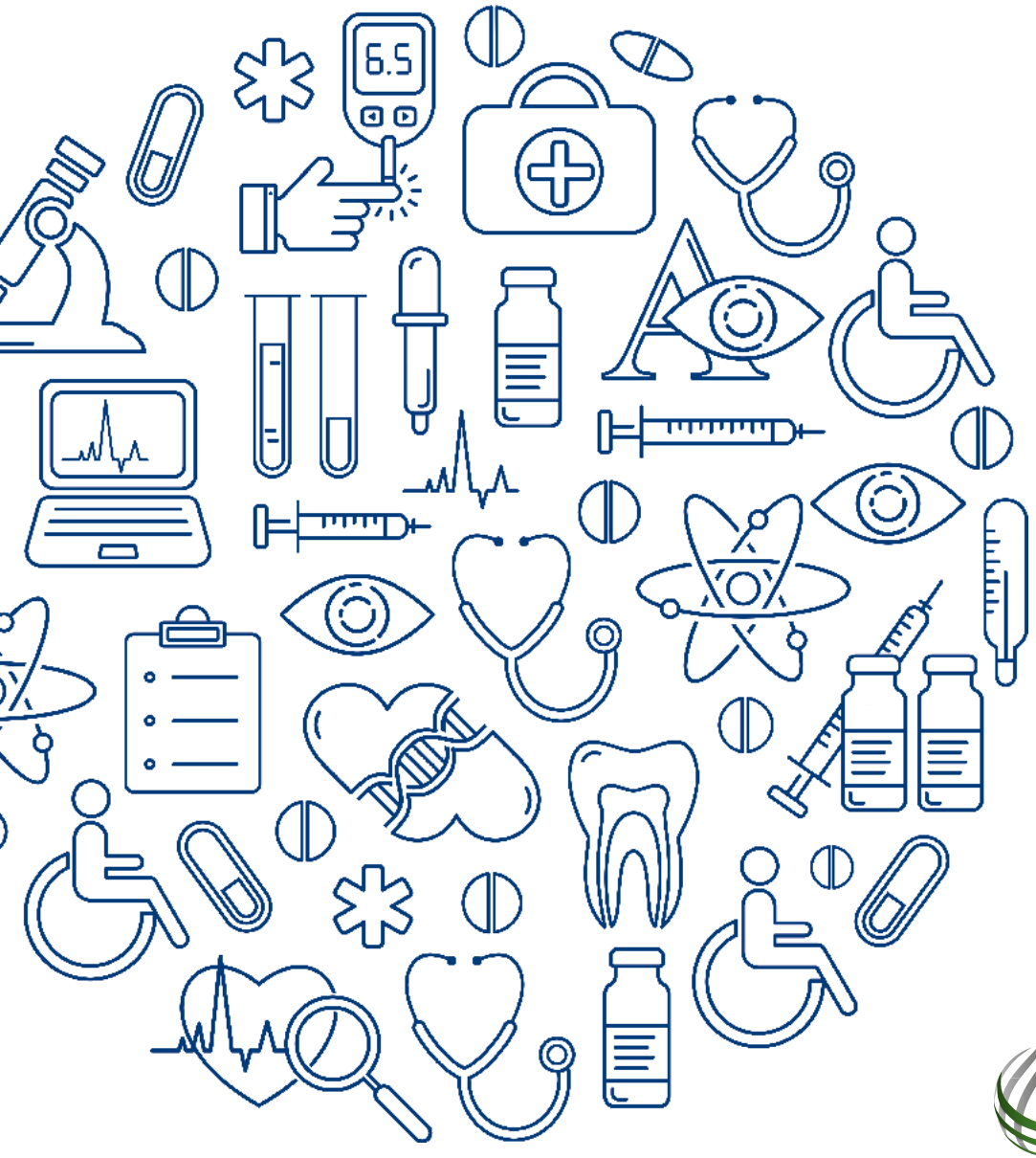
Claremont Hospital

Quality Account

April 2017 – March 2018



claremont
PRIVATE HOSPITAL

Contents

Aspen Healthcare

Welcome to Aspen Healthcare

Claremont Hospital is part of the Aspen Healthcare Group

Aspen Healthcare was established in 1998 and is a UK-based private healthcare provider with extensive knowledge of the healthcare market. The Group's core business is the management and operation of private hospitals and other medical facilities, such as day surgery clinics, a number of which are in joint partnership with our Consultants.

Aspen Healthcare is the proud operator of four acute hospitals, two specialist cancer centres and three day-surgery hospitals in the UK. Aspen Healthcare's current facilities are:

- **Cancer Centre London**
  Wimbledon, SW London
- **The Chelmsford Private Day Surgery Hospital**
  Chelmsford, Essex
- **The Claremont Hospital**, Sheffield
- **The Edinburgh Clinic**, Edinburgh
- **Highgate Private Hospital**
  Highgate, N London
- **The Holly Private Hospital**
  Buckhurst Hill, NE London
- **Midland Eye**, Solihull
- **Nova Healthcare**, Leeds
- **Parkside Hospital**
  Wimbledon, SW London

Aspen Healthcare's facilities cover a wide range of specialties and treatments providing consulting, diagnostic and surgical services, as well as state of the art oncological services. Within these nine facilities, comprising over 250 beds and 19 theatres, in 2017 alone Aspen has delivered care to:

- more than 43,000 patients who were admitted into our facilities
- just under 9,000 patients who stayed as an inpatient for overnight care
- over 34,000 patients who required day case surgery
- almost 310,000 patients who attended our outpatient departments
- more than 370,000 patients who attended our diagnostic departments.

We have delivered this care always with Aspen Healthcare's mission statement underpinning the delivery of all our care and services:

> **"Our aim is to provide first-class independent healthcare for the local community in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families."**

Aspen is now one of the main providers of independent hospital services in the UK and, through a variety of local contracts we provided 18,000 NHS patient episodes of care last year, comprising nearly 41% of our patient numbers. We work very closely with other healthcare providers in each locality including GPs, Clinical Commissioning Groups and NHS Acute Trusts to deliver the highest standard of services to all our patients.

