Practice Plus Group

Quality Account

2022-2023

Contents

Introduction

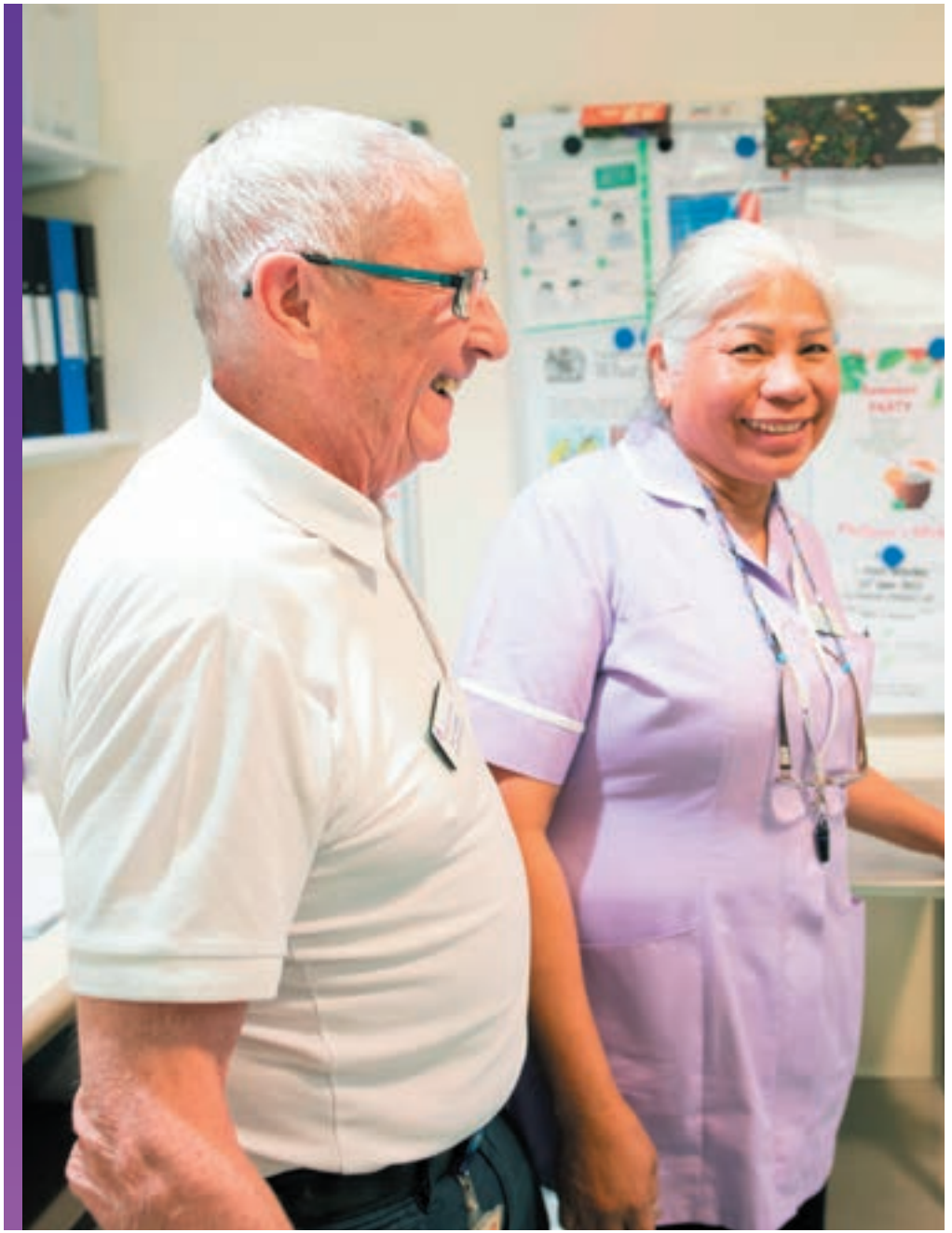
Part 1 is a statement on quality from our chief executive.

In Part 2 we have included details of priorities for improvement that we intend to deliver during 2023/24.

There are also a number of statements of assurance from the board.

Part 3 describes how we performed against the quality priorities we set for ourselves during 2022/23, together with performance against key national priorities for organisations delivering NHS care.

Annex 1 outlines feedback on the draft Quality Account from Practice Plus Group Secondary Care key stakeholders and how we have addressed the feedback.



Part 1
Statement on quality
from the Chief Executive

This last year has seen the NHS and independent healthcare providers faced with the enormous challenge of reducing waiting lists caused by the COVID-19 pandemic, while tackling a particularly pressurised winter, a series of nurse and junior doctor strikes, and staff well-being challenges.

Given this unprecedented context, I am proud to report that throughout this year, Practice Plus Group was once again able to support the NHS and all of our patients with consistently high levels of healthcare provision. We have and continue to play our part in helping the NHS reduce record-breaking waiting lists, we have seen excellent patient outcomes across our hospitals and surgical centres, and have continued to support and develop the workforce who have made this possible.

All of our Hospitals and Surgical Centres remain rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC) in 2022/3, we maintained our 100% clean rate with zero C-difficile infections, scored an above average 97% in the national Friends and Family Test, and have achieved a great deal against last year's priority objectives.

In the year from April 2022 to March 2023 we carried out:

- 10,522 Inpatient Admissions;
- 62,194 Daycase Admissions (inc Endoscopy/Diagnostic admissions);
- 191,785 Outpatient attendances.

This year, we reached stage three of our plan to achieve Quality Standard Image Accreditation. Our service gap analysis has identified the changes we need to make, which are now being implemented and fully embraced by our engaged imaging team. We will continue to work towards the accreditation in 2023/4.

We rolled out a new patient administration system across all sites, which will allow clinical teams to spend more time with patients, and will improve continuity of care between departments. The new system will also support quality improvement and process enhancement across the business.

Having been awarded NJR (National Joint Registry) Quality Data Provider status for 2021/22 after successfully completing a national programme of local data audits, all Practice Plus Group hospitals continue to achieve excellent compliance with this national patient safety initiative, meeting targets for data submission towards the NJR's quality audit process.

Our Equality, Diversity, and Inclusion Steering Group has recently changed its name to the Equity, Diversity and Inclusion Steering Group, to reflect the importance of providing staff with protected characteristics the support they need to fulfil their potential, rather than giving everyone the same. The committee has new members, and a renewed focus to further improve our inclusivity. We were delighted to be named the UK's top 'Diversity Leader' in healthcare by the Financial Times and are currently expanding a successful Reverse Mentoring programme to help raise awareness amongst managers of some of the challenges our colleagues have faced.

We continue to invest significantly in the development of our workforce, for example this year we were able to introduce retention bonuses for registered nurses as well as additional special leave to improve the work life balance for all our staff. We also remain dedicated to 'growing our own', with a wide range of apprenticeships and professional training in progress across the group from nursing to endoscopy to radiography. We also welcomed our first international nurses to the Practice Plus Group family this year, and are supporting them as they settle in to their new roles.

This Quality Account sets out our performance on a range of key measures for our patients, the wider public, partners and commissioners. It demonstrates what we have achieved in another atypical year and what we plan to do next in our secondary care services. These currently cover:

- Six hospitals, with plans to expand our services in 2023;
- Three surgical centres;
- Two urgent treatment centres and walk-in centres;
- Our Ophthalmology Service and its eleven mobile units;
- Two county-wide multi-location musculoskeletal services.

Practice Plus Group's priorities for 2023/24 reflect the five key lines of enquiry set by the Care Quality Commission:

- Safe;
- Caring;
- Responsive;
- Effective;
- Well-led.

We have set four priorities:

Priority 1: Quality Standard for Imaging Accreditation (continued from 2022/23).

Priority 2: Enhance the functionality of the Health Information System (HIS) to mitigate risks to patient safety.

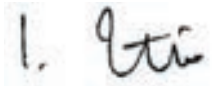
Priority 3: Build on the Quality Academy methodology to provide a structured approach that is integrated with PSIRP.

Priority 4: Implement a pre-operative surgical site infection risk assessment.

I am confident that we have the right overarching strategy, people, processes and plans to deliver against these priorities and that we will continue to aim for excellence for our patients, staff and the wider systems we operate in.

We are in a strong position to remain a reliable partner to the NHS during its recovery and beyond, and remain committed to helping more patients unlock access to excellent healthcare.

To the best of my knowledge, the information in this report is accurate.



Jim Easton
Managing Director

Part 2
Priorities for improvement and
statements of assurance from the board

2.1 Priorities for improvement 2023/24

Priority 1: Quality Standard for Imaging Accreditation

Why have we chosen this priority?

This priority for improvement was included last year and has been carried forward to allow completion of the UKAS accreditation process.

How will we improve?

We have progressed from stage zero to stage three over the last year, with resultant sharing of best practice across sites and a standardised approach to service provision. The next phases will result in the completion and implementation of the Practice Plus Group quality standards manual.

How will we measure our improvement and what are our targets?

Successful assessment and subsequent accreditation.

How will we report and monitor our progress?

Progress with this improvement priority will be monitored through the project documentation and reported to the Secondary Care Quality and Governance Assurance Committee.

Priority 2: Enhance the functionality of the Health Information System (HIS) to mitigate risks to patient safety

Why have we chosen this priority?

This priority improvement has been carried forward from last year as the single, unified electronic Health Information System has not been completely embedded across secondary care services. The ongoing procurement process for a new PACS and RIS system for Practice Plus Group has further delayed implementation of this quality initiative.

How will we improve?

Diagnostic testing will be the initial focus of this improvement priority, with the development of a standardised process for requesting externally-provided tests and monitoring and electronically documenting the input of results and acknowledgement of findings.

How will we measure our improvement and what are our targets?

The success of this quality improvement priority will be measured through the adoption of the electronic process across all Practice Plus Group Secondary Care Hospitals and Surgical Centres.

How will we report and monitor our progress?

Progress with this improvement priority will be monitored through the project documentation and reported to the Secondary Care Quality and Governance Assurance Committee.

Priority 3: Build on the Quality Academy methodology to provide a structured approach that is integrated with PSIRP

Why have we chosen this priority?

In the 2021/22 Quality Account we identified the development and introduction of a Quality Academy within each secondary care service as a priority. We are now in a position to build on this work.

How will we improve?

The Quality Academy approach will be developed and adopt a more formalised and structured model.

Local Quality Improvement programmes will be informed by the local patient safety risk profiles in line with the secondary care PSIRF methodology, and will be reflected in the local addenda to the overarching secondary care PSIRP.

Local Quality Improvement initiatives that are suitable for adopting across all sites will be identified and implemented.

How will we measure our improvement and what are our targets?

Local PSIRP priorities for improvement and incident responses will be formalised in the secondary care overarching PSIRP where they differ from the standard secondary care priorities and responses.

Local Quality Improvement initiatives that are suitable for adopting across all sites will be identified and implemented.

How will we report and monitor our progress?

Progress with implementation will be monitored via quarterly reports

to the Clinical Audit and Effectiveness Group (CAG).

Priority 4: Implement a pre-operative surgical site infection risk assessment

Why have we chosen this priority?

Due to a small increase in surgical site infections across Practice Plus Group Secondary Care servicers it is important that we assess patients pre-operatively for risk factors so that individual patient management plans can be put into place and close monitoring to ensure that all measures are taken to reduce the incident within our services.

How will we improve?

The use of the surgical site infection risk assessment will ensure that each patient that is higher risk of getting a surgical site infection has the correct pathway, management and monitoring to prevent a surgical site infection and risk factors can be determined early in the patient's journey so that these can be reduced as much as possible.

How will we measure our improvement and what are our targets?

It is hoped that using the surgical site infection risk assessment will ensure that there is a lowered risk of both superficial and deep infections across our secondary care services especially in major joints and our aim is to ensure that it remains below the national average and a reduction is seen of at least fifty percent within the first year but aiming for an eighty percent reduction over the next 2 years and onwards.

How will we report and monitor our progress?

We will monitor progress by reporting quarterly by site how many high risk patients identified, actions taken and then monitor these patients for a one year period to see if they develop a surgical site infection. This will be reported on our internal Datix system and on the national UKHSA data base. The data collected will be presented in an annual report to the Infection Prevention and Control Committee and to the Board.

2.2 Statements of assurance from the board

These statements of assurance follow the statutory requirements for the presentation of quality accounts, as set out in the Department of Health's quality account regulations.

2.2.1 Quality of services

During 2022/23 Practice Plus Group Secondary Care provided and/or subcontracted relevant health services in ten main specialities.

Practice Plus Group has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Practice Plus Group for 2022/23.

2.2.2 Clinical audit

During 2022/23 five national clinical audits and zero national confidential enquiries covered relevant health services that Practice Plus Group provides.

During that period Practice Plus Group participated (or had no qualifying cases) in 80% national clinical audits which it was eligible to participate in.

The national clinical audits that Practice Plus Group was eligible to participate in during 2022/23 are identified in table 1.

The national clinical audits that Practice Plus Group participated in, and for which data collection was completed during 2022/23 are listed in table 1.

