified that there were often delays with sample arrival for a range of reasons. They therefore met with the porter management team to agree an initiative and improve porter performance by rescheduling sample pick-up and delivery times.

The SIT identified that urgent cancer samples were often not arriving in the laboratory labelled as an urgent sample but had been sent as routine. This is important because the laboratory will always process a cancer sample immediately, whereas routine samples have clinically agreed slower TAT. Therefore the team designed colour coded bags to help clinicians, transport and laboratory employees identify 2WWCP specimens quickly to ensure that they were placed in the correct process.

The laboratory team worked with the SIT to ensure that they displayed clear labels both on the analysers and on specimens, to ensure that the sample process was highly visible to minimise errors.

All of these improvements have significantly reduced the time which samples take to get to the laboratory – extremely important when a patient is awaiting the results of tests to see if they have cancer or a serious condition. The laboratory team, Trust and SIT continue to work together to continuously improve the service for patients.



Customers

Customer Services

In 2018, an internal review was conducted to establish how we can improve the service offered to our customers and users. As a result, the team has been restructured. The feedback also suggested that changes in our communication with customers would improve the customer experience and their confidence in our service.

We have improved our offering for customers including:

- Enhanced customer services training plans for existing and new employees to ensure that we improve our interactions and feedback with customers
- Targeted recruitment for customer service team colleagues, designed to ensure that all candidates fully met the required standards of the department
- Improvements in the process for handling customer queries, reducing call wait times across the organisation.

On the following page is the customer services team at Viapath who are always ready to assist with any query that arise.