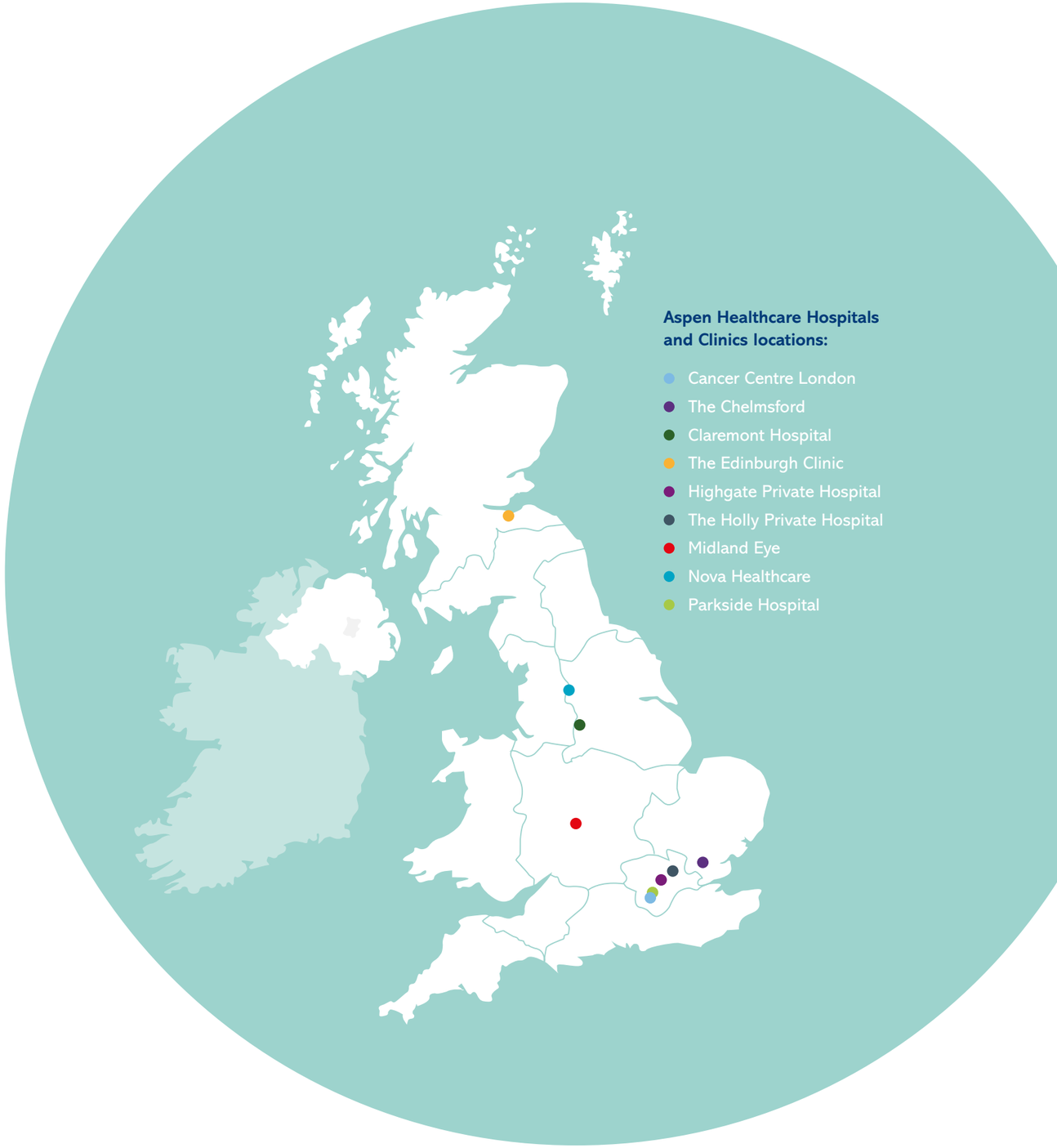
It is our aim to serve the local community and excel in the provision of quality acute private healthcare services in the UK.

We are pleased to report that in 2017

99.4%
of our inpatients and day patients rated the overall quality of their care as 'excellent', 'very good' or 'good'.

99%
of inpatients and outpatients stated that they were 'extremely likely' or 'likely' to recommend the Aspen hospital/ clinic they visited.

Across Aspen we strive to go 'beyond compliance' in meeting required national standards and excel in all that we endeavour to do. Although every year we are happy to look back and reflect on what we have achieved, more importantly we look forward and set our quality goals even higher to constantly improve upon how we deliver our care and services.



The Edinburgh Clinic · The Chelmsford Private Day Surgery Hospital · claremont PRIVATE HOSPITAL · HIGHGATE PRIVATE HOSPITAL · MidlandEye Specialists in complete eye care

The Holly PRIVATE HOSPITAL · parkside hospital · cancer centre london · NOVA healthcare

“I have already recommended the hospital to several people as the service is second to none.”

Mrs S, Sheffield

Statement on Quality from Aspen Healthcare’s Chief Executive

Welcome to the 2017-2018 Quality Account, which describes how we did this year against our quality and safety standards.

On behalf of Aspen Healthcare I am pleased to provide our latest annual Quality Account for Claremont Hospital. This report focuses on the quality of services we provided over the last year (April 2017 to March 2018) and, importantly, looks forward to setting out our plans for further quality improvements in the forthcoming year.

As this last year draws to a close I am pleased to be able to reflect on how we have further improved our safety and quality of care. At Aspen Healthcare we aim to excel in the provision of the highest quality healthcare services and work in partnership with the NHS to ensure that the services delivered result in safe, effective and personalised care for all our patients. Each year we review the quality priorities we agreed in the previous year’s Quality Account. These quality priorities form part of Aspen’s overall quality framework which centres on nine drivers of quality and safety, helping to ensure that quality is incorporated into every one of our hospitals and clinics, and that safety, quality and excellence remain the focus of all we do, whilst delivering the highest standards of patient care. This is underpinned by Aspen’s Quality Strategy, which focuses on the three dimensions of quality: patient safety, clinical effectiveness and patient experience.

All our hospitals and clinics in England have now been externally inspected by the health and social care regulator, the Care Quality Commission (CQC). These comprehensive inspections have provided external validation of the quality and safety of care we deliver and we are proud to report that all our hospitals and clinics have been rated as ‘Outstanding’ or ‘Good’, with commendations received on our staff’s professionalism, kindness and compassionate care.

This Quality Account presents our achievements in terms of clinical effectiveness, safety and patient experience, and demonstrates that all our managers, clinicians and staff at Claremont Hospital are committed to providing the highest standards of quality care to our patients. The Account aims to provide a balanced view of what we are good at and where additional improvements can still be made. In addition, our quality priorities for the coming year (2018-2019), as agreed with the Aspen Senior Management Team, are outlined within this report.

In 2017-2018 we maintained our excellent record on reducing avoidable harm across our organisation, and saw further improvements made to both patient safety and increasing our already high levels of patient satisfaction. We remain committed to monitoring all aspects of our patients’ experience within Claremont Hospital, ensuring this feedback is effectively utilised to continue to drive quality improvement. Our staff survey in 2017 also showed further improvement in staff engagement and a pride to work for Aspen. You will find more details outlined within the relevant sections of this report.

I would like to thank all our staff who everyday show commitment to our values, high standards and goals, and for their contribution to the continuous improvements we strive to make to our patients’ care and experience.

The majority of information provided in this report is for all the patients we have cared for during 2017-2018, both NHS and private. To the best of my knowledge the information included is an accurate and fair reflection of our performance. I hope that this Quality Account provides you with a clear picture of how important quality improvement, patient safety and patient experience are to us at Aspen Healthcare.

Des Shiels
Chief Executive
Aspen Healthcare

> *A clean and well maintained hospital with efficient staff – nothing was too much trouble.*
>
> *Mr R, Sheffield*

Introduction to Claremont Hospital

Claremont Hospital has been at the heart of the South Yorkshire community providing first class healthcare for over 60 years. The hospital is situated in grounds to the South West of the City of Sheffield. Originally founded by the Sisters of Our Lady of Mercy, a religious institute which relocated from Ireland to Sheffield in 1883, the hospital opened in 1921 and moved to its current location in 1953.

Since 2012 Claremont Hospital has been proud to be part of Aspen Healthcare and has benefited from significant investment which has supported extensive refurbishment and improvements to patient and staff facilities. During 2018-2019 additional investment of almost £1m will allow us to:

- Refurbish the operating theatre department lift
- Upgrade the air-conditioning in two of our operating theatres
- Refurbish an additional five patient rooms
- Develop the Premier Suite in our outpatient department
- Undertake a conversion of the digital X-ray room
- Purchase addition operating theatre instrumentation
- Replace the current ophthalmology microscope
- Complete a range of projects already in progress

With 223 dedicated staff employed and 212 Consultants with Practising Privileges, Claremont Hospital specialises in elective short stay surgery, welcoming both NHS funded and privately funded patients. Our main surgical specialities include orthopaedics, general surgery, plastic surgery, ophthalmology, gynaecology, urology and ENT.