Table 1 : Participation in national clinical audits and national confidential enquiries

National Clinical Audit	Eligible to participate	Participated	Comments
Breast and Cosmetic Implant Registry	No	-	Practice Plus Group does not provide these services
Case Mix Programme	No	-	Practice Plus Group does not provide these services
Child Health Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Cleft Registry and Audit Network Database	No	-	Practice Plus Group does not provide these services
Elective Surgery - National PROMs Programme	Yes	✓	See section 2.3.1 Patient-Reported Outcome Measures (PROMs)
Emergency Medicine QIP	No	-	Practice Plus Group does not provide these services
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Childrenand Young People	No	-	Practice Plus Group does not provide these services
Falls and Fragility Fractures Audit programme	No	-	Currently exploring the possibility of participating in the future
Gastro-intestinal Cancer Audit	No	-	Practice Plus Group does not provide these services
Inflammatory Bowel Disease Audit	No	-	Practice Plus Group does not provide these services
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	No	-	Practice Plus Group does not provide these services
Maternal and Newborn Infant Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Medical and Surgical Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Mental Health Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Muscle Invasive Bladder Cancer Audit	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
National Adult Diabetes Audit	No	-	Practice Plus Group does not provide these services
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	No	-	Practice Plus Group does not provide these services
National Audit of Breast Cancer in Older People (NABCOP)	No	-	Practice Plus Group does not provide these services
National Audit of Cardiac Rehabilitation (NACR)	No	-	Practice Plus Group does not provide these services
National Audit of Cardiovascular Disease Prevention	No	-	Practice Plus Group does not provide these services
National Audit of Care at the End of Life (NACEL)	No	-	Practice Plus Group does not provide these services
National Audit of Dementia (Care in general hospitals)	No	-	Practice Plus Group does not provide these services
National Audit of Pulmonary Hypertension (NAPH)	No	-	Practice Plus Group does not provide these services
National Bariatric Surgery Registry	No	-	Practice Plus Group does not provide these services
National Cardiac Arrest Audit (NCAA)	Yes	X	The frequency of cardiac arrests within the services doesn't justify subscription. During the reporting period one cardiac arrest occurred. This incident underwent a comprehensive investigation against the NCAA criteria.
National Cardiac Audit Programme (NCAP)	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
National Child Mortality Database	No	-	Practice Plus Group does not provide these services
National Clinical Audit of Psychosis	No	-	Practice Plus Group does not provide these services
National Early Inflammatory Arthritis Audit (NEIAA)	No	-	Practice Plus Group does not provide these services
National Emergency Laparotomy Audit (NELA)	No	-	Practice Plus Group does not provide these services
National Joint Registry (NJR)	Yes	✓	See Part 4: Local quality updates for local site participation details
National Lung Cancer Audit (NLCA)	No	-	Practice Plus Group does not provide these services
National Maternity and Perinatal Audit (NMPA)	No	-	Practice Plus Group does not provide these services
National Neonatal Audit Programme	No	-	Practice Plus Group does not provide these services
National Obesity Audit	No	-	Practice Plus Group does not provide these services
National Ophthalmology Database Audit	Yes	✓	See table 2 for an overview
National Paediatric Diabetes Audit	No	-	Practice Plus Group does not provide these services
National Perinatal Mortality Review Tool	No	-	Practice Plus Group does not provide these services
National Prostate Cancer Audit	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
National Vascular Registry	No	-	Practice Plus Group does not provide these services
Neurosurgical National Audit Programme	No	-	Practice Plus Group does not provide these services
Out-of-Hospital Cardiac Arrest Outcomes	No	-	Practice Plus Group does not provide these services
Paediatric Intensive Care Audit	No	-	Practice Plus Group does not provide these services
Perioperative Quality Improvement Programme	No	-	Practice Plus Group does not provide these services
Prescribing Observatory for Mental Health	No	-	Practice Plus Group does not provide these services
Renal Audits	No	-	Practice Plus Group does not provide these services
Respiratory Audits	No	-	Practice Plus Group does not provide these services
Sentinel Stroke National Audit programme	No	-	Practice Plus Group does not provide these services
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	X	There were no qualifying incidents during the reporting period
Society for Acute Medicine's Benchmarking Audit	No	-	Practice Plus Group does not provide these services
Trauma Audit and Research Network	No	-	Practice Plus Group does not provide these services
UK Cystic Fibrosis Registry	No	-	Practice Plus Group does not provide these services
UK Parkinson's Audit	No	-	Practice Plus Group does not provide these services

The report of one national clinical audit was reviewed by the provider in 2022/23 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

Table 2: Actions taken in response to recommendations from national clinical audits

National clinical audit report	Actions in response to report recommendations
National Ophthalmic Database (NOD) 2021	Published results show that all PPG sites are within accepted limits for posterior capsular rupture and visual loss. Low post-operative complications reported and no outliers

The reports of four local clinical audits were reviewed by the provider in 2022/23 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

Table 3: Actions taken in response to recommendations from local clinical audits

Local clinical audit report	Findings / actions
Prophylactic Antibiotic Audit	This audit identified that not all sites were administering prophy-lactic antibiotics in line with PPG guidance. The findings from this audit have led to a review of the Practice Plus Group Secondary Care prophylactic antibiotic policy to ensure best practice across all sites. This audit will be completed again after all actions have been completed
Pharmacy Interventions Audit	The Chief Pharmacist introduced this audit to monitor compliance with national guidelines. This audit has been added to the 22/23 audit schedule for all sites
UTC Mattress and Trolley Audit	It was identified by the Head of IPC that the mattresses and trol-lies in the UTCs required regular checking as any tears or damage could have an IPC implication. This audit has been added quarter-ly to the 22/23 audit schedule to offer assurance
Cataract Surgery Retained Lens Fragments Audit	This audit was initiated at the request of the PPG Ophthalmic Lead to ensure that none of our sites were outliers in complica-tions relating to cataract surgery. The audit, along with the latest NOD update, show that none of our sites are outliers and all sites have low complication rates

The above local clinical audits are either in addition to those included in the generic audit schedule or have been added to the generic audit schedule, described in Appendix 1 due to findings. Individual actions are created at the time of the scheduled audits to address any areas of non-compliance identified.

2.2.3 Research

The number of patients receiving relevant health services provided or subcontracted by Practice Plus Group in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee zero.

2.2.4 CQUIN framework

Practice Plus Group's income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because CQUIN is no longer applicable to the contracts Practice Plus Group holds with Commissioners.

2.2.5 Care Quality Commission

Practice Plus Group is required to register with the Care Quality Commission and its current registration status is as follows:

Site	CQC Status
Practice Plus Group Hospital, Plymouth	Good
Practice Plus Group Hospital, Shepton Mallet	Outstanding
Practice Plus Group Hospital, Barlborough	Good
Practice Plus Group Hospital, Emersons Green	Good
Practice Plus Group Hospital, Ilford	Good
Practice Plus Group Hospital, Southampton	Good
Practice Plus Group MSK & Spinal Service, Lincolnshire	Good
Practice Plus Group Ophthalmology	Outstanding
Practice Plus Group Diagnostics, Buckinghamshire	Good
Practice Plus Group MSK, Buckinghamshire	Good
Practice Plus Group Surgical Centre Portsmouth	Good
Practice Plus Group Surgical Centre, Devizes	Good
Practice Plus Group Surgical Centre, Gillingham	Good
Practice Plus Group UTC, Southampton	Good

Practice Plus Group has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Practice Plus Group during 2022/23.

Practice Plus Group has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.6 Secondary Uses Service

Practice Plus Group submitted records during 2022/23 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 and;
  100% for outpatient care.

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

  100% for admitted patient care;
  100% for outpatient care and;
  NA for accident and emergency care.

2.2.7 Information Governance

Practice Plus Group's 2022/23 annual Data Security and Protection (DSP) toolkit submission achieved 100%.

Practice Plus Group understand the need to protect and maintain the confidentiality of patient information, and take our responsibilities in this important area very seriously. We pride ourselves on our accountability and transparency. The Caldicott Guardian, who is responsible for the security of patient information, leads this work and is ably supported by the Senior Information Risk Owner and Data Protection Officer.

We have continued our historic focus on accountability, audit and transparency; this meant that we have been well placed to continually improve our compliance.

We have continued to update our internal information and security management (ISMS) policies and patient privacy notices to match and address any work model changes for all our services.

Staff have continued to report incidents when they do take place.

For the period 01 Apr 2022 to 31 Mar 2023, we have had a total of:

- 6 internal IT security incidents;
- 42 Internal Confidentiality breaches, with none being external SIRI Level ICO reportable incident.

We continued our compliance commitments with the mandatory ISO27001 Certification framework of externally audited continual assessment visits (CAVs) by the British Standards Institute (BSI) where we received our 3 year recertification certificate in October 2022 and there were no non-conformances raised. We have commenced our transition preparations for the new ISO 27001:2022 standard in order to enhance our compliance program across all the organisations operational units, through a rigorous self-assessment internal audit program that ensures total coverage of all PPG operational units and increase our compliance evidence base.

Our 2022 annual Data Security and Protection (DSP) toolkit submission achieved 100% Standards Exceeded Compliance status for the second time and we are on track to achieve the same in the 2023 DSP Toolkit submission due on the 30th June 2023.

We also obtained our Cyber Essentials Plus Certification recertification in June 2022, demonstrating our high standards in Cyber Security posture.

We have scheduled an annual independent external audit review in March 2023 of our DSP Toolkit submission using the NHS DSP Toolkit Independent Assessment Framework guidelines. The DSP toolkit audit is conducted by Teamwork IMS, an independent assessor against our self-assessment responses to provide an independent review of our responses.

The National Data Guidance Mean score achieved a continued improvement from the previous audit in 2021 of 1.35 to 1.20 in 2022/23 audit.

The score means the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment. For example, the independent assessor exercises professional judgement in comparing the self-assessment submission to their independent assessment and there is a non-trivial deviation or discord between the two.

- There were no standards rated as 'Unsatisfactory', and none were rated as 'Limited'. However, not all standards are rated as 'Substantial';
- Therefore, the results achieved a DSP Toolkit rating of Moderate assurance level for all the National Data Guidance Standards used to measure the DSP Toolkit submission.

We are confident we will continually improve on this score in the 2023 Independent DSP Toolkit Assessment.

2.2.8 Payment by results

Practice Plus Group internal clinical coding audit programme is based on the Data Security Guide. The audit programme is in line with the national clinical coding audit requirements and audits are carried out following DSDT guidance and NHS Digital clinical coding audit methodology. Practice Plus Group Secondary Care have exceeded the Terminology and Classifications Delivery Service standards for primary and secondary diagnosis and primary and secondary procedure..

2.2.9 Data quality

Practice Plus Group has undertaken the following actions to improve data quality

- PPG has updated the Information Request Policy to include the requests for governmental departments;
- We have completed the transformation all records archiving from paper to electronic archiving for existing and new records;
- We have continued to enhance our Cyber Security management through external reviews and the implementation of advanced security tools to address the findings recorded in the PPG Continual System Improvement plan and enhanced our Cyber Security defences;
- We have continued to closely monitor historical and inherited electronic records We have implemented additional records validation checks and verification processes.

2.2.10 Learning from deaths

During 2022/23 four Practice Plus Group patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

2 in the first quarter;
1 in the second quarter;
1 in the third quarter;
0 in the fourth quarter.

By April 2023, four case record reviews and four investigations have been carried out in relation to four of the deaths included above.

In all four cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

2 in the first quarter;
1 in the second quarter;
1 in the third quarter;
0 in the fourth quarter.

None of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

One case record review and one investigation completed after April 2022 related to a death which took place before the start of the reporting period.

One, representing 100% of the patient deaths before the reporting period (March 2022), is judged to be more likely than not to have been due to problems in the care provided to the patient.

As a result of this there has been a change in the presentation of the venous thromboembolism prophylaxis flow chart to de-prioritise the prominence of prescribing aspirin, to ensure more aggressive anti coagulants are used for patients undergoing joint replacement surgery.

2.3 Reporting against core indicators

2.3.1 Patient-Reported Outcome Measures (PROMs)

PROMs assess the quality of care from the patient's perspective. PROMs calculate the health gains from surgery using pre- and post-operative questionnaires.

The procedures measured include

- Hip replacements;
- Knee replacements.

Explanatory notes:

The "Improved" figures are the percentage of patients who have reported an improvement in each health gain score following surgery.

Health gain measures – all patients are asked to complete the following questionnaires, both before and after surgery:

- EQ-5D (EuroQol-5D) Index which evaluates the generic quality of life. It includes one question for each of the five dimensions that include mobility, self-care, usual activities, pain/discomfort, and anxiety/depression;
- The EQ-VAS is a vertical visual analogue scale that takes values between 100 (best imaginable health) and 0 (worst imaginable health), on which patients provide a global assessment of their health;
- The Oxford Hip / Knee Score is designed to assess function and pain in the joint using a self-assessment questionnaire.

2020/21 data

Health Gains			
Average adjusted health gains – Total HIP Replacement			
	Oxford hip	EQ VAS	EQ-5D index
	Improved	Improved	Improved
Practice Plus Group	98.7%	68.4%	92.2%
England	97.2%	69.7%	89.8%

Health Gains			
Average adjusted health gains – Total KNEE Replacement			
	Oxford knee	EQ VAS	EQ-5D index
	Improved	Improved	Improved
Practice Plus Group	97.2%	56.2%	81.4%
England	94.1%	58.6%	82.2%

Data source: NHS Digital, Patient Reported Outcome Measures.