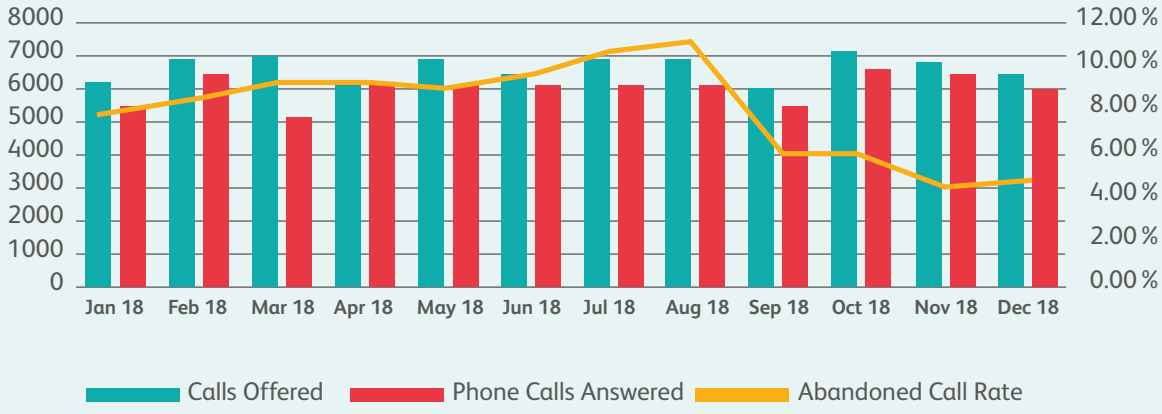


Table 7: Call rate and answer data 2018

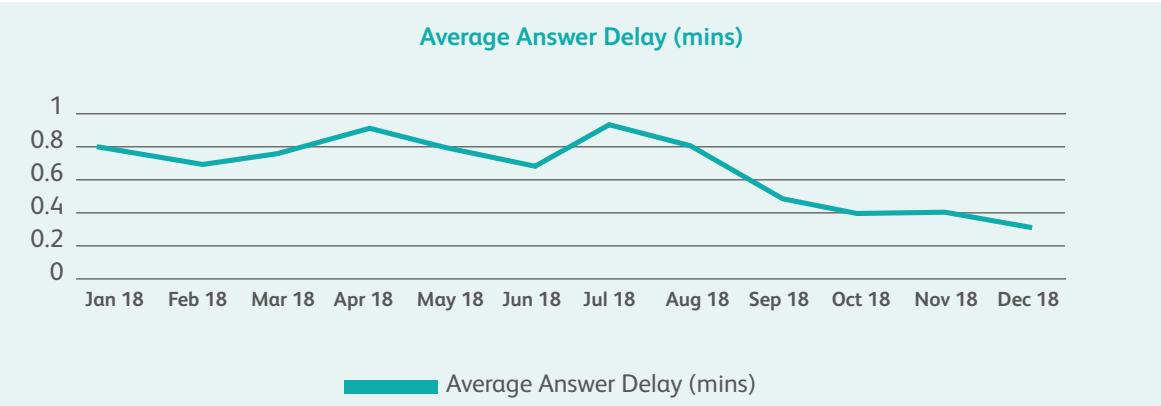


Table 8: call answer delay rates in 2018

Viapath customer service team

The new team members were recruited in August 2018 and training progressed for the remaining part of the year. The charts on the previous page show the performance of the customer service
queue call line throughout 2018. They clearly demonstrate the impact of the new team members and our service improvements, on abandoned calls and wait times. All decreased sharply from August 2018 and have continued to do so in 2019.

We have actively engaged with customers and they have told us that they would like to see more electronic reporting. We have already begun work on this objective in 2019 and are in the process of rolling out the solutions identified.

During 2019, we will be increasing the range of customer service functions and support we offer, with both new and existing customers.

Front row left to right: Gabrielle Morrison, Cam Johal, Rachel Anderson, Alfeeza Ladak, Jessica Palmer & Alfonso Magalong
Back row left to right: Flavia Quigley, Rita Prescott & Iain Traynor

Customer Service Team Manager – winner of Viapath Bright Beginner Award 2018

A great example of the impact of customer service improvements, has been our new Customer Service Team Manager, Matthew Aruldoss-Hines, receiving the Viapath 2018 Bright New Beginner Award from Mary Fitzgerald Viapath Director of Human Resources & Internal Communications.

This award is to reward and encourage employees who have made a shining example of themselves in their first year at Viapath through their customer focus and living the company's ICE (Innovation, Collaboration & Expertise) brand values.

Complaints

Complaint: Hinchinbrook NHS Trust called to complain about the turnaround times for a test from the Purine Laboratory. The concern was that it had taken nearly two weeks for the clinician to receive the reports following authorisation. The customer service team immediately launched an investigation with the hospital.

Response: The investigation identified that the result reports had been completed within the turnaround times, but had been sitting in the customer hospital post room for a considerable timeframe, before being delivered to the pathology team.

Viapath therefore agreed with the customer an alternative method for sending results and electronic mailing has avoided any more delays.

Hinchinbrook Hospital 16/11/2018

Complaint: Private patient contacted customer services and requested support in obtaining their test results. Unfortunately, the customer had experienced delays in getting information despite numerous telephone calls and was losing confidence in the process at Viapath.

Response: Customer service team member who received the call took individual responsibility for the problem and investigated what had gone wrong. It was discovered that unfortunately the customer had been given the incorrect details of who to contact for their results, hence the delay. The team member ensured that the results were available and processed promptly. They also reported their findings to their manager, who met with the team who had given the incorrect information to the patient and ensured that their process was corrected.

The patient reported that they were 'pleased with the support' offered by Customer Services at Viapath and now 'trusted the process in place'.

Private Patient – 19/11/2018

> "This award is to reward and encourage employees who have made a shining example of themselves in their first year at Viapath."

Compliments

Background: An acutely ill patient had a test at Hammersmith Medicines Research Unit (HMRU). Unfortunately there had been issues with previous testing, so the HMRU contacted Viapath to see if we could process another request to a tight deadline. The customer service team arranged this with our laboratory and ensured samples were delivered and sent correctly to us. Once the results were available, they were immediately sent to the HMRU so they could progress the patient's treatment.

Compliment: "I would like to sincerely thank you for all that you did in order to finalise this urgent result of ours. I don't have 'L's' email address so please do let them know it is much appreciated."

Hammersmith Medicines Research Unit 19/03/2018

Compliment: "I would also like to let you know how good the customer services team is, they have been helping out with queries and are usually very quick to respond. I thought you may want to pass this feedback on. Thank you very much for all your efforts."

Clinical Director Abbott (formerly Alere) 01/06/2018

Background: Duty Biochemist at Maidstone & Tunbridge Wells Hospital (MTW) called needing an urgent valproate result on a patient, but unfortunately the sample had already been sent with the routine samples, about an hour before, using the regular Viapath courier.

Compliment: "I would like to pass on a compliment from 'SV' Duty Biochemist at Maidstone.