Vital Statistics

✓ Total beds	42
✓ Operating theatres	3
✓ Consulting rooms	15
✓ Endoscopy suite	
✓ Physiotherapy	
✓ Pharmacy	
✓ MRI	
✓ CT	
✓ Ultrasound	
✓ X-ray	
✓ Private GP services	
✓ Satellite clinics	
✓ NHS e-Referral service	
✓ Free parking	
✓ Accepting all major insurers	
✓ Consultant delivered service	
✓ 24/7 Resident Medical Officer	
✓ AfPP accreditation for for theatres safety standards	
✓ WorldHost® Business Status in Customer Service training	

During 2018-2019 we will continue to work hard to protect our reputation for safe, high quality care delivery and outcomes. Our organisational development ambitions for the forthcoming year, as detailed in this report, will drive and challenge us whilst ensuring safety and quality are incorporated into everything we do.

Statement on Quality

Having joined Claremont Hospital in January this year, I am pleased to introduce you to the hospital's Quality Account for 2017-2018. Our Quality Account gives us the opportunity to share with the public an honest and balanced account of our performance during the reporting period and to demonstrate our commitment to continuous evidence-based quality improvement, whilst also outlining the future improvements we aim to make during 2018-2019.

I am delighted to share the outcome of our most recent Care Quality Commission (CQC) inspection. Our hospital is subject to the same CQC inspection regime as all NHS hospitals in England. The inspection of our services took place in February and March 2017 but the report was not available in time for us to include in our Quality Account last year. The hospital received an overall rating of 'Outstanding' which was, and continues to be, testament to the huge efforts made on a daily basis by staff and teams across the hospital. It also reflects the consistent positive feedback we receive from our patients; 99% of whom report they would recommend our hospital to friends and family if they needed similar treatment.

Inevitably there is always room for improvement within the individual inspection domains and these will require our continued focus. We have implemented specific improvement plans to address the points raised from our regulatory inspection. The actions we have identified will support our staff in implementing sustainable improvements which will become part of the fabric of everyday practice.

Each year, through our proactive and dynamic governance framework, we continually track and measure our progress objectively against the challenging targets we set for ourselves and also those targets required of us by other bodies, including the CQC and local clinical commissioning groups. We are never complacent and continually look to adopt best practice, drive innovation and, most importantly, learn and improve when we do not meet the high standards we have set for ourselves.

Our focus on Quality and Safety as driving forces will continue and strengthen through our objectives and priorities for 2018-2019. Having already made many improvements in the way that we work to ensure our patients receive the highest standards of care and good clinical outcomes we have laid a solid base on which to continue building. We frequently re-examine each stage of the patient journey and experience from a customer viewpoint to ensure we optimise our operational efficiency to bring about real benefits for our patients.

Our continuing success could not be achieved or maintained without our outstanding team of people who, through their dedication and unstinting efforts, deliver first-class care to our patients. We continue to support and encourage our staff to be actively engaged and involved in decisions because we believe our staff are key to the delivery of excellent patient care. Our focus on improving the experience of our staff in their day to day work through training, development and supporting them to make changes for the better, was reflected in the results from our annual staff survey. 63% of our staff now feel fully engaged/'bought into' our organisation – this is against a national figure of 41%.

We also greatly value the comments and feedback we receive from our patients as it is only by listening and hearing what our patients tell us that we can begin to be as responsive as possible to any changes in their values and perceptions and ensure our services are fit to deliver best practice within modern, high quality surroundings.

Our patients' care is central to everything we do. We are committed to providing our patients with the highest quality of care which is safe and effective and which is delivered at the right time, in the right way, by the right people. Our teams are dedicated to pursuing excellent outcomes for patients in a professional, caring, compassionate and safe environment where personalised care is delivered with dignity and respect at all times.

We are committed to providing our patients with the highest quality of care which is safe and effective and which is delivered at the right time, in the right way, by the right people.

We remain committed to working in partnership with a variety of parties, including the NHS from which many of our patients come to us, to realise closer working arrangements and provide assurances to GPs and Commissioners that they can refer their patients to us easily and in the knowledge that they will receive high quality, safe and appropriate care.

The following pages provide further detail about our progress against previous objectives and outline our key priorities for the coming year. We give our absolute assurance that Claremont Hospital will continue to put patients at the heart of everything we do.

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.

Andrew Thornton, Hospital Director, Claremont Hospital
Date: 14 May 2018

This report has been reviewed and approved by:

Mr Chris Blundell, Medical Advisory Committee Chair
Mr Robert Kerry, Quality Governance Committee Chair
Mr Des Shiels, Chief Executive, Aspen Healthcare
Mrs Judi Ingram, Clinical Director, Aspen Healthcare

Quality Priorities for 2018-2019

Aspen's Quality Strategy sets out our approach to quality and how we plan to progress a number of quality and safety improvement initiatives that we will be focussing on over the coming years. National Quality Account guidelines require us to identify at least three priorities for improvement and the following information outlines our main priorities for 2018-2019. These priorities have been agreed with our senior management team and were informed by feedback from our patients and staff, audit results, national guidance and recommendations from the various hospital/clinic teams across Aspen Healthcare.

Our quality priorities are regularly reviewed by Aspen's Quality Governance Committee which meets quarterly, to monitor, manage and improve the processes designed to ensure safe and effective service delivery.

Claremont Hospital is committed to delivering services that are safe, of a high quality and clinically effective; we constantly strive to improve our clinical safety and standards. The priorities we have identified will, we believe, drive the three domains of quality: patient safety, clinical effectiveness and patient experience.

The key quality priorities identified for 2018-2019 are as follows:

Patient Safety

Continue to embed Aspen's STEP-up to Safety Programme

Aspen Healthcare aims to be a recognised leader in patient safety and our STEP-up to Safety programme (STEP-up) is an innovative staff engagement initiative for all our staff, helping them to fully understand their role in patient safety. This programme has resulted in a significant improvement in safety measures, including an increase in safety reporting whilst having a reduction in the number of incidents reported with harm. It was also shortlisted as a finalist for many national safety awards last year.

In 2018-2019, we will work to further embed this programme into 'how we do safety round here' at Aspen. This will include developing our Core Induction for all new staff to incorporate the STEP-up to Safety workshop, making STEP-up part of our mandatory staff training and promoting the involvement of our visiting Consultant staff with STEP-up. We will also support our staff in raising concerns by developing 'Stop the Line' – supporting them to feel able to raise safety concerns 'in the moment' of a busy healthcare environment.

Patient Safety

Improving and increasing the safety of our care and services provided.

Clinical Effectiveness

Improving the outcome of any assessment, treatment and care patients receive, to optimise health and well-being.

Patient Experience

Aspiring to ensure we exceed the expectations of all our patients.

Clinical Effectiveness

Improve the Effectiveness and Standards of our Handover Practice and Clinical Communication

Safe, effective clinical care depends on reliable, flawless communication between caregivers. Handover communication relates to the process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregivers to the patient and family for the purpose of ensuring patient care continuity and safety. Poor handover communication between units and amongst care teams might not include all the essential information, or information may be misunderstood and cause delay in diagnosis or treatment, missed or duplicated tests, incorrect treatment or errors, and a poor patient experience.