Further PROMS data has not been published by NHS Digital since the 2020/21 data shown above, with no date at which publication will be resumed announced at this present time.

2.3.2 Emergency readmissions

	2020/21	2021/22	2022/23
Practice Plus Group (local data)	0.24%	0.74%	0.80%

Data source: QG Indicator report (Readmissions and QG Indicators all sites format worksheets).

National comparative data not available.

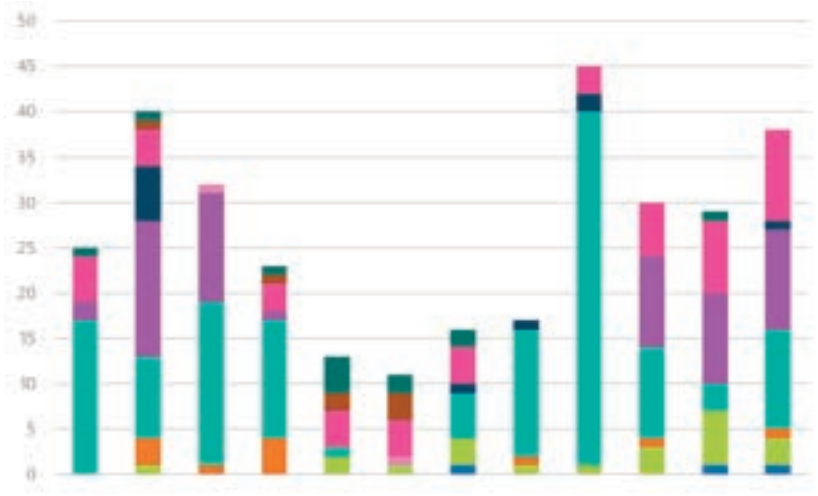
Practice Plus Group considers that this data is as described for the following reason:

- The figure may be slightly higher than stated as patient may not return to the private sector, but be admitted to their local NHS hospital and Practice Plus Group not be made aware.

Practice Plus Group intends to take the following actions to improve this percentage, and so the quality of its services, by undertaking a Patient Safety Incident Investigation for all readmissions to identify any areas for improvement to reduce the risk of readmission.

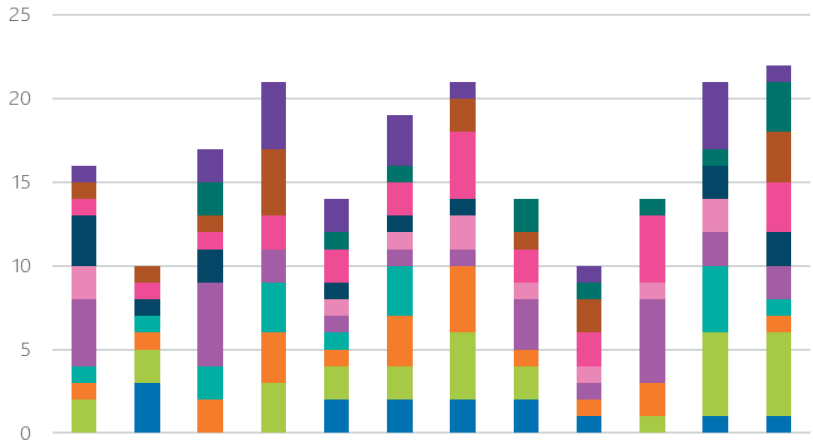
2.3.3 Responsiveness to the personal needs of patients

Number of compliments received by each site



	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Barlborough Hospital	0	0	0	0	0	0	1	0	0	0	1	1
Ilford Hospital	0	1	0	0	2	1	3	1	1	3	6	3
Plymouth Hospital	0	3	1	4	0	0	0	1	0	1	0	1
Shepton Mallet Hospital	17	9	18	13	1	0	5	14	39	10	3	11
Southampton Hospital	2	15	12	1	0	0	0	0	0	10	10	11
Devizes Surgical Centre	0	0	1	0	0	1	0	0	0	0	0	0
Gillingham	0	6	0	0	0	0	1	1	2	0	0	1
St Mary's Portsmouth	5	4	0	3	4	4	4	0	3	6	8	10
UTC, Southampton	0	1	0	1	2	3	0	0	0	0	0	0
UTC, St Mary's Portsmouth	1	1	0	1	4	2	2	0	0	0	1	0

Number of complaints received by each site



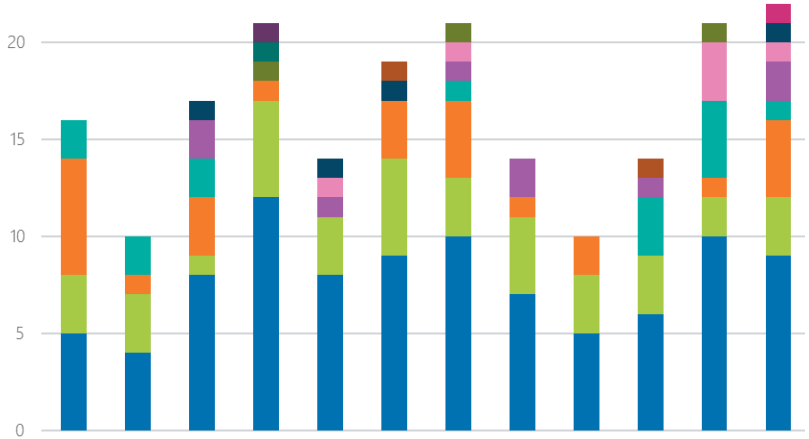
	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Barlborough Hospital	0	3	0	0	2	2	2	2	1	0	1	1
Ilford Hospital	2	2	0	3	2	2	4	2	0	1	5	5
Plymouth Hospital	1	1	2	3	1	3	4	1	1	2	0	1
Shepton Mallet Hospital	1	1	2	3	1	3	0	0	0	0	4	1
Southampton Hospital	4	0	5	2	1	1	1	3	1	5	2	2
Devizes Surgical Centre	2	0	0	0	1	1	2	1	1	1	2	0
Gillingham	3	1	2	0	1	1	1	0	0	0	2	2
St Mary's Portsmouth	1	1	1	2	2	2	4	2	2	4	0	3
UTC, Southampton	1	1	1	4	0	0	2	1	2	0	0	3
UTC, St Mary's Portsmouth	0	0	2	0	1	1	0	2	1	1	1	3
Emerson's Green	1	0	2	4	2	3	1	0	1	0	4	1

A total of 199 complaints were received during the reporting period, 196 of which provided the complainant with a satisfactory resolution from the initial investigation and response at stage 1. Thirteen complaints (i.e., 6.53% of complaints made) were escalated to stage 2, whereby the complaint was not resolved to the complainant's satisfaction at stage 1 and a review of the complaint was requested by the Managing Director. Two of the complaints during the reporting period were escalated to the Parliamentary and Health Service Ombudsman as stage 3 complaints.

90% of complaints (144/160) were acknowledged within 3 working days while 56% (45/80) of complainants received a response with the outcome of the investigation within 20 working days.

29% of complaints received during the reporting period were not upheld, 38% were partially upheld while 33% were upheld.

Subjects of complaints received



		May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Clinical treatment	5	4	8	12	8	9	10	7	5	6	10	9
Communication (oral)	3	3	1	5	3	5	3	4	3	3	2	3
Staff attitude/behaviour	6	1	3	1	0	3	4	1	2		1	4
Date for appointment	2	2	2	0	0	0	1	0	0	3	4	1
Communication (written)	0	0	2	0	1	0	1	2	0	1	0	2
Date of admission/attendance	0	0	0	0	1	0	1	0	0	0	3	1
Test results	0	0	1	0	1	1	0	0	0	0	0	1
Personal records	0	0	0	1	0	0	1	0	0	0	1	0
Failure to follow agreed procedures	0	0	0	0	0	1	0	0	0	1	0	0
Consent to treatment	0	0	0	1	0	0	0	0	0	0	0	0
Policy & commercial decisions of the organisation	0	0	0	1	0	0	0	0	0	0	0	0
Premises	0	0	0	0	0	0	0	0	0	0	0	1

Practice Plus Group considers that this data is as described for the following reasons:

- Data are taken directly from the feedback module of the Datix electronic complaint management system;
- Complaints are reviewed by a senior member of staff on each site to ensure that they are recorded accurately;
- Complainants are consulted prior to investigation to confirm understanding of the focus of the complaint investigation.

Practice Plus Group has taken the following actions to improve this data, and so the quality of its services, by:

- Each site discussing clinical performance with the central governance team at monthly quality reviews.

2.3.4 Percentage of staff who would recommend Practice Plus Group

The data used to inform the response to this section is taken from the Practice Plus Group annual staff survey, Over to You. All respondents are categorised as either detractors or promoters and the Net Promoter Score is calculated by subtracting the percentage of detractors from the percentage of promoters.

The Net Promoter Score for staff employed by, or under contract to, Practice Plus Group during the reporting period who would recommend Practice Plus Group as a provider of care to their family or friends is as follows:

	2020/21	2021/22	2022/23
Practice Plus Group	49*	**	44

Data source; Practice Plus Group Over to You survey, The Survey Initiative

*The score for 2020/21 was reported in the last Quality Account for Practice Plus Group overall, as opposed to the score for Practice Plus Group secondary care. This has been corrected for this report.

** *The Over to You* survey data collection for 2021/22 was postponed until May 2022, with a Secondary Care Strategy Survey being held in December 2021, providing staff consultation on the proposed direction of travel for the organisation.

Practice Plus Group considers that this data is as described for the following reason:

- The Over To You survey is administered and analysed by an independent agency.

Practice Plus Group has taken the following actions to improve this rate, and so the quality of its services, by extending the discount policy for surgery at Practice Plus Group Hospitals and Surgical Centres for the friends of staff, as well as for their family as was the case previously.

2.3.5 Venous thromboembolism risk assessment

	2020/21	2021/22	2022/23
Practice Plus Group (local data)	98.9%	99.1%	97.9%

Data source: https://improvement.nhs.uk/resources/vte/

The national VTE data collection and publication was suspended in March 2020 to release capacity in providers and commissioners to manage the COVID-19 pandemic. Consequently, it is not possible to provide comparative data.

Practice Plus Group considers that this data is as described for the following reasons:

All sites record data for this measure and patients missed are followed up.

Practice Plus Group intends to undertake a full review of VTE assessment and management. The introduction of a new electronic patient records system will aid with the digital recording of VTE assessments undertaken.

2.3.6 C. difficile infection

	2020/21	2021/22	2022/23
Practice Plus Group (local data)	0	0	0
Best performance nationally	0	0	*
National average	22.2	44.04	*
Worst performance nationally	140.5	138.4	*

Data source: PHE, C. difficile infections: financial year counts and rates by acute trust and CCG, up to financial year 2021-2022

* National data for 2022/23 not yet made available

Practice Plus Group considers that this data is as described for the following reasons:

It is taken directly from the Public Health England published data.

2.3.7 Patient safety incidents

Patient safety incidents that...	2020/21		2021/22		2022/23	
	#	%	#	%	#	%
...resulted in severe harm	0	-	8	0.41%	7	0.51%
...resulted in death	0	-	2	0.10%	1	0.07%
...were classified as never events	0	-	1	0.05%	1	0.07%
...were classified as serious incidents requiring external reporting	5	0.59%	12	0.61%	9	0.66%
Total number of incidents reported	854		1,970		1,370	

Practice Plus Group considers that this data is as described for the following reasons:

- Data are taken directly from the incident module of the Datix electronic incident management system;
- Incidents are reviewed by a senior member of staff on each site within three days of reporting to ensure that the severity of harm and categorisation are recorded accurately;
- All potentially serious incidents/never events are reviewed by a panel led by the Medical Director and Chief Nurse within 48 hours of occurrence.

Practice Plus Group intends to take the following actions to improve this data and so the quality of its services, by:

- Implementing the Patient Safety Incident Response Framework, which will include a programme of quality improvement projects to address identified risks to patient safety;
- All clinical staff completing module 1 of the National Patient Safety Syllabus (current compliance is at 74% completion);
- Repeating the Patient Safety Culture Survey to determine progress.

2.3.8 Friends and family test

	Jan 21	Jan 22	Jan 23
Practice Plus Group (local data)	99%	99%	97%
Best performance nationally	100%	100%	100%
National average	95%	95%	95%
Worst performance nationally	60%	79%	79%

Data source: NHSE at NHS England » Friends and Family Test.

Data is based on inpatient data for the month of January each year for comparative purposes.