'J' and 'B' in CSR liaised with their teams so that this sample was identified as soon as it arrived, allowing it to be processed urgently. The results were provided immediately after processing to MTW. With everyone's help, we had a result for this sample within 30 minutes of arrival and in under two hours from the initial telephone call.

'SV' was very impressed with your response and service. Thank you to everyone. I would like to add that I really enjoy working with you and think we all work really well together. "

Senior Clinical Scientist at Viapath on behalf of the Duty Biochemist MTW – 21/10/201

"I would like to add that I really enjoy working with you and think we all work really well together."

Our people progress

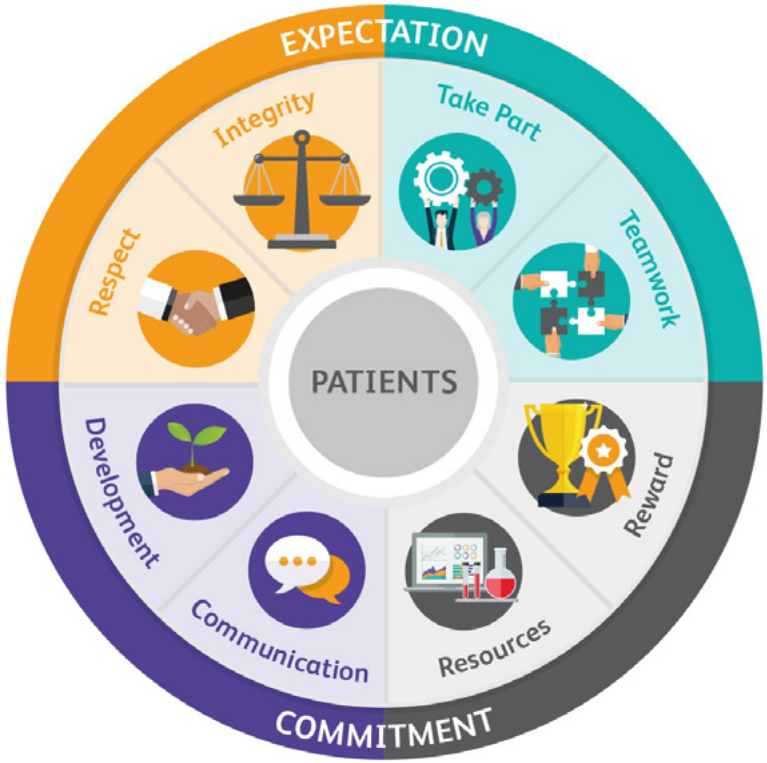
Our Human Resources Director Mary Fitzgerald

Mary Fitzgerald
Human Resources Director

We have defined our cultural ambition and The Viapath Way describes "the way we do things around here". Behind each segment sit some simple statements describing what is expected of our employees, and what they can expect in return.

We are on a journey to embed a clear and distinct culture, and this year we will use the model to assess candidates in recruitment and employees in the appraisal process.

2018 saw a particular focus on reward and recognition. We increased annual leave, improved life assurance cover, and introduced an employee recognition programme.



In the Spotlight

The Spotlight Awards provide a mechanism through which managers can reward outstanding contribution through 'in-the-moment' recognition.

In December we celebrated the hard work, dedication and achievements of around 60 individuals and teams at our annual Viapath Heroes Awards ceremony.

We also started to look at pay and grading and have created a Viapath grading structure which will, in time, be underpinned by new pay arrangements.

Achieving our financial target in 2018 meant that again the Viapath Incentive Plan paid out £500 to eligible employees, representing a significant pay enhancement for many people.

A final highlight of 2018 was the implementation of a new employee database – MyHR – which provides our managers and employees with self-service access to data, and a payroll system, enabling us to in-source payroll, resulting in greater flexibility and speed of response to queries and improved accuracy.

Dr Guy Orchard at 2018 Viapath Heroes Awards

Employee initiatives

Healthcare Science Week

Healthcare Science Week is an annual event designed to promote the amazing work of healthcare science professionals in the NHS.