In 2018-2019 we will develop a standardised approach to handover communication, with associated training for our staff, utilising a recognised model such as ISBAR (Identify, Situation, Background, Assessment, and Recommendation). Handover tools, such as ISBAR, are easy to remember and can be used to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. These tools enable clarification of what information should be communicated between members of the team, and how. It will also help to develop teamwork and support our culture of patient safety.

Improve Availability of Patient Reported Outcome Measures Data

Patient Reported Outcome Measures (PROMs) collect information on the effectiveness of care delivered to patients as perceived by the patients themselves, based on responses to questionnaires before and after surgery. In 2018-2019 we will work to improve the registration of patients for PROMs for certain surgical procedures, to complement the availability of our existing information on the quality of services and patient outcomes and improve the validity of the outcome data collected.

Patient Experience

Implementation of Complainants Survey Toolkit

We will further develop our management of complaints by utilising NHS England's Complainants Survey Toolkit to assess and measure complainants' experiences. This will permit us to survey complainants in a consistent and systematic way, and will provide a means of recording how complainants experience our complaints system and the extent to which we learn from complaints. This survey will also help us to assess the effectiveness of our approach and management of complaints, and will inform and drive improvements in our complaint handling and resolution.

While targeting the areas above, we will also:

- Strive to further improve upon all our quality and safety measures
- Continue with our programme of development relating to other quality initiatives
- Continue to develop our workforce to ensure they have the skills to deliver high quality care, in the most appropriate and effective way
- Embed our 2018-2019 Commissioning for Quality and Innovation (CQUIN) initiatives so they become 'business as usual', and work to implement any locally agreed CQUINs with our commissioners
- Meet and exceed the Quality Schedule of our NHS Contracts.

"I was impressed by the courteous, caring and compassionate attitude of all staff."

Mrs A, Derbyshire

“If I was to draw up a plan for the kind of hospital I would like to be in, this is it.”

Mr M, Sheffield

Statements of Assurance

Review of NHS Services Provided 2017 - 2018

This section of our Quality Account provides the mandatory information for inclusion as determined by Department of Health regulations, and reviews our performance over the last year between April 2017 and March 2018 but reported in June as required by the guidelines.

During April 2017 to March 2018, Claremont Hospital provided and/or sub-contracted the following NHS services:

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

The income generated by the NHS services reviewed in 2017-2018 represents 100% of the total income generated from the provision of NHS services by Claremont Hospital for 1st April 2017 to 31st March 2018.

Speciality	Activity
Ear, Nose and Throat	52
General Surgery	2969
Gynaecology	333
Neurosurgery (spinal)	1315
Ophthalmology	409
Orthopaedics	2345
Urology	124

Participation in Clinical Audit

National clinical audits are a set of national projects that provide a common format by which to collect audit data. National confidential enquiries aim to detect areas of deficiencies in clinical practice and devise recommendations to resolve them.

During April 2017 to March 2018, five national clinical audits and one national confidential enquiry covered NHS services that Claremont Hospital provides.

During that period Claremont Hospital participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Claremont Hospital was eligible to participate in during April 2017 to March 2018 are as follows:

- Perioperative management of surgical patients with diabetes
- National Joint Registry
- Elective Surgery (National PROMs Programme)
- National Bariatric Surgery Registry
- British Spine Registry
- Breast and Cosmetic Implant Registry

The national clinical audits and national confidential enquiries that Claremont Hospital participated in, and for which data collection was completed during April 2017 to March 2018, are listed overleaf 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.

National Confidential Enquiry		
Name of Audit	Participation	Number of cases submitted
Perioperative management of surgical patients with diabetes	Yes	30 (100%)

National Clinical Audits		
Name of Audit	Participation	Number of cases submitted
National Joint Registry	Yes	758 (100%)
Elective Surgery (National PROMs Programme)	Yes	528 (64%)
National Bariatric Surgery Registry (NBSR)	Yes	112 (30%)
British Spine Registry	Yes	381 (43%)
Breast and Cosmetic Implant Registry	Yes	95 (100%)

The reports of five national clinical audits were reviewed by the provider in April 2017 to March 2018 and Claremont Hospital intends to take the following actions to improve the quality of healthcare provided:

- Ensure consented joint revision surgery cases continue to be submitted to the National Joint Registry
- Ensure the email addresses of those patients who have email accounts are recorded on admission and available for inclusion in consented submissions to the British Spine Registry.

Local Audits

The following local clinical audits were reviewed by Claremont Hospital during April 2017 to March 2018. All of the audits were undertaken at least three times during the reporting period with many of the audits being undertaken much more frequently.

Audit	Average % Compliance April 2017 - March 2018
Venous Thromboembolism (VTE) – patient risk assessments fully documented	96%
Record Keeping (general) – documentation in clinical records compliant with national and local standards and requirements	94%
Consultant Record Keeping – documentation in clinical records compliant with national and local standards and requirements	96%
Practising Privileges – documentation supporting the granting of practising privileges to Consultants is accurate and up-to-date e.g. appraisal documentation	100%
Intentional Rounding – patients routinely visited by nursing staff each hour during the day and every two hours at night	76%[1]
National Early Warning System (NEWS) – observations fully recorded to aid early detection of potential deteriorating conditions	90%
Pain management – one element of NEWS. Pain as perceived by the patient is well controlled.	82%
Health Records Access Request – a clear audit trail to monitor the progress and completion of Health Record Access Requests	87%
Patient Consent – consent process accurately completed and recorded	96%
Safeguarding (Adults and Children) – staff training completed	98%
Operating Theatre Traceability – accurate recording of all equipment, prostheses and implants	98%
Maintaining Normothermia – compliance with measures taken to prevent perioperative hypothermia in patients having surgery	100%
World Health Organisation (WHO) Surgical Safety Checklist – process accurately undertaken for every patient having a surgical procedure	95%
Surgical Safety Observational Checklist – complements the audit above by an independent observer determining robust surgical safety processes are embedded within the Theatre department	95%
Fasting – the time patients are fasted pre-surgery in the context of local and national standards	89%
Cardiac Arrest – in the event of a cardiac arrest, local and national standards are met	100%
Medicines Management – includes a range of processes that determine how medicines are used and looks at compliance with national standards and legislation	85%
Controlled Drugs – the ordering, supply and destruction of controlled drugs meets national and local standards	88%
Prescribing – the appropriateness, accuracy and legibility of prescribing meets national and local standards	84%
Medical Gases – are used safely and stored securely	67%[2]
Security – the ordering and supply of medicines (other than controlled drugs) meets national and local standards	87%
Patient Group Directives – the documentation and use of the directives meets national and local standards	99%
Blood Transfusion Compliance – national and local standards met	95%
Consultant Visits – Consultants document their visits to review inpatients on a daily basis	89%
Physiotherapy – national and local standards met	94%
Diagnostics – national and local standards met	93%
Resuscitation – equipment checks fully and accurately recorded	94%
Information Governance – national and local standards met	99%
Patient Led Assessment of the Care Environment (PLACE)	90% (nationally 88%)
Patient Privacy and Dignity Audit – interviews with randomly selected patients to understand if each patient believes they have been treated with dignity and respect and their privacy has been protected	95%
15 Steps Challenge – an observational study to understand how patients and visitors perceive the hospital environment within 15 footsteps of entering the facility	There is no compliance score associated with this initiative. Our Patient Representative commented that it was with difficulty that he found any recommendations as, in his opinion, the hospital has a very high standard of patient and visitor care and attention.
Prophylactic Antimicrobial Prescribing and Usage	There is no compliance score associated with this audit. The results confirmed that our prescribing and usage of prophylactic antibiotics is aligned with nationally recognised best practice.