Practice Plus Group considers that this data is as described for the following reason:

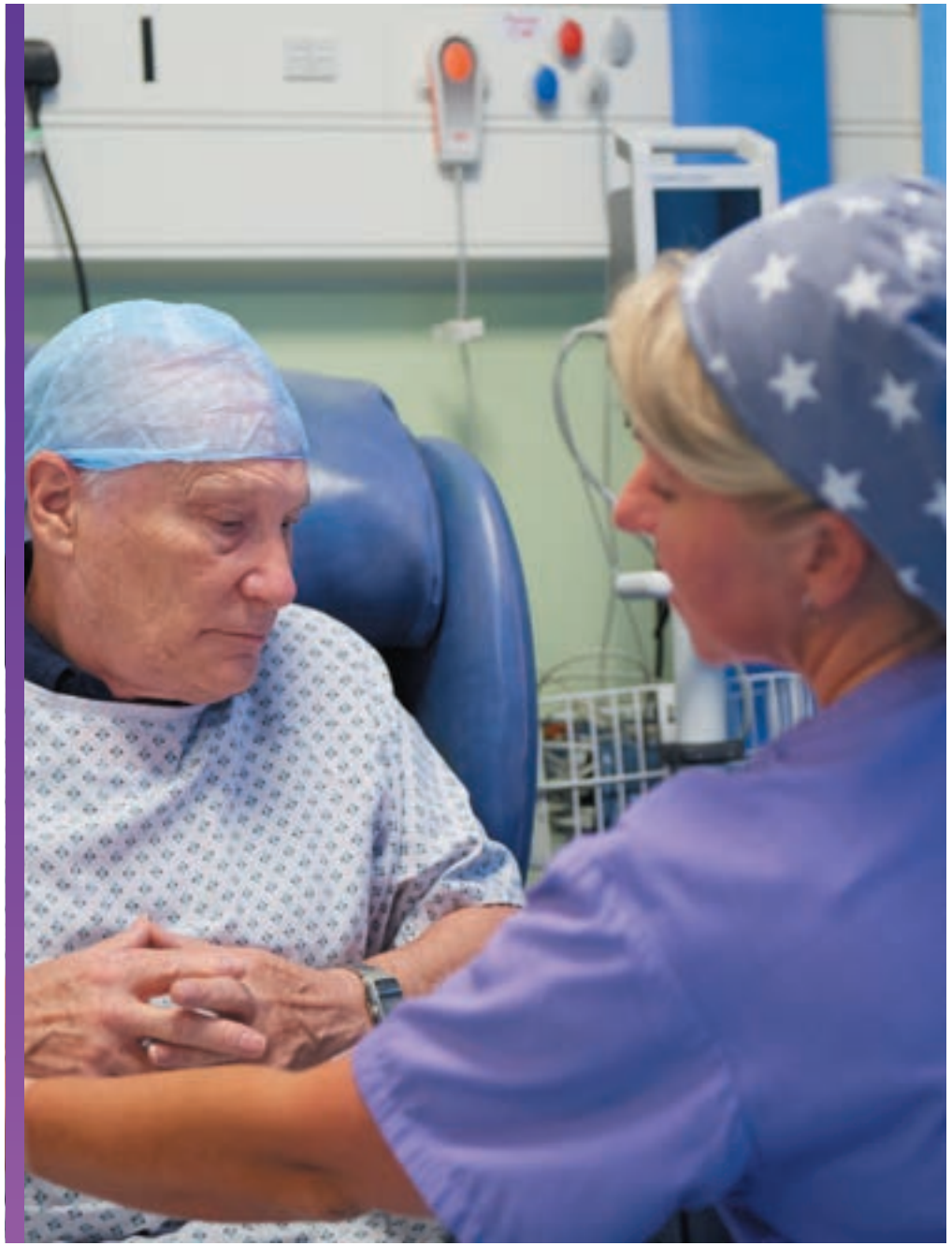
- It is taken directly from the NHS England site.

Practice Plus Group intend to explore digital options to capturing patient feedback which would improve the response rates.

2.3.9 Freedom to speak up

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

There have been no instances of concerns raised during the reporting period.



Part 3
Other information

3.1 Performance against the priorities set for 2022/23

Priority 1: Quality Standard for Imaging Accreditation

We said we would:

Embed the quality standard for imaging (QSI) to facilitate a gradual and meaningful change which will allow us to demonstrate to our stakeholders, service users and patients the high standard of Practice Plus Group Imaging services.

What we have achieved:

A great deal has been achieved in terms of the QSI. We have moved from stage zero, which was the start of the conversation and building support for the quality improvement plan, through to stage one which was formal business plan application and assignment of staff. We now sit in stage three which is implementing the changes identified in the imaging service gap analysis which formed a large bulk of the work in stage two and the work thus far.

The main areas of challenge so far have been the need for language translation services to encompass all aspects of patient communication be that written or oral. The redesign of all patient information sources including the website and leaflets with a move towards the design of QR codes. Patient feedback methods incorporating patient and community engagement has also been restructured to comply with QSI guidance. Consent training has been designed and tested. The environment for all service users' needs have been audited and issues identified with QSI compliance. Identification of roles with management diagrams have been completed ready for the new quality management manual to start to be drafted.

Many benefits have been identified through the process of a service-wide review and gap analysis. Engagement is growing within the imaging service, bringing with it a sharing of best practice and a uniformed approach to service provision. Changes are now being discussed and implemented across the group to ensure the change fundamentals that underpin the QSI project are active at all sites. Advantages we are starting to see are:

- A building of a uniformed framework for delivering high quality and patient focused care;
- Improvements to efficiency and validity of services;
- Clearer idea of compliance with regulations, leading to greater compliance as a group.

Other benefits that have been key so far are that QSI has supported teamwork and collaboration, both within Practice Plus Group and with outside. New connections have been made with NHS and independent providers of imaging for healthcare through the QSI network.

As we progress through stage three and continue the construction of the Practice Plus Group quality standards manual, we will see the hard work of the stage two gap analysis paying off. Rolling out the new manual for imaging will enable the uniformity needed to drive continuous improvement and ensure patients receive the best care possible and improvements are identified and implemented on an ongoing basis across all imaging sites in Practice Plus Group.

Priority 2: Increase mechanisms to gather patient feedback

We said we would:

Identify and test alternative mechanisms for collecting patient feedback, with at least one mechanism used across all services. At least one site will enlist the support of Patient Safety Partners in gathering patient feedback.

What we have achieved:

Sites have started to reinstate patient groups and forums which has resulted in a renewed approach to how feedback can be captured and actioned.

Efforts to recruit Patient Safety Partners over the last 12 months have been successful, with one appointed and three other potential candidates applied. None are in post to date.

Priority 3: Enhance the functionality of the Health Information System (HIS) to mitigate risks to patient safety

We said we would:

Develop a standardised process for requesting externally-provided diagnostic tests, with monitoring and electronical documentation of results and acknowledgement of findings.

We said the success of this quality improvement priority would be measured through the adoption of the electronic process across all Practice Plus Group Secondary Care Hospitals and Surgical Centres.

What we have achieved:

We have started to make externally requested tests across various sites however since establishing this objective a programme has been rolling to replace and update the

Health Information System (HIS) used across Practice Plus Group.

This in conjunction with the ongoing procurement process for a new PACS and RIS system for Practice Plus Group has delayed the further implementation of this quality initiative.

The updated HIS that is being implemented across Practice Plus Group has enhanced functionality which will support quality improvement and process enhancement across the business.

Priority 4: Development and introduction of a Quality Academy within each Secondary Care service

We said we would:

The primary aim of the Practice Plus Group Quality Academy is to build and support the understanding of the staff in aspects of quality, planning, improvement and control of processes relating to our patients' care pathways. This is building on the existing quality projects already in place within services.

We committed to ensuring that all services have a Quality Academy in place, with replication of Quality Improvement projects across services.

The Quality Academy will allow a structured approach to quality improvement and consistent reporting of the impact of quality initiatives. The introduction of CPD will also allow recognition and personal development of individual staff members undertaking quality projects.

What we have achieved:

All sites are committed to Quality Improvement (QI) and have local QI programmes in place. The Quality Academy approach is still in the early stages at most sites and the QI programmes which are being followed are less formal and not as structured.

Sites are keen to use the structured Quality Academy approach to QI as all are committed to ensuring our care pathways are providing the most clinically effective care to our patients and the sharing of best practice.

There is a QI training plan in development which will be available to all staff to encourage them to identify and undertake QI with confidence, following an approved process and with support.

The Quality Academy will continue as a focus for 23/24.

Priority 5: Introduction of wellbeing champions for staff in each Secondary Care service

We said we would:

Ensure that staff are provided with an environment and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

What we have achieved:

There are a number of staff wellbeing initiatives in place across the organisation. Sites have implemented a staff pantry where staples are available free of charge and without the need to request.

There is an employee assistance programme (EAP) in place which provides free counselling as required.

There are staff discount schemes available in addition to cycle to work schemes.

Sites have also implemented healthy fruit days for staff or free meal vouchers.

As an organisation there has been a change to terms and conditions with the addition of adjustments to the Time Away from Work Policy and Occupational sick leave Policy to either improve existing, or create new provisions as follows:

- The introduction of up to 2 days paid leave in any rolling 12 month period for urgent domestic incidents (such as a flood, fire, storm damage or burglary);
- The introduction of up to 5 days paid leave in any rolling 12 month period for fertility treatment – this applies equally to both employees and their partners undergoing fertility treatment;
- Alongside the existing entitlement to reasonable paid time off for pregnant employees for antenatal appointments, the introduction of reasonable paid time off for antenatal appointments for employees who have a qualifying relationship with someone who is pregnant to accompany that individual to antenatal appointments;
- The introduction of up to 2 days paid leave in any rolling 12 month period for dealing with issues relating to dependents (this is where someone who is genuinely or reasonably reliant upon you or needs your help at short notice or in an emergency);
- The introduction of up to 1 day of paid leave in any rolling 12 month period for volunteering for good causes to benefit the lives of others;
- The extension of bereavement leave from up to 5 days paid leave to up to 10 days paid leave where the bereavement relates to an immediate family member and the employee is responsible for making related arrangements.

3.2 National Joint Registry (NJR) Quality Data Provider Awards

All Practice Plus Group hospitals were awarded NJR Quality Data Provider status for 2021/22 after successfully completing a national programme of local data audits.

The 'NJR Quality Data Provider' scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets.

The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers. The registry collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care, and overall cost-effectiveness in joint replacement surgery. The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and to reward those who have met registry targets.

In order to achieve the award, hospitals are required to meet a series of six ambitious targets during the audit period 2020/21. One of the targets which hospitals are required to complete is compliance with the NJR's mandatory national audit aimed at assessing data completeness and quality within the registry.

The NJR Data Quality Audit investigates the accurate number of joint replacement procedures submitted to the registry compared to the number carried out and recorded in the local hospital Patient Administration System. The audit ensures that the NJR is collecting and reporting upon the most complete, accurate data possible across all hospitals performing joint replacement operations, including:

- Barlborough Hospital;
- Emerson's Green Hospital;
- Ilford Hospital;
- Plymouth Hospital;
- Shepton Mallet Hospital;
- Southampton Hospital.

NJR targets also include having a high level of patients consenting for their details to be included in the registry and for hospitals to demonstrate timely responses to any alerts issued by the NJR in relation to potential patient safety concerns.

3.3 Diagnostic Imaging

Practice Plus Group provides a range of diagnostic imaging services within its hospitals, Diagnostic Centres and Urgent Hospitals including: plain film X-ray; non- obstetric (NOUS), General and MSK ultrasound, Echocardiography, Coned Beam CT (CBCT) and Magnetic Resonance Imaging (MRI).

These services are delivered using state of the art imaging systems at both fixed and mobile locations. Flexible opening hours, which include weekends and evenings, offer patients greater accessibility and convenience.

Our team of dedicated imaging staff, made up of consultant radiologists, radiographers, sonographers and support staff, are all highly experienced healthcare professionals, registered with their respective professional bodies where required. Our first two apprentice radiographers have entered their second year of training and continue to go from strength to strength. We are looking at the possibility of introducing an assistant practitioner role via an apprenticeship programme to support skill mix within the workforce.

We are also working in collaboration with other Independent Sector Healthcare providers to support them in the training of apprentice radiographers to reduce the potential burden on NHS hospitals.

We now have four qualified reporting radiographers who are reporting plain film x-ray and MRI cases in-house, with another reporting radiographer training in MRI reporting due to qualify in spring 2024.

Referrals to our diagnostic imaging services come from a range of healthcare professionals including doctors, nurses and allied health professionals with the results of completed imaging examinations usually available within 48 hours of the patient's attendance.

Practice Plus Group has a robust quality governance framework for diagnostic imaging includes elements such as: clinical audit; use of latest evidence-based policies, protocols and NICE guidance; competency assessment of staff and a Quality Assurance (QA) programme.

This framework ensures that services delivered by our operational teams are safe and clinically effective. Service-based teams have been supported by an experienced divisional team which includes: a Clinical Director for Diagnostic Imaging and a Head of Diagnostic Imaging who oversee all diagnostic imaging services within Practice Plus Group's Secondary Care Division.

In addition, support can be obtained from external providers, such as Alliance Medical, Cobalt, Hexarad, Xyla Diagnostics and the various NHS trusts we work in conjunction with. Over the last year we have increased the number of sites providing MRI and echocardiography on site by increasing our use of Cobalt as a mobile MRI provider and Xyla Diagnostics for echocardiography. This not only improves the pathway for our patients by reducing waiting times but also reduces the number of third-party providers that we use so improving governance and quality.

We have a comprehensive QA programme, modality meetings and discrepancy review meetings as well as monthly site department meetings. These are all aimed at supporting and informing staff as well as sharing learning from incidents and investigations.