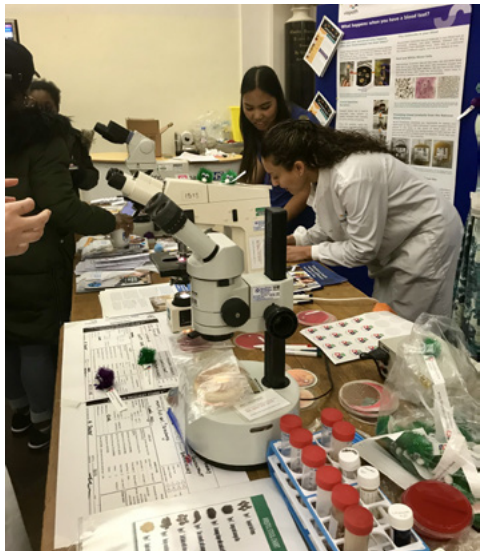
This year, Viapath teams from Infection and Blood Sciences participated in a publicity event in the Central Hall at St. Thomas' on the 14 March 2018.

The team, made up of medical laboratory assistants, biomedical and clinical scientists, spent a few hours showcasing laboratory healthcare science to highlight the difference it makes to patient care.

The team's display had lots of interest from patients, many of whom explained they had their bloods taken often, but no idea what happened to them after that. They were very interested to learn about haematology, biochemistry and transfusion work and about how many samples we received each day.

Trainee nurses also stopped by and were glad to take the opportunity to meet us and ask questions such as: why some samples are not able to produce certain test results such as clotted or haemolysed samples, how results are calculated and how diagnosis is made using blood films such as malaria.

Other visitors included individuals, including patient relatives, who were interested in pursuing a healthcare science career and a number of children who found the microscope fascinating!



World Quality Day

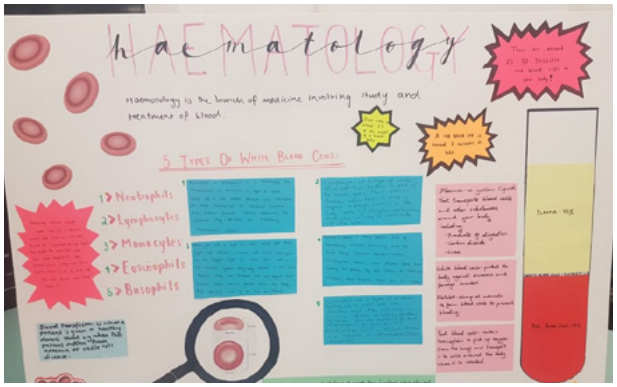
Each year the Viapath Future Leaders in Innovation lead the celebrations of World Quality Day in November. Here are some photos taken on the day with teams across Viapath, having a great British bake off and a series of team games. The day raised XXXX pounds for charity.

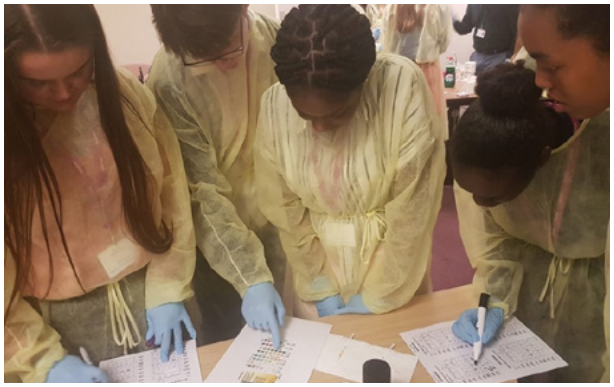
Reach Out for Healthcare

Each year, Viapath takes part in organising Reach Out for Healthcare Science. This is a national initiative and involves two days of pathology-related activities, to inspire local GCSE students and give them a taste for what a career in pathology entails. In South East London, King's Health Partners, which includes Guy's and St Thomas' hospital, King's College hospital, South London and Maudsley mental health Trust and King's College, London University, coordinates the event.

In 2018, Viapath took a different approach from previous years, with Krutika Deuchande, a member of the Viapath Future leaders in Innovation group, leading our involvement. Krutika organised the entire week in partnership with the previous King's Health Partners Reach Out lead, Richard Fernandez, and the STEM Reach Out provider, Exscitec.

The week consisted of healthcare scientists from a range of disciplines delivering lectures and fun-filled practical sessions to engage the students at St Thomas', Guy's and King's College hospitals.





Thank you

Acknowledgements

We would like to thank all our contributors to the 2018 Quality Account.

Contact us

Do you want further information about Viapath or our services?

Corporate Office:
Francis House
9 King's Head Yard
London
SE1 1NA

Reception:
020 7188 2500

Customer Services:
customersupport@viapath.co.uk

viapath.co.uk

linkedin.com/company/viapath-llp

viapath
pioneers in pathology