The reports of 177 local clinical audits were reviewed by the provider in April 2017 to March 2018 and Claremont Hospital has taken/intends to take the following actions to improve the quality of healthcare provided:

[1] Although a good improvement on last year's overall score, completion of the Intentional Rounding forms continued to show inconsistency. Intentional Rounding is aimed at pre-empting patient needs by a member of the care delivery team visiting the patient every one hour during the day and every two hours during the night. The Intentional Rounding form is now placed such that it is the first piece of documentation a member of the care team will see when entering a patient's room. This has improved the level of completion of the form and the overall audit scores are beginning to improve.

[2] A number of matters relating to medical gases have been addressed during the past year and include: the master key providing access to the medical gas store is now kept upon the person of the senior porter on duty; the medical gas stock list has been reviewed and stock levels agreed; newly appointed porters are scheduled to attend medical gas training and all combustible items have been permanently removed from the liquid nitrogen store. These actions should lead to improved audit scores during the coming year.

The actions taken in relation to both Intentional Rounding and Medical Gases are aimed at securing long term sustainable improvements.

Participation in Research

There were no NHS patients recruited during the reporting period for this Quality Account to participate in research approved by a research ethics committee.

Goals Agreed with Commissioners

A proportion of Claremont Hospital income in April 2017 to March 2018 was conditional on achieving quality improvement and innovation goals agreed between Claremont Hospital and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Through locally agreed key performance indicators, these were monitored and reviewed at monthly Quality meetings attended by members of the quality team from the Clinical Commissioning Group and members of the clinical team from Claremont Hospital. All indicators were successfully achieved.

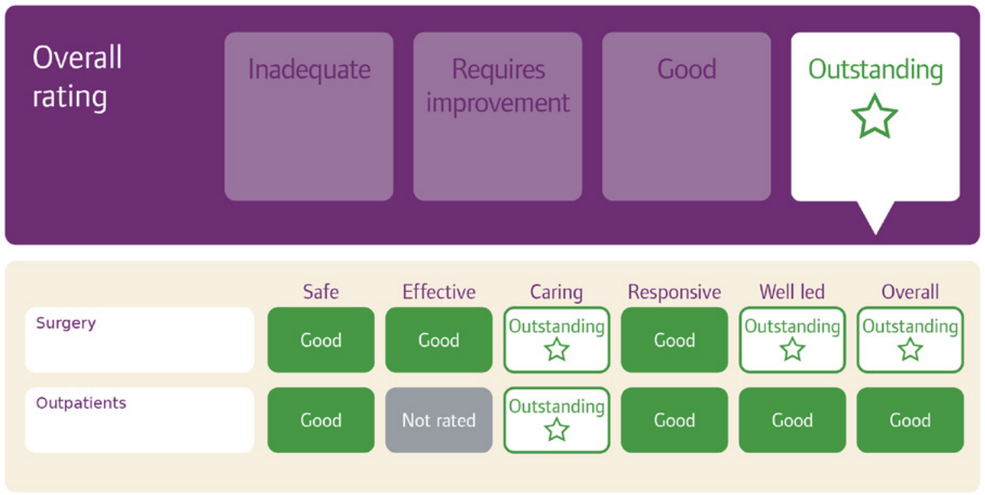
Statement from the Care Quality Commission

Claremont Hospital is required to register with the Care Quality Commission (CQC) and its current registration status is fully compliant.

The Care Quality Commission has taken no enforcement action against Claremont Hospital during April 2017 to March 2018.

Claremont Hospital has not participated in any special reviews or investigations by the CQC during the reporting period.

In March 2017 the CQC published its Inspection Report of Claremont Hospital and awarded an overall rating of **'Outstanding'**.



We were rated 'Good' in the Safe, Effective, and Responsive domains and 'Outstanding' in the Caring and Well-led domains.

Areas of outstanding practice identified by the CQC included:

- Staff were trained in a nationally recognised accreditation programme in customer care. Following this, staff completed a Values Partners programme, which is a workshop to explore values and behaviours between staff and towards patients, and aims to create a positive working culture.
- The hospital took part in a comprehensive observational study to consider the approach by staff to the general care of patients, the level of patient/visitor engagement, and the environmental factors within patient reception areas. We saw an example of one survey in July 2016 and there had been an overall score of 97%.
- We observed that staff were empowered to deliver a caring service and make improvements or drive policy changes.
- Staff we spoke with had a clear knowledge of the vision of the service. They could tell us how this had been put into practice on a daily basis. We were told by one registered nurse that she was comfortable with the inspection as she aimed to go 'beyond compliance' every day.
- The hospital undertook an in-depth patient survey which benchmarked a variety of patient experience against other Aspen Healthcare sites. This included aspects of caring. The Claremont Hospital scored highly in all factors ranging from 93% to 98%.
- There had been a successful pilot of the anaesthetic led pre-assessment process with the aim to minimise risks, cancellations and improve patient experience. This was being monitored by auditing the number of cancellations and unplanned transfers.

The CQC also identified some areas for improvement:

- Ensure the 'Safer Steps to Surgery', including the World Health Organisation checklist, is consistently used.
- Ensure all eligible staff receive an appropriate level of safeguarding training to allow them to recognise any issues of concern.
- Address the maintenance of the theatre environment and equipment.
- Ensure staff in theatre check and record controlled drugs, fridge and fluid warming cabinet temperatures in line with hospital policy.
- Ensure mandatory training levels meet Aspen Healthcare compliance target.

All the above improvement points have been fully addressed.

"All staff at the hospital were exceptional and I would highly recommend to others."

Mr T, Sheffield

Statements on Data Quality

Claremont Hospital takes Data Quality very seriously and recognises that good quality information is fundamental to the effective delivery of patient care and, is essential if improvements in quality of care and value for money are to be realised.

For the past year we have submitted non-identifiable data to the Private Health Information Network (PHIN), an independent Information Organisation with a mandate to ensure that patients using independent healthcare facilities will be able to access comparative performance measures including activity levels, length of stay, patient satisfaction and rates of unplanned readmission, for both hospitals and individual consultants. This is another useful tool by which we can demonstrate the quality of our services and identify opportunities for improvement.

Our Information Governance policies continue to inform our standards of record keeping which support and evidence the delivery of care and treatment. Records are regularly monitored for accuracy, completeness, and legibility providing timely identification of quality issues and any remedial steps required.

Claremont Hospital has/will be taking the following actions to improve data quality:

- Continue to expand on our monthly data submissions to PHIN and maintain/improve on our data quality compliance.
- Ensure adherence to Competition and Marketing Authority remedies in terms of fee structure transparency with outpatients.
- Undertake a mass data cleansing exercise across our Patient Administration System (PAS) to ensure our data quality is as good as possible.
- Upgrade our PAS to utilise the latest Microsoft technologies to drive a change of workflow processes throughout the hospital, to improve efficiencies and data quality throughout our care systems.
- Fully automate the ordering of histopathology removing the potential for human error and allowing results from the laboratory to appear in real time within the patient's record in our PAS.
- Continued refinement of the accuracy and timeliness of reporting management information to support the hospital's business.
- To commence a project to centralise the imaging Picture Archiving and Communication System (PACS) throughout the Aspen Healthcare group which will also streamline the flow of patient data through the Image Exchange Portal (IEP).
- To complete an exercise to ensure we are compliant with the General Data Protection Regulation prior to this becoming legislation on 25th May 2018, at which point it replaces the Data Protection Act 1998. This exercise has involved documenting all data flows within the organisation giving improved visibility and ensuring we have the right controls over the data we hold.