The last year has seen continued investment in diagnostic imaging equipment DR full equipment upgrade at one site and new DR mobiles at two sites and a retrofit DR mobile at a further site. We have invested in three new ultrasound machines with matrix probes to improve the quality of our ultrasound services. We now provide Coned Beam CT (CBCT) services at two sites.

We are working hard to embed the Quality Standard for Imaging across the business and are currently developing a Quality Manual for Diagnostic Imaging with in Practice Plus Group.

We are working to improve our Friends and Family responses in Diagnostic Imaging by introducing a dedicated question set and supporting a variety of communication options to suit the diverse needs of our communities.

3.4 Infection Prevention and Control

Practice Plus Group maintains high standards of infection prevention and control which contributes towards achieving safe environments and the protection of staff and patients from avoidable harm.

Our Infection Prevention framework consists of robust policies and procedures, continuous audit and education to ensure that our infection prevention and control practices are evidence based and standards are maintained across all of our sites.

Our Infection Prevention and Control service is led by the Group Director and Deputy Director of Infection Prevention and Control with the Head of Infection Prevention and Control providing daily support to Infection Prevention and Control Leads at our individual sites. The IPC committee provides sites and staff with up-to-date guidance to ensures patient safety. Any identified surgical site infection is investigated using a clear process and standard using a post infection review tool. Our Infection Prevention and Control Team are in the process of devising a surgical site infection risk tool that can be used at the pre-assessment of patients which will highlight the need for extra precautions that need to be followed e.g., specialist negative pressure dressings.

Cleaning

The Head of Infection Prevention and Control has led on improving cleaning standards across the group and ensuring that we comply with the National Standards of Healthcare Cleanliness (2021). Practice Plus Group have implemented an internal cleaning manual so that standards can be maintained and improved and all cleaning staff are expected to undertake the level 2 qualification in Cleaning Knowledge and Skills. We are ensuring a focused collaborative working across all teams, clinical and non-clinical, to meet the cleanliness standard for all our sites. Overall cleaning audit scores are in compliance with the national standards and remained high throughout the year.

Part 4
Local quality updates

Barlborough Hospital

Performance against the priorities set for 2022/23

Priority 1

We said we would:

- Increase in private pay and insured with high patient satisfaction;
- Successful introduction of general surgery;
- Waiting lists reduced.

What we have achieved:

- General Surgery has been introduced with simple procedures. We are currently looking at what else we can offer in order to grow this service;
- Private pay continues to grow although we would like it to be better. With our new Business Development Manager, we aim to build on this;
- Patient satisfaction is consistently high and monitored closely. We have an excellent response rate when dealing with patient feedback and complaints.

Priority 2

We said we would:

- Increase the reporting of near misses and low harm incidents in order to learn and improve;
- Continue to strive for innovation;
- Achieve outstanding CQC rating;
- Continue to achieve quality standards set by CCG;
- Achieve Dignity Award.

What we have achieved:

- Incident reporting at Barlborough is always a focus and we are consistently reporting high number of incidents. Lessons learned are shared;
- Dignity Award achieved;
- ICB visit was very successful and they were very happy with our hospital. We have submitted our quality account and all standards have been achieved. We have a very good working relationship with our ICB Quality Manager. We also have good links with the local trusts and continue to work with them closely;
- We are in regular contact with our CQC representative and have had excellent feedback from our monitoring assessments.

Priority 3

We said we would:

- Staff wellbeing and work life balance;
- Mental health awareness.

What we have achieved:

- Mental health first aiders trained and are able to provide support and guidance;
- Outdoor walking groups and allotment commenced;
- Staff are able to access the physiotherapy gymnasium out of hours;
- Free lunch vouchers given to staff each month;
- Food bank set up for staff in need;
- Employee assistance programme promoted at the Barlborough update sessions;
- Health and wellbeing noticeboard helps to signpost staff and patients to services they can access or additional resources;
- Healthcare heroes awarded every month.

Local outcomes

Barlborough	#	%	Comments
NJR submission	1,834	100%	Hospital Profile - NJR Surgeon and Hospital Profile (njrcentre.org.uk) In the NJR reporting period for April 2022 – March 2023 Barlborough Hos-pital exceeded the national average with the number of procedures under-taken at our hospital. 100% of our pa-tients were con-sented to take part in the NJR data collec-tion. 100% of sub-missions had a valid NHS number and 100% of the data was entered within 4 days of the procedure
VTE risk assessment	4,329	100%	
VTE incidents	3/3,808	0.08%	We had 3 VTE incidents from 2022/23. Patient safety investigations were car-ried out for each incident and no caus-ative factors were identified and all cor-rect VTE protocols were followed
Complaints received	14		11 Clinical treatment 1 Communication (oral) 1 Communication (Written) 1 Staff attitude / Behaviour
Complaints upheld/partially upheld	5/14	36%	
Incidents relating to patient harm	74/304	24%	
Serious patient safety incidents	0	0%	No externally reportable serious incidents or never events

Priorities for 2023/24

Priority 1

What are we trying to improve?

Continue to grow our Private Pay and insured service.

What will success look like?

Increased volumes of private pay and insured.

How will we monitor progress?

- Referrals and procedure volumes;
- Increased revenue from PP and insured;
- High patient satisfaction and low number of complaints;
- Excellent reputation as a PP provider.

Priority 2

What are we trying to improve?

Ophthalmology Service Growth.

What will success look like?

Delivering a high-quality service with high volumes, high patient satisfaction and excellent outcomes.

How will we monitor progress?

- Referrals and procedure volumes;
- Patient satisfaction;
- CPD accredited courses for local optometrists.

Priority 3

What are we trying to improve?

Introduction of PSIRF.

What will success look like?

- Successful introduction of PSIRF;
- High quality incident reporting;
- Incidents and near misses are reported and any lessons learned are shared.

Patient stories

"I had a full hip replacement on the 9th of January the consultant surgeon that performed the procedure was Mr Mersich. Coincidently Mr Mersich replaced my other hip joint 10 years ago and it was because of the good experience I had then that I decided to return to Barlborough even though we have now moved home.

This recent procedure went really well and just two months later I feel able to carry on with my life without being blighted by the pain that I had before. I am walking well and able to cover several kilometres without problem. Mr Mersich is clearly very skilled but more than that he inspires confidence that the procedure will improve quality of life and in my case that certainly is true, he has excellent inter-personal skills and takes time to explain what to expect. I am personally very grateful for what he did for me and I did thank him when we met a few weeks ago, in my opinion he is a credit to your organisation.

It would be remiss of me not to mention Mr Marks, the anaesthetist who looked after me throughout the procedure. He is excellent not only in his area of expertise but also in his communication skills which he used to put me at ease throughout the operation. I am very grateful to Mr. Marks, I did thank him but I want you to know what an asset he is to Barlborough.

Finally, I can't mention everyone of your staff I met and who looked after me but suffice it to say you have a great team and their friendliness and attitude helps when you are feeling a bit under the weather. So a big thank you from me to everyone at Barlborough!

Patient stories

I have been under the care of Barlborough since June 2018 when I was diagnosed with severe osteoarthritis in my right knee and both hips.

Mr Toth replaced my right knee and right hip and I was planning to have my left hip replaced but unfortunately I also had severe osteoarthritis in the lower spine and had to undergo multilevel decompression surgery.

I then returned to Barlborough in Feb 2021 to have my left hip replaced, but this time by Mr Minhas because of complexities with the joint. Shortly after, Mr Minhas discovered that my right hip had failed and I had to come back in to Barlborough for right hip revision surgery involving a stem replacement.

Today over four years later, I am able to at last regain my life!

I just want to ask you to thank on my behalf your team at Barlborough who have looked after me so well over the last 4 years, including Mr Toth and Mr Minhas, the theatre staff, the wonderful nurses who I drove mad in the recovery wards(!), the admin team who bent over backwards to fix dates for surgery and the reception staff who are always so welcoming as they were this morning,

I walked out of the Hospital today with tears of joy! I cannot thank you all enough and I hope not to have to see you again under those circumstances again for a very long time!

Patient stories

I was admitted to the hospital on Friday 17th February 23 for a total left hip replacement, under the care of Mr Springer and his surgical team.

The hospital was recommended to me by my physio as she had heard good things about it and thought this might be the place to go for my procedure, and how right she was.

I am writing to express my sincere thanks to all the departments who took part in my care. The treatment I received was exemplary throughout, from the surgical and anaesthesia teams, the ward nursing staff (day and night) Ward D, the physios and the catering team (the food was superb at all times).

I cannot praise the staff highly enough and my experience whilst in your facility was exceptional.

I would be most grateful if you could pass on my thanks to all concerned. I will, at some point, need my right hip replaced and, following my recent experience, there is nowhere else I would consider going.

Emerson's Green Hospital and Devizes Surgical Centre

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Improve patient access to advice and contact with the hospital if they have a concern post-operatively via the 24-hour helpline.

What we have achieved:

We now have weekend screening of phone calls, with clinician call back within the hour.

Priority 2

We said we would:

Ensure patients experience maximized pre-operative preparation for surgery, enhanced recovery, reduction in levels of post-operative pain and shorter lengths of stay.

What we have achieved:

Success will be monitored by auditing both the patient pathway and the patient experience. This will include, but is not limited to, a review of cancellations on the day of surgery, pain scores, length of stay data, patient feedback and patient satisfaction scores.

Priority 3

We said we would:

Raise awareness and understanding of patients with special needs, i.e., dementia, autism, delirium, acute anxiety and people with learning difficulties, with the development of a training programme for all staff and Standard Operating Procedures.

What we have achieved:

We have specific training for staff including autism available on LMS. We have included Autism awareness sessions on two clinical governance days. As part of the Autism pathway; we have a reception project in place "Get to know you". Including pre-op visits, which enable patients to become familiar with staff and the environment, before any procedure and points of contacted in the patients plan of care prior to procedure.

We know have a Dementia friendly room and signage. Staff now have dementia friendly badges. We have significantly improved the numbers of staff who have completed training in preventing falls in Dementia.

Priority 4

We said we would:

Increase levels of cleanliness, standardization of cleaning regimes across all areas, high audit score results and full compliance with National Standards of Cleanliness 2021.

What we have achieved:

Cleaning score have improved every month. We have increased our capital spend on fabric and equipment; with a focus on increasing the 'ease' of cleaning.

Local outcomes

Emerson's Green & Devizes	#	%	Comments
NJR submission			
VTE risk assessment			
VTE incidents	3	0.2	
Complaints received	30	0.18	
Complaints upheld/partially upheld	1	3.3	
Incidents relating to patient harm	53	35	
Serious patient safety incidents	2	1.3	

Priorities for 2023/24

Priority 1

What are we trying to improve?

Patient optimisation.

What will success look like?

- Review practice to consider booking treatment on the day of consultation;
- Review practice to increase day 0 discharges;
- Pre-operation call, using an MDT approach 2 weeks ahead;
- Learning from incidents.

How will we monitor progress?

- PROMS / LOS Data. Review post-operative pain;
- Increased productivity rates.

Priority 2

What are we trying to improve?

Improve the patient journey, with particular focus on diversity that drive reductions in inequalities.

What will success look like?

Implementation QR codes to allow SMART phone access to patient information leaflets in different languages. Consideration to information being shared on 'what to expect pre-post-surgery in the form of videos'. Phone translator available 24/7 to support patients and families.

How will we monitor progress?

Reduction in associated complaints. Increase in compliments.

Priority 3

What are we trying to improve?

Our Commitment to a clean and safe environment.

What will success look like?

- Regular cleaning standards meetings and cleaning charters. Embed the head of housekeeping meetings with the Heads of Departments to complete audits; driving improvements and ensuring accuracy in audits;
- We are trialing a new range of cleaning products and have commenced training.

How will we monitor progress?

- Continue with regular audits;
- Feedback from any external stakeholders.

Patient stories

"I just wanted to say a massive thank you to you all for a very positive experience. I was frankly terrified of being able to hear see or feel the procedure despite having an epidural. As it turned out your fantastic anaesthetist was reassuring and I was sedated so well I slept all the way through (apologies if I snored). Actually, I have now recommended two friends to you as both of them have the same fear. Very best wishes to you all."

"Just a very big thank you to the whole team that looked after me for my rotator cuff op on the 6.10.22. I was kept happy and busy chatting while waiting. All went amazingly and I was looked after in recovery with care and professionalism. I was discharged with full info of what to expect, how to control pain, how to do exercises. But the most impressive was the friendliness and care shown by all. Nothing was too much trouble and I was made to feel very much at ease. A great team and not stuffy, very easy to spend time with. I waited over 2 years for the op as unfortunately the NHS is struggling but I was treated as if I was a private patient. Thank you all so very much."

Ilford Hospital

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Improve our Datix Incident reporting investigation timescales.

What we have achieved:

- 95% of incidents are reported in 24 hours;
- 99% of incidents are reviewed within 3 days;
- 98% of incidents are investigated within 20 days.

Priority 2

We said we would:

Reduce infection rates to zero.

What we have achieved:

One deep infection noted in January 23- investigated to understand source of the infection and being presented at IPC forum to share learning across PPG. Following investigation, the risk of infection was high with no identified source.

Priority 3

We said we would:

Reduce the number of complaints to 50% lower than 2021.

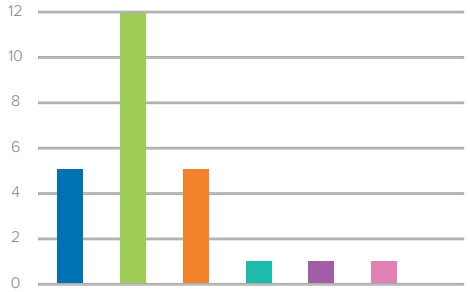
What we have achieved:

- 2021-2022 we had received 39 complaints;
- 2022-2023 we have received 26 complaints;
- A 34% reduction in complaints.

Local outcomes

Ilford	#	%	Comments
NJR submission	429	100	NJR submission and upload to the NJR database successful. Data Quality award presented to PPG Ilford for the 2nd year
VTE risk assessment	7885	99%	
VTE incidents	7	0.63%	Based on 1103 inpatients
Complaints received	26	0.31 %	Based on 8269 patients. Complaints by subject graph below
Complaints upheld/partially upheld	4 upheld, 4 Partially upheld, 14 Not upheld	15% 15% 55%	2 complaints are currently being investigated, therefore no outcome. Another 2 complaints are related to internal investigations and investigations are not complete
Incidents relating to patient harm	21	18.9%	Total of 111 incidents relating to patients. 17-Low minimal Harm 4-Moderate short term harm 90-No harm
Serious patient safety incidents	0	0%	

NHS complaints by subject



	Number of NHS Complaints by Subject
Clinical Treatment	5
Communication (oral)	12
Date for Appointment	5
Date of Admission/Attendance	1
Policy and Commercial	1
Staff Attitude/Behaviour	2

Priorities for 2023/24

Priority 1

What are we trying to improve?

Improve our Datix Incident reporting investigation timescales.

What will success look like?

All Datix will be closed off within the allocated timeframe.

How will we monitor progress?

Monthly reporting.

Priority 2

What are we trying to improve?

Reduction in Infection rates – there has been a recent increase in the number of infections our patients have experienced.

What will success look like?

No reported infections.

How will we monitor progress?

Monthly KPI reporting data.

Priority 3

What are we trying to improve?

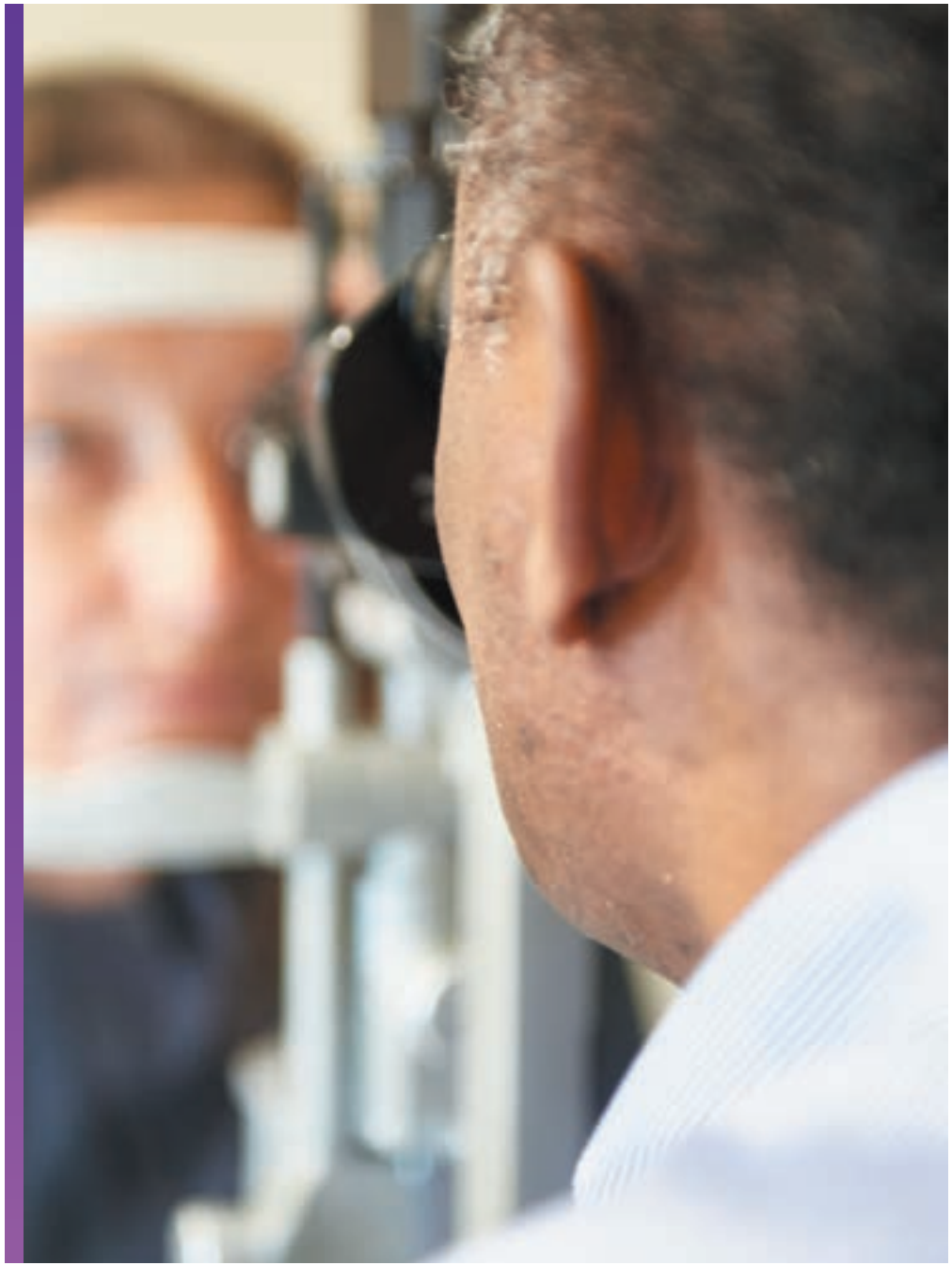
Reduction in number of complaints.

What will success look like?

The number of complaints will be 50% lower than 2021.

How will we monitor progress?

Monthly KPI reporting.



Plymouth Hospital

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Reduce length of stay for all inpatients to 1 or 0 days. ERAS (Enhanced Recovery After Surgery) meetings to commence in April to begin same day discharge for patients undergoing hip replacement. We are already undertaking same day discharge for shoulder replacements.

What we have achieved:

Our average length of stay remains 1-2 days. This is primarily due to the increased length of time patients are having to wait for surgery as a consequence of the COVID pandemic. Patients are presenting with more comorbidities and mobility problems prior to admission.

Priority 2

We said we would:

- Improve productivity within theatres;
- Currently have staffing issues which limit or restrict the lists we are able to complete.

What we have achieved:

Staffing within theatres has improved and this means we are able to run more lists.

Priority 3

We said we would:

Improve patient pathway via Enhanced Recovery with a further reduction in length of stay and improved patient feedback on postoperative results.

What we have achieved:

Patient feedback and outcomes are shared with departments on a monthly basis to aid service improvement and share best practice.

Local outcomes

Plymouth	#	%	Comments
NJR submission	1976	100%	
PROMS response rate	110/167	65.9%	2020- 2021 data
VTE risk assessment	2162	97.8%	48 missed VTE assessments since April 2022
VTE incidents	8	0.37%	
Complaints received	19	0.02%	7, clinical treatment, 5 communication (oral), 1 communication (written), 1 consent to treatment, 1 date of admission, 1 personal records, 2 staff attitude, 1 test results
Complaints upheld/partially upheld	18	94.7%	7 upheld, 10 partially upheld, 1 not up-held, 1 ongoing investigation
Incidents relating to patient harm	84	42.42%	65 low patient harm, 19 moderate harm
Serious patient safety incidents	0		2 potential SI incidents waiting for out-come of investigations

Priorities for 2023/24

Priority 1

What are we trying to improve?

To increase the number of day 0 hip, knee and uni knee replacements.

What will success look like?

Pathway already in place and agreed by clinical teams. Implementation will reduce length of stay and improve patient experience.

How will we monitor progress?

By reviewing clinical outcomes and patient feedback.

Priority 2

What are we trying to improve?

Improving patient access to treatment.

What will success look like?

- Improved theatre utilisation;
- Introduction of BMI clinics.to promote healthy lifestyle choices and reduce waiting times;
- Reduction in waiting and active monitoring lists;
- Improved staffing.

How will we monitor progress?

- Regular waiting list/rota meetings;
- Patient feedback;
- Regular review of waiting times during Governance meetings.

Priority 3

What are we trying to improve?

Improved responses to patient feedback.

What will success look like?

- Improved friends and family response rates across all departments;
- Shared learning across all departments for both positive and negative feedback on Clinical Governance Days.

How will we monitor progress?

- Patient forum meetings;
- Monitoring complaints;
- Patient feedback is shared with departments on a monthly basis and teams will be asked to share service improvement ideas.

Patient stories

Mrs Y a 69 year old lady was referred to Practice plus Group Hospital Plymouth in August 2022 with severe bilateral hip pain that was affecting every aspect of her day to day life. She was diagnosed with osteoarthritis and required bilateral hip replacement. Her first surgery was performed in October 2022 and her second February 2023.

Speaking of her surgery Mrs Y states "The staff were brilliant and allayed all my fears prior to my operation. The care I received afterwards was first class. I'm delighted with the outcome of my surgery and after 3-4 years of constant pain I am now pain free and able to enjoy everyday life again"

Mrs D was referred to Practice plus Group Hospital Plymouth with progressive hip pain that was impacting on her everyday life and preventing her doing the activities she enjoyed. X rays confirmed she needed a hip replacement that was completed in September 2022.

Speaking of her surgery Mrs D thanked the staff at Practice Plus Group for giving her life back. She has made a full recovery and is back to playing golf, gardening and cycling.

Shepton Mallet Hospital

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Improve our patient pathways to ensure they are fit for purpose, following significant changes to them as a result of the pandemic, going forwards. We will use a Remind, Review and Renew ethos to check that all colleagues (both clinical and non-clinical) within the Hospital are following the standard operating procedures linked to those pathways. Focus will be given to new starters, to ensure their induction packs cover all relevant aspects of these patient pathways.

What we have achieved:

- All patient pathways have been reviewed by both clinical and non-clinical teams;
- EPR upgrade, all pathways were reviewed as part of this upgrade;
- Induction packs have been revised.

Priority 2

We said we would:

- Improve our recruitment rates, at times over the last 2 years our vacancy rates have reached more than 20%. A figure this high can lead to patient safety incidents, increased use of agency staff and can affect staff morale;
- We have worked tirelessly with our Talent Acquisition Partners to assure all of our job descriptions and adverts are clear and informative;
- We will implement new initiatives to include International Nurses Recruitment, retention action plans, increase the scope of apprenticeships and further embed our 'Grow your Own' methodology.

What we have achieved:

- Recruitment rates now at 13.13%;
- Apprenticeships programme well underway;
- Staff development/Grow your own embedded – Lucia's story;
- Retention action plan, examples of improvement from this – Ask us..., welcome packs, first Annual Celebration Event – put photos in...;
- Staff wellbeing initiatives, Ask Martha, lunches, pantry, newsletter....

Priority 3

We said we would:

- Do what we can do to help with the emissions of greenhouse gases;
- PPG are already working with partners to see what we can do. One of these partners are Trees for Travel whereby we offset travel and mileage into a plantation of trees in Haiti. PPG have also agreed to backdate this from the last 3 years to realise the seriousness of this issue. Planting will start early this year;
- Over the course of the next year, we will move our electricity supply to renewable sources;
- We will be rolling out recycled A4 paper and envelopes across PPG over the coming year. Over time this will replace the current paper that we order from Banner. This single change will save 1,000s of Tonne's of CO2 and millions of litres of water that are used in the production of new A4 paper. We will make a virtue of this by including a message explaining our commitment to Net Zero at the bottom of our letter templates. The existing A4 paper will still be available from our stationery supplier, but recycled paper will become our default;
- Locally, we are aiming to change non-clinical processes to reduce our use of paper. We are managing to do this with the introduction of our new PAS which will allow us to import and share documents with the appropriate persons without the need to waste paper and time. This in turn will also adhere to GDPR as there is less risk that paper documents are found in the wrong place or not secure.

What we have achieved:

- We have not yet managed to move to using recycled paper within the hospital but this an aspiration for the coming year
- We have reviewed our website to ensure accurate patient and referrer information is available reducing the need for this to be posted/printed and handed to the patient
- Staff are actively encouraged to turn off electrical equipment
- We purchase items in bulk where possible to reduce the carbon emissions from deliveries
- Recycling is in place throughout the hospital

Local outcome

Shepton Mallet		#	%	Comments
NJR submission		1740/1740	100%	
PROMS submission	hips knees	923 749	98.36% 98.8%	
PROMS health gain	hips knees			91.4% - EQ-5D index England average of 90.1%, Oxford scores are 98.7% for SM against 96.9% for England **87.4% - EQ-5D index England average 82.2%. Oxford scores are 97.3% for SM against 94.9% for England**
VTE risk assessment		7049	97.12%	
VTE incidents		5	0.07%	
Complaints received		30	0.29%	
Complaints upheld/partially upheld		15	50%	
Incidents relating to patient harm		22	0.08%	
Serious patient safety incidents		0	0	

Southampton Hospital

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Improve information given to patients and their relatives/carers on discharge home from the Inpatient Ward regarding wound care and medication, with an emphasis on analgesics.