Information Governance Toolkit attainment levels:

The Information Governance Toolkit is a performance assessment tool produced by the Department of Health. It is a set of standards that organisations providing NHS care must complete and submit annually by 31st March each year. The toolkit enables organisations to measure their compliance with a range of information handling requirements, thus ensuring that confidentiality and security of personal information is managed safely and securely.

Aspen Healthcare's Information Governance Assessment Report overall score for April 2017 to March 2018 was 72% and was graded satisfactory, achieving Level 2 in all categories and meeting national requirements.

Secondary Uses System (SUS)

Claremont Hospital submitted records during April 2017 to March 2018 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 100% for admitted patient care (not clinics)
- 100% for outpatient care.

And which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care (not clinics)
- 100% for outpatient care.

Clinical Coding Error Rate

Claremont Hospital was not subject to a Payment by Results clinical coding audit during April 2017 to March 2018 by the Audit Commission.

Quality Indicators

In January 2013, the Department of Health advised amendments had been made to the National Health Service (Quality Accounts) Regulations 2010. A core set of quality indicators were identified for inclusion in the quality account.

Not all indicator measures that are routinely collated in the NHS are currently available in the independent sector and work will continue during 2018-2019 on improving the consistency and standard of quality indicators reported across Aspen Healthcare.

A number of metrics have been chosen to summarise our performance against key quality indicators of effectiveness, safety and patient experience.

Claremont Hospital considers that this data is as described in this section as it is collated on a continuous basis and does not rely on retrospective analysis.

Claremont Hospital continually reviews how to improve data collection submissions, and the quality of its services, by working with the Private Healthcare Information Network (PHIN). Data is collected and published about private and independent healthcare, which includes quality indicators. Aspen Healthcare is an active member of PHIN and is working with other member organisations to further develop the information available to the public. See: www.phin.org.uk.

When anomalies arise, each one of the indicators is reviewed with a view to learning why an event or incident occurred so that steps can be taken to reduce the risk of it happening again.

Number of Patient Safety Incidents, including Never Events
Source: From Aspen Healthcare's incident reporting system:

2016-2017		% of patient contacts	2017-2018		% of patient contacts
Serious Incidents resulting in harm or death	2	0.002%	Serious Incidents resulting in harm or death	4	0.008%
Never Events	1	0.001%	Never Events	1	0.001%
Total	2	0.002%	**Total**	4	0.008%

NB. *All Never Events are also recorded as serious incidents so there is a duplication as reported above.*

The key learning from the above serious incidents in 2017-2018 include:

- It is essential that a gap analysis is completed when relevant policies are issued/updated and that processes are put in place to ensure full compliance
- Within the Operating Theatre Department team briefs must include a patient's relevant past medical/surgical history
- Prior to the insertion of implants the checking process must follow the Aspen Healthcare policy for the verification of implants
- A continuing focus on professional record keeping to ensure it consistently reflects the high standards of care delivered
- A 'Falls Prevention – Advice for patients' insertion has been added to the Patient Information Guide at each bedside
- Small brightly coloured posters have been included at each bed area to remind patients to take care when mobilising and to 'call - don't fall'.

Hospital Level Mortality Indicator and Percentage of Patient Deaths with Palliative Care Code

This indicator measures whether the number of people who die in hospital is higher or lower than would be expected. This data is not currently routinely collected in the independent sector.

Learning From Deaths

Aspen Healthcare has a 'Reporting, Management and Review of Patient Deaths' policy which is in line with the national guidance on 'Learning from Deaths'.

There were no patients that died within the reporting period [April 2017 to March 2018] at Claremont Hospital and, therefore, no case record reviews were undertaken.

Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) assess general health improvement from the patient perspective. These currently cover four clinical procedures in the NHS and one clinical procedure in the independent sector, and calculate the health gains after surgical treatment using pre and post-operative surveys.

Patient Reported Outcome Measures (PROMs)	2016-2017	2017-2018
Hip replacement surgery: % of respondents who recorded an increase in their EQ 5D index score following operation	92.6% (National NHS Comparator 88.8%)	90% (National NHS Comparator N/A)
Knee replacement surgery: % of respondents who recorded an increase in their EQ 5D index score following operation	89.5% (National NHS Comparator 80.9%)	79% (National NHS Comparator N/A)
Groin hernia surgery:	Statistically insufficient data	Statistically insufficient data
Cataract Surgery (private patients only): % of respondents who recorded an increase in their Catquest rating following operation	75%	85%

Other Mandatory Indicators

All performance indicators are monitored on a monthly basis at key meetings and then reviewed quarterly by both local and corporate level Quality Governance Committees. Any significant anomaly is carefully investigated and any changes that are required are actioned within identified time frames. Learning is disseminated through various quality forums in order to prevent similar situations occurring again.

Indicator	Source	2016 - 2017	2017 - 2018	Actions to improve quality
Number of people aged 16 years and over readmitted within 28 days of discharge	CQC performance indicator Clinical audit report	11	4	We will continue to ensure planning for discharge commences prior to admission; that our patients are discharged from our care appropriately; and they are supported with good information which they understand.
Number of admissions risk assessed for VTE	CQUIN data	100%	100%	Ongoing monitoring
Number of Clostridium difficile infections reported	From national Public Health England/ Scotland returns	0	0	Ongoing monitoring
Number of patient safety incidents which resulted in severe harm or death	From hospital incident reports (Datix)	2	6	Where a patient experiences unexpected or unintended harm resulting from an incident, a root cause analysis investigation is completed to identify learning which can be applied to prevent similar incidents in the future. The actions we take are aimed at achieving sustainable improvements which become embedded into daily practice for the long term.
Responsiveness to personal needs of patients	Patient satisfaction survey data – for overall level of care	97%	98%	Ongoing monitoring and review.
Friends and Family Test - patients	Patient satisfaction survey – rated extremely likely/likely	99%	98%	Ongoing monitoring and review.
Friends and Family Test - staff	Staff satisfaction survey	89%	99%	Ongoing monitoring and review.

Infection Prevention and Control

The overriding aim and purpose of Claremont Hospital's Infection Prevention Committee is to reduce the risk of harm from Healthcare Associated Infections (HCAIs) to patients, staff and visitors. It also aims to reduce the costs associated with preventable infections by promoting and enabling excellence in Infection Prevention and Control (IPC) practice through robust systems of quality governance.

Proactively participating in Aspen Healthcare's audit programme, along with robust corporate and local policies and procedures, and with the support of the Aspen Healthcare Group IPC Lead, we have the tools to predict any potential outbreaks or system failures and the ability to take prompt action accordingly.

Reducing HCAI's remains high on our safety and quality agenda. In 2017 Claremont Hospital achieved its fourth consecutive year with a zero rate for any reportable infection. This is testimony to the processes and principles applied by teams across the hospital, to the standards of care delivered to our patients, and to the cleanliness of the environment in which we work.