What we have achieved:

Discharge information on wounds and medication has been reviewed. The number of calls for wound and medication information to the 24 hour helpline have reduced.

Priority 2

We said we would:

Reduce length of stay for patients having hip and knee replacements. This will show that patients are making better and quicker recoveries from operations, as well as getting back home sooner.

What we have achieved:

The average length of stay for a hip replacement at PPG Hospital Southampton has reduced by 22% from 2021/22 to 2022/23. The average length of stay for a knee replacement has reduced by 24% in the same time period.

Local outcomes

Southampton		#	%	Comments
NJR submission		733	99.3%	
PROMS submission	hips knees	211 183	384% 258%	Last quarter available is Jul-Sep 22
PROMS health gain	hips knees	See below See below		See table below for average health gain
VTE risk assessment		12795/12878	99.3%	

Southampton	#	%	Comments
VTE incidents	1	0.01%	Investigation in progress
Complaints received	30	0.2%	13937 inpatients and day cases
Complaints upheld/partially up-held	25	83%	2 not upheld, 3 still ongoing
Incidents relating to patient harm	51	32%	(Total 159)
Serious patient safety incidents	1	0.6%	

Measure	Total Hip Replacement	Primary Unicondylar Knee Replacement	Primary Bicondylar Knee Replacement
Oxford Hip Score	22.5	22.6	16.2
EQ-5D Index	0.447	0.462	0.298
EQ VAS	13	20.6	5.2

Priorities for 2023/24

Priority 1

We said we would:

Improve the patient pathway through the pre-assessment process.

What we have achieved:

Reduced number of patient visits to PPGHS.

How will we monitor progress?

Fewer patient face to face pre-assessment visits.

Priority 2

What are we trying to improve?

Chronic pain management prior to surgery.

What will success look like?

Monthly chronic pain clinics introduced.

How will we monitor progress?

Opioid use reduced pre-surgery.

St. Mary's Surgical Centre

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Increase patient satisfaction response rate with an uptake of 10% on current figures.

What we have achieved:

We have introduced the use of QR codes and text messages to gain feedback. Our current score of patient who say they would recommend us is consistently between 99-100% each month.

Priority 2

We said we would:

Ensure staff are attending mandatory face to face training and completion of on-line training.

What we have achieved:

An action plan is being developed to improve face-to-face training. Access to new companies who can deliver our required face-to-face training has been implemented to ensure training is up to date. Training stats are circulated weekly, with monthly follow up at the managers meeting.

Priority 3

We said we would:

Increase the number of Patient Participation Group members from 4 to 8.

What we have achieved:

Although we have advertised in the local paper and put notices up around the centre, unfortunately we have had no response. The current small group still meet regularly, chaired by the Healthwatch Portsmouth Chairman. We will continue our attempts to recruit.

Priority 4

We said we would:

Deliver a Civility saves lives campaign to include:

- Listening surgeries in each department including speak up champions;
- Purple Hearts being put up in all departments allowing staff to recognise best practice behaviours for their work colleagues;
- Name badges for all staff as part of the uniform policy to improve communication.

What we have achieved:

The civility saves lives campaign was launched and all of the above actions were completed.

Local outcomes

St. Mary's	#	%	Comments
VTE risk assessment		100%	Completed for all relevant patients
VTE incidents	1	0.013%	
Complaints received	17	0.119%	
Complaints upheld/partially upheld	12	0.049%	
Incidents relating to patient harm	25	0.103%	
Serious patient safety incidents	0	0%	

Priorities for 2023/24

Priority 1

What are we trying to improve?

The rate of cancellations, particularly on the day cancellations. This will be done through a review of previous cancellations to understand causes, alongside a review of triage and pre-assessment clinic pathways.

What will success look like?

Reduction in the % of cancellations from 2022/23 in 2023/24.

How will we monitor progress?

Monthly cancellation reviews.

Priority 2

What are we trying to improve?

Staff retention within the surgical centre.

What will success look like?

A sustained, stable workforce in place.

How will we monitor progress?

Recruitment into advertised positions and minimal requirement to advertise further vacancies.

Priority 3

What are we trying to improve?

Accessibility for a wider range of patients to our services.

What will success look like?

Increase in number of patients on our waiting lists, enabling improved theatre utilisation.

How will we monitor progress?

Monthly reviews of availability on waiting lists.

Patient stories

"I attended the centre in August for my eye operation. I wish to thank you very much for giving me clearing vision and a stress free procedure. Your team were so kind and so professional, making the whole experience easy. Many thanks once again."

"I had an appointment today at the treatment centre at St Mary's (Portsmouth), I wanted to congratulate and commend all of the staff for their professionalism, care and helpfulness. From the moment I arrived the receptionist was incredibly helpful and all of the staff whom I met were consummate professionals in all that they did. I reserve the highest compliments for everyone I encountered and would certainly recommend this excellent service to anyone considering using it. Well done!"

Gillingham Surgical Centre

Performance against the priorities set for 2023/24

Priority 1

We said we would:

Reduce the number of surgical site infections.

What we have achieved:

There has been a sustained reduction of the reported number of infections. We have introduces the ANTT implementation cycle and audited practice, key team members for each department attended the ANTT Train the Trainers to assess the knowledge and practice of staff, monitored compliance and evaluated outcomes. We have introduced standardisation of aseptic techniques which successfully reduced variability in practice and further protected patients from avoidable infections.

Priority 2

We said we would:

Reduce the number of avoidable clinical cancellations of the day of surgery.

What we have achieved:

Although there has been an improvement in the number of voidable cancelation we have not manage a sustained compliance as expected and therefore this priority will roll over to 2023/2024.

Priority 3

We said we would:

Improve the WET AMD service to ensure patients are not waiting excessive times for their injections by training and introducing nurse injectors.

What we have achieved:

The Wet AMD service has been revamped and much improved with several change. Three non-medical injectors have completed their training and competencies and is now providing this service with excellent outcomes.

Local outcomes

Gillingham	#	%	Comments
VTE risk assessment			
VTE incidents	0	0%	
Complaints received	13	0.23%	Based on 5663 day cases
Complaints upheld/partially upheld	1 upheld 2 partial upheld 10 not upheld	7% 15% 78%	
Incidents relating to patient harm	48	44%	Total of 108 incidents relating to patients. 4-Low minimal Harm 3-Moderate short term harm 41-No harm
Serious patient safety incidents	1	0.9%	

Priorities for 2022/23

Priority 1

What are we trying to improve?

Reduce the number of clinical cancellations on the day of surgery.

What will success look like?

- Review and improved all process from outpatients to procedure;
- Review all information leaflet and...;
- Education and training programme for team members as required.

Priority 2

What are we trying to improve?

Improve our Datix Incident reporting investigation timeframes.

What will success look like?

All Datixes to the access, review and closed within the required timeframe.

How will we monitor progress?

Monthly monitoring and feedback.

Priority 3

What are we trying to improve?

Theatre start times.

What will success look like?

A theatre start time compliance of 90%.

How will we monitor progress?

- Daily monitoring of compliance;
- Monthly meetings with Theatre manager and Medical Director;
- Regular update meetings with non-compliant team members;
- Update feedback to with wider team at bi-monthly Governance meetings.

Diagnostics and Urgent Hospitals

Performance against the priorities set for 2022/23

Priority 1

We said we would:

Improve staff retention and recruitment.

What we have achieved:

Staff recruitment has improved, but retention/turnover the turnover requires improvement.

Priority 2

We said we would:

Put in place a full UTC governance structure.

What we have achieved:

Due to a turbulent period with exceptional volumes attending the UTC along with reliance on bank and agency staffing, the full governance agenda has not be rolled out in this period. However, we have recruited a lead GP who will oversees the governance agenda.

Priority 3

We said we would:

Review and improve work rotas to ensure they are meeting the patient's needs.

What we have achieved:

Full care model and rota review has taken place and been implemented to ensure the appropriate skill mix is recruited to, ensuring patients are seen and treated by the most appropriately skilled staff in line with their presenting complaint.

Local outcomes

St. Mary's UTC	#	%	Comments
Complaints	24	0.03%	17 complaints upheld or partially upheld
Incidents relating to patient harm	25	0.03%	
Serious patient safety incidents	3	0.004%	
Southampton UTC			Comments
Complaints	12	0.019%	10 complaints upheld or partially upheld
Incidents relating to patient harm	3	0.004%	
Serious patient safety incidents	0	0%	
St. Mary's & Havant Diagnostics			Comments
Complaints	7	0.02%	5 complaints upheld or partially upheld
Incidents relating to patient harm	0	0%	
Serious patient safety incidents	0	0%	

Priorities for 2023/24

Priority 1

What are we trying to improve?

Full incorporation into wider site governance structure for UTC and diagnostics staff.

What will success look like?

Planned governance time to include education and regular scenario training to ensure skills remain updated.

How will we monitor progress?

Minutes of meetings site action plan

Priority 2

What are we trying to improve?

Training and development opportunities in place for all staff appropriate to role, and role development to build a highly motivated, multi skilled and committed work force.

What will success look like?

Training and development plans and signed off competencies in place for all staff. A reduction in complaints and incidents, improved staff turnover?

How will we monitor progress?

Weekly reviews of training taking place via circulated training stats. Monthly follow up at managers meeting.

Patient stories

Diagnostics

"I have used this facility over many years and without exception every time I have been there the staff are exceptional.

Today I had an Echo Cardiogram with the technician who was wonderful. All the staff in the imaging department are always so helpful and so very kind.

Please let them all know they are doing such an amazing job. And all the other departments too. I was recently upstairs in another department which was also exceptional.

Once again a huge thank you."

Patient stories

Portsmouth UTC

"I attended St Mary's Treatment Centre on Sunday with my 7 year old daughter as she had broken her ankle and just wanted to feedback on our experience, the centre was exceptionally busy but every member of staff we encountered was amazing: positive, calm and just absolute stars! The situation could have easily felt really out of control with how busy it was but we were given regular updates to waiting times and to thank us for our patience. We were seen by a lovely woman on triage (sorry- horrific with names), the most smiley technician at x-ray and a doctor who took time to explain what was happening to my daughter. I just wanted to say thank you for everything you do. You truly went above and beyond what you had to do for us and were still compassionate, despite the fact you should have already been home an hour earlier. I am truly grateful."

"I was seen by nurse who went above and beyond with her knowledge and expertise of my condition, they talked me through what would happen and even though it was way passed 8pm they kept going with the phone calls until they had gotten me an appointment at QA hospitals DVT unit. I am so very grateful to them and all the hard working people at UTC you are AMAZING!!"

Appendix 1
Local clinical audit schedule

Audit	Purpose
Emergency Response Audit	All services must hold a 'planned' emergency scenario every three months. It is also good practice to incorporate an 'un-planned' scenario on an annual basis (MHRA (2007) and ABPI (2007). All emergency scenarios should be seen as learning exercises and all of the outcomes shared with the entire team.
Documentation	Supports best practice in clinical documentation and guidance from professional bodies. All clinical areas to be audited and templates align.
Universal Urgent and Emergency Care Clinical Audit Tool	To be completed by the UTCs. This audit is based on the clinical audit tool developed by the Royal College of General Practitioners. It is designed to be applied to a minimum of 1% of cases per department every six months, more depending on results.
Safeguarding Assurance Frame-work Audit	To ensure that safeguarding concerns are referred and logged, providing assurance that safeguarding responsibilities are discharged.
Accessible Information Standard	The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with infor-mation that they can easily read or understand so they can communicate effectively with health and social care services.
Endoscopy Decontamination QMS	To determine whether endoscopy decontamination is undertaken in accordance with policy.
CSSD QMS	To assess compliance with standards for decontamination of reusable sterile equipment.
Controlled Drugs	Compliance with the documentation element of Controlled Drugs.
Non-medical prescribing Path-ways	To ensure compliance with PGDs and non-medical prescribers.
VTE pathway audit	This audit focuses clearly on auditing the key elements of VTE assessment and evaluating the compliance of our services against PPG's VTE Risk Assessment.
Safe and secure handling of medicines in clinical areas	To be carried out alongside the controlled drugs audit.
Inpatient medication chart doc-umentation	To ensure compliance with NICE guidance, focusing on reconciliation of medicines.
Antibiotic Stewardship audit	To reduce the risk of inappropriate antibiotic usage in line with Practice Plus Group policy and national Antibiotic Stewardship guidelines.
Pharmacy interventions	To monitor usage of medications and compliance with required documentation.
Pre-labelled TTO medication audit	To ensure medication management processes and arrangements are robust and that documentation and audit trails are comprehensive.
Diagnostics X-Ray Interpretation	Data collection to determine the percentage of correctly-interpreted images to identify trends.
Diagnostics Reject Analysis Audit	A more in-depth review of the reasons for rejection in order to highlight trends.
Diagnostics Clinical Practice Review and Documentation	Assessment of compliance with the diagnostics standards for documentation.
MRI Safety Questionnaire Audit	To provide assurance of MRI safety.
Diagnostics DRL Audit	To ensure that local dose levels of radiation for common imaging examinations are in line with National Regulatory Dose reference levels.
Diagnostics peer review	A monthly audit of each sonographer's randomly-selected images and reports to review for clinical discrepancies within the report.
Diagnostics clinical evaluation on auto-reported x-rays	A clinical evaluation of the outcome of medical exposures where there is no formal radiological report.
Health & Safety and Environment Departmental Audit Tool	Routine H&S inspections of departments and offices by individual department H&S Representatives.
Annual Fire Check	Fire safety assurance.
IPC assurance tool	Assessment of compliance with the IPC Strategy.
Hand Hygiene Technique	Hand hygiene is performed by staff at every appropriate opportunity according to the Five Moments of Hand Hygiene.
Cleaning and Decontamination of Reusable Equipment	To ensure that re-usable equipment is managed in accordance with best practice to reduce the risk of infection.
ANTT	The risk of infection is minimised through implementation of evidence-based practice.
UTC mattress / trolley audit	To ensure that the mattresses are fit for purpose.
Ward environmental audit tool	To assess the cleanliness of areas, both clinical and non-clinical.
Theatre, minor ops, endoscopy environmental audit	To assess the cleanliness of areas, both clinical and non-clinical.
OPD, UTC, Diagnostics & Physio environmental audit	To assess the cleanliness of areas, both clinical and non-clinical.
IPC audit for mobile ophthalmology units	To assess the cleanliness of areas, both clinical and non-clinical.
Environmental Cleanliness Audit Tool for Mobile Ophthalmology Units	To assess the cleanliness of areas, both clinical and non-clinical.
One together Assessment	Audit of the interventions aimed at reducing surgical site infection.