In 2015 the Operating Theatre Department achieved Association for Perioperative Practice (AfPP) accreditation and during 2017-2018 they successfully retained this status through continued development and scrutiny of practice, demonstrating their continuing attention to maintaining high standards of care delivery.

During 2017-2018 the hospital continued to enhance its facilities through a number of building projects. Throughout this time, a dedicated in-house Project Coordinator actively monitored the building work areas and ensured they had been appropriately sealed off to protect the clinical environments within the hospital. High levels of cleanliness during these times have been essential and have been maintained.

The new, purpose built, Endoscopy Suite opened in June 2017 and, together with the continued development of processes, staff skills and a focus on the quality of the patient journey through the suite, the staff are pursuing Joint Association of Gastroenterology accreditation (JAG). An accreditation visit is scheduled for 16th May 2018.

Each year we develop our infection prevention strategy. During 2017-2018 we continued to enhance and develop educational tools which have since been delivered to our staff. Our Consultant Microbiologist has also been instrumental in the delivery of educational sessions, tailoring these to specifically relate to our fields of surgery. We also completed an innovative two day cross-discipline interactive training event consisting of challenging quizzes, product demonstrations, and work station scenarios. 77% of clinical and non-clinical staff attended this event and participant feedback was very positive.

Successful vaccination programmes for employees were provided in-house giving staff easy access to the influenza vaccine. The volume of vaccinations delivered was greater than the previous year and was instrumental in providing protection to patients and staff and allowing business continuity.

During the period April 2017 to March 2018 a total of fifty seven local IPC audits were completed by the Infection Prevention Link Practitioners. In support of this local programme of audits, the Aspen Healthcare Group IPC Lead also completed one unannounced 'Deep Dive' inspection of the hospital. This inspection very thoroughly assesses the effectiveness of local implementation of Aspen Healthcare's Quality Governance framework and national Infection Prevention and Control standards. Areas to be developed and improved are identified and, equally importantly, areas of good practice are acknowledged and shared.

Infection Prevention and Control Audit	Average % Compliance April 2016 – March 2017	Average % Compliance April 2017 – March 2018
Infection Prevention – cleanliness of the hospital environment compliant with national standards	94%	93%
Hand Hygiene – hand washing facilities and practices compliant with national standards	93%	96%
Surgical Site Infection – preventative practices compliant with national standards	100%	100%
Peripheral Intravenous Devices – practice compliant with national standards and best practice	96%	98%
Urinary Catheter – practice compliant with national standards and best practice	99%	99%
'Deep Dive' inspections	There is no compliance score associated with this initiative. Action plans are implemented according to the findings.	There is no compliance score associated with this initiative. Action plans are implemented according to the findings.

Actions which have been implemented as a result of the audit outcomes and the 'Deep Dive' inspection include:

- Educational updates have been held regularly to improve clinical documentation and data collection, and improve overall compliance levels
- A quarterly Infection Prevention Link Practitioner forum to provide updates and training is being planned and will commence during 2018-2019
- Extensive departmental monthly environmental cleaning audits have continued with action plans and implementations recorded and monitored
- Less onerous weekly spot check cleaning audits have also been performed in randomly chosen sections of departments to give greater continuity of monitoring
- The hospital pharmacy now supply any recommended emollients, as requested by Occupational Health, for individuals who develop sensitivity to hand hygiene products in the workplace
- An information leaflet regarding Infection Prevention and Control is provided to each patient at their pre-admission assessment and is aimed at helping patients to help us in the fight against infection.

There have been

0

healthcare associated infections at Claremont in 2017 - 2018.

Infection	2016-2017	2017-2018
MRSA positive blood culture	0	0
MSSA positive blood culture	0	0
E. Coli positive blood culture	0	0
Clostridium difficile hospital acquired infections	0	0

Complaints

Claremont Hospital is committed to ensuring that those who use our services are readily able to access information about how to make a complaint or raise a concern, and that when issues are raised they are dealt with promptly and fairly, and used to inform our care delivery and service provision.

During 2017-2018 our Complaints Policy was reviewed to ensure it continues to reflect current legislation and best practice guidance. Our website and patient information leaflets assisting our patients in the process of making a complaint were also reviewed and updated accordingly.

We reviewed the Parliamentary and Health Service Ombudsman report 'A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged', and assured ourselves that the recommendations arising from this report are implemented in our hospital.

All patients attending our hospital services receive a satisfaction questionnaire which they are encouraged to complete and return to us once their episode of care has finished. All feedback received from patients is regularly reviewed by the senior management team and cascaded via various committees and meetings to all staff.

We continue to strengthen a more meaningful engagement and involvement with our patients encouraging face-to-face meetings at the start of the complaint process to ensure that we not only proactively involve our patients at every stage, but also confidently gain clarity of the real issues.

We believe that complaints are not simply a process to be managed but a genuine opportunity to reflect, learn and improve our services further. Thus the collection and analysis of data from complaints is an integral part of our governance procedures.

Infection	2016-2017	2017-2018
Total number of complaints received	42	42
Number of complaints as a percentage per 100 admissions	0.6%	0.5%
Percentage of complaints responded to within 20 days	100%	100%
Number of complaints upheld	32 (76%)	21 (50%)
Number of complaints partially upheld	5 (12%)	12 (28%)
Number of complaints not upheld	5 (12%)	9 (21%)
Complaints referred to the Independent Sector Complaints Adjudication Service (ISCAS)/ Commissioners/Care Quality Commission/ Ombudsman	0	1

The key learning and changes made as a result of the complaints received include:

- Implementation of new cosmetic surgery guidelines. Whilst not a hospital response to the number of complaints around cosmetic outcomes, the information given to patients and the collection of cosmetic surgery specific patient reported outcome measures [called Q-PROMs] should help address this type of complaint.
- Patient information is constantly under review and we will work closely with our patient information leaflet provider, EIDO, to ensure information continues to accurately reflect practice.
- As a result of complaints regarding pain relief or lack of nursing care, we now have a 'Back to Basics' nursing forum and a 'Pain Management' forum, both of whom meet regularly.
- In relation to complaints received regarding waiting times, we have monitored the consultants who regularly attend later than planned or overrun clinic times and, where necessary, we have amended start times of clinics to ensure the first scheduled patient is seen on time.

Key initiatives for 2018-2019 include:

- Ensuring cosmetic guidelines are adhered to in respect of patients receiving information to inform the decision making process and the implementation of Q-PROMs.
- Ensure patients have up-to-date relevant information about their surgery and surgical outcome.
- Continue to monitor patient waiting times and address any late starts in clinic.
- Support and maintain the 'Back to Basics' and 'Pain Management' fora.

Review of Quality Performance 2017-2018

This section reviews our progress with the key quality priorities we identified in last year's Quality Account.

Patient Safety

Patient Safety Survey

Providing healthcare is inherently complex and risky. Patient safety involves the prevention of avoidable harm to patients associated with the delivery of healthcare. Our patients' experience is essential to understanding the impact of harm and how we can work together to improve patient safety.

Patients are central to the services we provide and we wished to meaningfully engage with them to further develop ways to improve our patient safety. We had little knowledge about how, if on occasions, patients have felt unsafe and the reasons for this. Building upon the work we have developed in previous years in providing patients with information and tips on how to keep safe whilst an inpatient/day case, we introduced a new survey that explored our patients' perceptions of safety. The survey enabled us to work in partnership with our patients and has provided us with areas for improvement, to support our service delivery and ensure our patients always feel safe.