Annex 1
Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) welcome the opportunity to review and comment on PPG's Quality Account for 2022/2023. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring and quality visits and is presented in the format required by NHSE/I presentation guidance.

The ICB recognises that 2022/2023 has continued to be a difficult year due to the workforce pressures and the continued recovery of services following the COVID-19 Pandemic. The ICB would like to thank PPG for their continued contribution to supporting the wider health and social care system during the COVID-19 recovery phase.

It is the view of the ICB that the Quality Account reflects PPG's on-going commitment to quality improvement and addressing key quality improvements in a focused and innovative way. Although achievement of some priorities during 2022/23 have continued to be affected by COVID-19, PPG has still been able to make achievements against all their priorities for 2022/23 including (for Emerson's Green Hospital and Devizes Surgical Centre):

1. Implementing screening of calls received on weekends with clinicians calling patients back within an hour.
2. Holding Autism awareness sessions and having specific staff training for subjects including Autism. Reception have an on-going "Get to know you" project which helps patients to familiarise themselves with the staff and environment before any procedures.
3. Improvements have been made to cleaning audit scores and PPG have increased their capital spend on fabric and equipment to make cleaning processes easier to complete.

Progress has also been achieved against PPG's nationally identified priorities, including:

1. Initiating the process for embedding the quality standard for imaging including involving and engaging with staff, creating a business plan, completing an imaging service gap analysis to identify areas where change or improvement was required.
2. Patient groups and forums beginning to be reinstated resulting in a renewed approach to capturing and identifying actions from patient feedback. Recruitment of Patient Safety Partners is on-going and has had some success.
3. Work to develop a standardised process for requesting externally provided diagnostic tests has begun, however has been impacted by decisions to replace their Health Information System and procure new systems for the organisation. The implementation of new systems will support achievement of this objective.
4. Development of a Quality Academy has begun and all sites have local quality improvement (QI) programmes in place. The move towards using a more structured approach to QI is continuing with the Quality Academy development being an identified objective for 2023/24 as well. Further to this a training plan has been established and will be made available to all staff.
5. A number of wellbeing initiatives have been introduced across PPG sites, including having healthy fruit days, access to a pantry for food staples, free meal vouchers and updates to two policies that provide greater availability of paid leave to allow staff to respond to the needs of themselves or their families at short notice.

The ICB supports PPG's identified Quality Priorities for 2023/2024. It is recognised that several of the priorities described in this Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance with a crucial focus on reducing inequalities. The ICB welcomes continued engagement in the agreed service improvement plan and local focus on:

1. Improvements to patient optimisation including reviewing practice to consider booking treatment on the day of consultation and also to increase discharges on day 0. Implementation of a pre-operation call using an MDT approach 2 weeks ahead and also to learn from any incidents.

2. Improve the patient journey, with a particular focus on reducing inequalities including patients being able to access information leaflets in different languages by using their phone; consideration of sharing “what to expect” videos; and ensuring translation services are available 24/7 to support patients and their families.
3. Continued focus on providing a clean and safe environment for patients with regular meetings focused on cleaning standards and charters; head of housekeeping meetings to be embedded with Heads of Departments to complete audits; driving improvements in the accuracy of audits; and rolling out training for a new range of cleaning products that is being trialled.

BSW ICB also recognises PPG’s national priorities, which include:

1. On-going work to allow for completion of the UKAS Quality Standard for Imaging Accreditation including completing and implementing the Practice Plus Group’s quality standards manual.
2. On-going work to embed the Health Information System across secondary care services with the aim to enhance functionality and mitigate patient safety risks. There will be an initial focus on diagnostic testing.
3. Implementation of a pre-operative surgical site infection risk assessment to ensure that each patient has the correct pathway, management and monitoring in order to identify and mitigate against risk factors and prevent surgical site infections.

We look forward to seeing progress with quality priorities identified in this Quality Account in conjunction with the continued transition to PSIRF and the formulation of the organisations Patient Safety Incident Response Plans (PSIRPs). We would encourage alignment to focus improvement in key areas.

NHS Bath and North East Somerset, Swindon and Wiltshire ICB are committed to sustaining strong working relationships with PPG, and together with wider stakeholders, will continue to work collaboratively to achieve our shared priorities as the Integrated Care System further develops in 2023/24.

Yours sincerely

Gill May
Chief Nurse Officer
BSW ICB

NHS Derby and Derbyshire Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board (DDICB) are pleased to comment on Practice Plus Group’s (PPG) Quality Account for 2022/23.

Firstly the DDICB would like to thank the Practice Plus Group for their continued efforts to support patients and partners in the local and surrounding areas.

Whilst we note that not all of the priorities for 22/23 were achieved, there has been good progress against the targets PPG set themselves and those that have been carried forward should continue to build on the work already completed. Further work to fully implement the Patient Safety Incident Response Framework (PSIRF) will undoubtedly complement the Quality Academy Approach and local quality initiatives.

For DDICB specifically, it was encouraging to read the views of the team at Barlborough regarding the good relationship with DDICB and it is hoped this will continue. The excellent patient comments, good external relationships, and positive quality indicators are certainly reflective of what is consistently observed during quality visits.

The DDICB look forward to supporting Barlborough on their continuing improvement journey.

Brigid Stacey
Chief Nursing Officer
On Behalf of DDICB

NHS Devon Integrated Care Board

NHS Devon Integrated Care Board (ICB) would like to thank Practice plus Group (PPG) for the opportunity to comment on the quality account for 2022/23. Practice Plus Group is commissioned by NHS Devon ICB to provide specific secondary care services in Plymouth.

Services described in the quality account highlight the breath of care and attention taken to provide support in planned and emergency situations. The ICB seeks assurance that care provided is safe and of high quality, that care is effective and that the experience of that care is a positive one.

As Commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the Commissioner over the 2022/23 period.

Priorities for 2023/24

The ICB welcomes the 2023/24 priorities outlined by PPG and will look forward to seeing the projected achievements as they aspire for continuous quality improvement, as commissioners we continue to support their priorities.

Each of priorities aim to evidence and improve quality and safety building on the lessons learned from 2022/23. The ICB notes the progress made under each of the priority areas:

Priority 1:

Quality Standard for Imaging Accreditation (continued from 2022/23).

Priority 2:

Enhance the functionality of the Health Information System (HIS) to mitigate risks to patient safety.

Priority 3:

Build on the Quality Academy methodology to provide a structured approach that is integrated with PSIRP.

Priority 4:

Implement a pre-operative surgical site infection risk assessment

Regulatory Oversight

The CQC conducted a short notice announced inspection during 9th and 10th November 2022, and held a follow up phone call on 22nd November 2022. In January 2023 a follow up visit was undertaken and a rating of 'good' was given for all five domains.

(Information taken from CQC official website)

Local Services

At the Plymouth Hospital site updates against the priority 2022/23 areas included:

- Continued effort to improve length of stay days from 1 to 0, despite efforts with Enhanced Recovery After Surgery improvement plans challenges

remain to achieve.
- Improved staffing has enabled increased patient lists.
- Established monthly patient feedback reporting at department level to further influence service improvement.

Further developments are expected in:
- Implementation of updated hip and knee pathways to reduce length of stay
- Improve patient access for treatment
- Improve patient engagement with feedback mechanisms

The inclusion of clinical audit and information of incident themes and trends illustrates a positive culture to learning in line with Patient Safety Strategy and feeds into the work and development of PSRIF.

The ICB notes the challenges PPG Plymouth have faced over the last year, and actions they have taken to continue to keep patients safe and have a positive experience.

The ICB notes the extensive detail provided in the entire report and looks forward to receiving updates on progress in these areas through the established regular reporting.

the lessons learned from 2022/23. The ICB notes the progress made under each of the priority areas:

NHS Hampshire and Isle of Wight Integrated Care Board

Hampshire and the Isle of Wight Integrated Care Board are pleased to be able to comment on Practice Plus Group's Quality Account for 2022/23.

Thank you for enabling us to work alongside your organisation to monitor the quality of care provided to our local population, to support the identification of opportunities for quality improvement and to share learning.

We are satisfied with the overall content of the Quality Account and believe that it meets the required mandated elements.

2022/23 Quality Priorities for Improvement

We supported Practice Plus Groups 2022/23 quality improvement priorities for Southampton, of which there were two for the Hospital: improving information provided to patients, relative and carers and reducing length of stay for patients having hip and knee replacements. We also supported Practice Plus Groups 2022/23 quality improvement priorities for St Mary's Surgical Centre, of which there were three: increasing patient satisfaction response rate, ensuring staff attend mandatory face to face training and completion of online training, and attempts at increasing the number of Patient Participation Group members. Also, three priorities that were applicable to the local Urgent Treatment Centres, relating to staff retention, governance structures and review and improvement of rotas to ensure they meet patient needs.

We recognise that having achieved the majority of their key priorities, Practice Plus Group has made some considerable improvements, which will have a positive impact on patient experience, safety and outcomes, for example:
- Reducing length of stay for hip and knee surgery by 22% and 24% respectively.
- Reducing wound and medication related calls to the 24-hour helpline through improvements in information provision.
- Improvements in staff recruitment
- Full care model review and implementation; ensuring appropriate skill mix of staff
- Introduction of QR codes and text messages to gain feedback.

It has been acknowledged in the Quality Account that further work is required relating to the roll out of the governance agenda at the UTCs, but we are pleased to see the recruitment of a GP Lead who will oversee this going forward. Also, that there will be a continued focus on staff retention during 2023/24.

It is recommended that the provider measures the impact that the 2022/23 priorities have had on patient outcomes during 2023/24.

It was really positive to read the patient stories included throughout the Quality Account.

We would encourage the exploration of more digital and other options for capturing patient feedback, wider than just for the Friends and Family test.

Care Quality Commission/Improvement Plans

We note that Practice Plus Group have not been required to participate in any special reviews or investigations during the reporting period and commend that all of their Hospitals and Surgical Centres are rated overall as good, including the Hospital and Urgent Treatment Centre in Southampton, and St Mary's Surgical Centre and Urgent Treatment Centre in Portsmouth, or outstanding.

National confidential enquiries, audits and local audit

We are pleased that Practice Plus Group participated in all those that they were eligible to participate in, except for two, where there were not enough qualifying incidents to enable participation.

It is noted that, where relevant, actions identified to improve practice and/or patient outcomes have been undertaken, for example, a review of the Practice Plus Group Secondary Care prophylactic antibiotic policy to ensure best practice across all sites.

Collaborative working:

We would like to thank Practice Plus Group for inviting us to participate in internal quality meetings to support our assurances processes.

2023/24 Quality priorities for improvement

We fully support Practice Plus Groups quality priorities for 2023/24. In Southampton, the intention to improve the patient pathway through the pre-assessment process and chronic pain management prior to surgery, as these have been identified as important areas for local quality improvement.

During 2023/24, we look forward to the teams at our local Urgent Treatment Centres, Hospital and Surgical Centre sharing the improvements in relation to the delivery of time critical medications, as one of our agreed areas of System focus.

Finally, we would like to thank the Practice Plus Group for its continued support and commitment to the delivery of safe, effective and patient-centred care during what has been a challenging year.

Overall, we are pleased to endorse the Quality Account for 2022/23 and look forward to continuing to work closely with Practice Plus Group during 2023/24 in further improving the quality of care delivered to our population.

Yours sincerely

Nicky Lucey
Chief Nursing Officer

James House
Southampton Place Director

Jo York
Portsmouth Place Director