The survey was launched in early 2018 and 96% of patients surveyed reported that they felt safe in our care. 95% of patients felt that there were enough staff on duty to meet their needs with 94% stating they had received information on how to keep safe during their stay with us. Other comments made included the friendliness and professionalism of our staff and the need to give accurate indications of waiting times and delays. Results from the survey will help us to build on strategies to further support our patients to feel safe under our care.

Using the results from the survey, we have taken the following actions to improve our patients' perception of their safety:

- A 'Falls Prevention' leaflet is sent to all patients with their pre-admission pack of information. The same information contained in the leaflet is also replicated in the Patient Guide folder found at each bedside. On admission, patients are encouraged to look through the Patient Guide.
- Patients are encouraged not to try and get out of bed/up from a chair without a member of staff present during the early phases following surgery.
- Colourful posters are located at each bed space reminding the patient to 'Call - don't fall'.
- A small safe is available for patients to lock possessions away when they go to theatre.
- Regular visits to the patient's room, by members of the team, are aimed at pre-empting patient requirements and the need to use the 'nurse call' system.
- Non-slip socks are available to all patients.
- Staff are reminded to politely challenge people in the hospital who they do not know to ascertain their legitimacy for being in the building.

96%
of patients surveyed reported that they felt safe in our care

95%
of patients felt that there were enough staff on duty to meet their needs

94%
stated they had received information on how to keep safe during their stay with us

Clinical Effectiveness

Implementation of Cosmetic Clinical Quality Indicators (CQIs)/Q-PROMs (Patient Reported Outcome Measures)

As a cosmetic surgery provider we have worked towards collecting the clinical outcome measures as developed by the Royal College of Surgeons. An annual audit has been created to capture these, whilst systems are being developed to collect outcome measures for cosmetic surgery that can be published by individual surgeons and hospitals.

The capturing of more accurate information about the demographics of patients having cosmetic surgical procedures will enable more consistent audit standards and quality improvement, permitting activity and outcomes to be monitored whilst supporting improved patient choice and informed decision-making.

We have implemented the Cosmetic Q-PROMs and these will be completed by our cosmetic patients pre- and post-operatively, allowing for a measurement of how patients feel, which is then attributable to the surgical cosmetic intervention. These will, over time, provide our patients with information which can be utilised to benchmark outcomes at both service and clinician level against national averages, as well as help us to further improve our services and standardise care.

Our dedicated private patient administrative team manage this process by registering each patient with our external Q-PROMs provider with whom we are working in partnership. The provider then facilitates the pre- and post-surgery questionnaire completion with the patient and provides us with regular reports throughout the year.

Patient Experience

Achieve 'Dementia Friendly' Clinical Environments

The number of people with dementia is increasing and, by 2025, it is expected that more than one million people will be living with dementia in the UK. A range of approaches were identified as being important in delivering better care for people with dementia and their families/carers while in hospital. These include education and training of staff, involvement of family carers, skilled assessment, individualised care and the availability of a specialist.

Aspen Healthcare has a Dementia Strategy which has guided our development and achievements in both dementia care and training. Over the last year we have worked to look at the clinical environment of care, to assist those people living with dementia when an inpatient at one of our hospitals/clinics and to help them manage the emotional impact that an admission may involve. This includes things like appropriate lighting, clear signage, use of accent colours, large face clocks, provision of calendars and memory aids, such as photographs to aid recall. The aim is to promote orientation whilst maximising independence, self-esteem, confidence and safety. This work is still ongoing and will be further progressed in 2018-2019, led by our local Dementia Champions.

During the past year our Dementia Champion has shared her knowledge and expertise through training sessions. Currently 75% of our staff (clinical and non-clinical) have received this training and further sessions are scheduled throughout 2018-2019. A Dementia Friends resource file has also been compiled. This enables us to respond promptly and appropriately when a patient with dementia is being admitted to our hospital. The file contains many useful and informative tools including 'This is me' leaflets which can be completed by the patient/carer to aid us in supporting the patient whilst they are in an unfamiliar environment. In preparation for surgery, relatives/carers can accompany the patient into the anaesthetic room and stay with the patient until they are anaesthetised. The relative/carer can then also remain with the patient in the recovery area, following surgery. The recovery area can be suitably sectioned to provide a calm, restful space, with or without music, and which avoids the sight of a potentially overwhelming array of equipment. Within the ward area accent coloured crockery and cutlery is available for mealtimes.

External Perspective on Quality Of Services

What others say about our service:

Statement from NHS Sheffield Clinical Commissioning Group

For a number of years NHS Sheffield Clinical Commissioning Group (CCG) has had contact with Claremont Hospital in relation to the provision of NHS elective care, managed under the conditions of the NHS Standard Contract. This has been and continues to be a very positive business relationship where we have been able to constructively discuss any issues that have arisen and practically resolve in a timely manner. The Director of Clinical Services has provided the clinical support to the contract and again has worked in a very positive way to resolve any clinical issues, according to the contract requirements.

The CCG has had the opportunity to review and comment on the information in this quality account prior to publication. Claremont Hospital has considered our comments and made amendments where appropriate. The CCG is confident that, to the best of its knowledge, the information supplied within this account is factually accurate and a true record, reflecting the Hospital's performance over the period April 2017 – March 2018.

The CCG supports the work areas involved within the Hospital's identified three Quality Improvement Priorities for 2018-2019 – Patient Safety, Clinical Effectiveness and Patient Experience.

Submitted by:
Rachael Hague
Senior Contract Manager

On behalf of:
Brian Hughes
Director of Commissioning and Performance
NHS Sheffield Clinical Commissioning Group
16th May 2018

Statement from Sheffield Teaching Hospitals NHS Foundation Trust

Throughout 2017-2018 Sheffield Teaching Hospital NHS Foundation Trust (STHFT) has commissioned a number of services with Aspen Healthcare (hosted at Claremont Hospital) in relation to the provision of NHS elective care within certain clinical pathways and procedures, which are managed under the conditions of the NHS Standard Contract. This has been, and continues to be, a collaborative business relationship focusing on patient safety, clinical effectiveness and a positive experience for patients; addressing any concerns that have arisen to resolve in a timely manner and to respond to clinical matters according to the contractual requirements.

STHFT has had the opportunity to review and comment on information in the Quality Account prior to publication. To the best of STHFT's knowledge, the information supplied within this account is factually accurate and a true record, reflecting the Hospital's performance over the period April 2017 – March 2018.

As agreed by Caroline Mabbot, Contracts Director, Sheffield Teaching Hospitals Foundation Trust.

Claremont Hospital requested Derbyshire CCG, the local Healthwatch, and Sheffield Health and Wellbeing, to comment on this Quality Account. Prior to publication no comments had been received.

Thank you for taking the time
to read our Quality Account.

Your comments are always welcome and we would be pleased to hear from you if you have any questions or wish to provide feedback.

Please contact us via our websites:
www.claremont-hospital.co.uk
www.aspen-healthcare.co.uk

Or call us on:
0114 263 0330 **Claremont Hospital**
020 7977 6080 Head Office, Aspen Healthcare

Write to us at:
Claremont Hospital
401 Sandygate Road
Sheffield S10 5UB

Aspen Healthcare Limited
Centurion House (3rd Floor)
37 Jewry Street
London EC3N 2ER

Aspen Healthcare