Practice Plus Group

Quality Account

2023-2024

Contents

Practice Plus Group Secondary Care
2023-2024 highlights

Top Secondary Care, Over To You, staff survey scores from 2023

96%

believe we embrace diversity.

95%

would recommend Practice Plus Group services to someone needing care.

95%

believe that at Practice Plus Group we act with integrity.

Organisational goals

Launched an entirely new brand for self-pay, Wellsoon from Practice Plus Group. Achieved 21% increase in private patient bookings during trial period.

Crowned Hospital Group of the Year award at the prestigious LaingBuisson Awards.

Expanded our speciality mix with bariatrics in Barlborough.

Agreed a contract with BUPA for the provision of healthcare services to their insured members.

Progressed plans to expand our geography into Birmingham.

Clinical

Made a significant investment in a new Patient Administration System across most locations.

Invested in new sterilisation facilities in Southampton and Shepton Mallet.

Launched a new mobile eye unit in Winchester and new locations for existing mobiles.

Secured a cataract contract with Derby and Derbyshire ICB.

Scored top of all independent providers across four areas in the Patient-led Assessment of Clinical Environments (PLACE) assessments.

Portsmouth became dementia friendly, and Plymouth veteran aware.

Implemented innovation and service development in physiotherapy and podiatry to support our HIJ secure estate.

Supported the NHS elective recovery program for Cornwall.

HR and Learning and Development

Invested in a record number of apprenticeships, with 53 live now and 75 by the end of this year.

Made further maternity, paternity and adoption pay improvements, new paid time off, enhanced sick leave and occupational sick pay, and matched NHS minimum salary.

From a record high staff vacancy level of 12.4% (around 220 vacancies) at the start of the year, we reduced to a record low of 3.8% (70 vacancies).

Turnover has reduced from a rate of 21.5% to 14.7% over the same period – showing greater stability in our workforce.

Equality Diversity and Inclusion

Signed Wellbeing of Women's Menopause Pledge.

Rolled out Reverse Mentoring programme.

Appointed Head of ED&I.

Communication

Introduced a new MyPracticePlus intranet to celebrate everyone's achievements, encourage senior team visibility, enable colleague recognition and to encourage everyone to engage in the organisation's goals.

Introduction

Organisations providing services under an NHS standard contract, have staff numbers over 50 and NHS income greater than £130k per annum are required to produce annual Quality Accounts to improve public accountability for the quality of care they deliver under the Health Act 2009 and subsequent Health and Social Care Act 2012.

Practice Plus Group Secondary Care welcomes the opportunity to detail, for all our stakeholders, the quality of the services we provide.

Part 1 is a statement on quality from our Chief Executive, Jim Easton.

In **Part 2** we have included details of the four priorities for improvement that we intend to deliver during 2024/25.

There are also a number of mandated statements of assurance from the board regarding specific aspects of service provision in section 2.2.

Part 3 describes how we performed against the quality priorities we set for ourselves during 2023/24, 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's key stakeholders and how we have addressed the feedback.

Part 1
Statement on quality from the Chief Executive

This year has been one of transformation for Practice Plus Group hospitals and surgical centres, with the launch of our new private healthcare brand, Wellsoon, attracting increasing numbers of people facing long NHS waiting lists for the life-changing surgery they need.

We have however remained and will remain predominantly an NHS provider, with the majority of our treatment and care provided to NHS patients. Through the growing success of Wellsoon, we have been able to continue to invest in our people and our services for the benefit of all our patients, and to position ourselves as a reliable, long-term partner to the NHS.

We were successful in our bid to take over the operation of what was the BMI Hospital, Edgbaston, representing our first new Practice Plus Group hospital for over 10 years and an expansion into a new, large population that has been particularly affected by long NHS waiting lists. I look forward to seeing as many NHS patients as we can and helping to reduce waiting lists, as well as offering Wellsoon in a new region.

This Quality Account sets out our performance on a range of key measures. It demonstrates what we have achieved and what we plan to do next in our secondary care services, which currently cover:

- Five hospitals.
- Three surgical centres.
- Two urgent treatment centres and walk-in centres.
- Our Ophthalmology Service and its 11 mobile units.
- Two county-wide, multi-location musculoskeletal services.

In the year from April 2023 to March 2024 we carried out:

- 68,993 day case procedures.
- 11,531 inpatient procedures.
- 284,330 outpatient consultations, including telephone consultations.

We are incredibly proud of our markers of quality this year: we were crowned Hospital Group of the Year in the LaingBuisson awards for an entry that centres on our well-established ‘same day joints’ service; in the national Friends and Family Test, 97% of our workforce said they would recommend us as a care provider to friends and family, well above the national average of 94%, and all of our hospitals and surgical centres remain rated ‘Good’ or ‘Outstanding’ by the Care Quality Commission (CQC).

All Practice Plus Group hospitals have been awarded NJR Quality Data Provider status, recognising excellence in supporting the promotion of patient safety standards through compliance with the mandatory National Joint Registry (NJR) data submission quality audit process.

As an organisation focussed on listening and learning, this year we have continued to put patient safety at the heart of everything we do.

We have now transitioned from the Serious Incident Framework (SIF) to the Patient Safety Incident Response Framework (PSIRF) to improve incident reporting and management and by extension the quality of the services we offer. With what we believe to be a record number of 57 volunteer champions, we launched our Freedom to Speak Up initiative to encourage a positive, open culture where people feel they can speak up and they will be heard.

We have made significant progress against the four priorities we set for this year, including employing a dedicated Quality Standard for Imaging (QSI) Lead, developing and embedding a Quality Manual for diagnostic imaging services, and rolling out a single Health Information System (HIS) across all sites. In addition, our quality improvement model has been adapted and integrated with PSIRF methodology, and a surgical site infection risk assessment tool is now being used in all localities where major orthopaedic procedures are undertaken.

I am as ever grateful to the skilled and dedicated people who deliver our high-quality services every day and ensure our patients get the treatment and care they need to get back to their best, and I remain committed to making Practice Plus Group an attractive place to work. This year, we have achieved greater stability in our workforce, reducing our vacancy level from 12.4% to a record low of just 3.8%, with retention also improving from 21.5% to 14.7% over the same period. We have made further improvements to maternity, paternity, and adoption pay arrangements and introduced a minimum Practice Plus Group annual salary level matching that of the NHS.

We have set four priorities for 2024-5:

Priority 1: Review and evaluate PSIRF implementation.

Priority 2: Achieve quality standards for imaging.

Priority 3: Enhance the perioperative pathway.

Priority 4: Evaluate annual site quality visits.

I am confident that we will continue to go from strength to strength and will deliver against these priorities, and that we will continue to aim for excellence for our patients, staff and the wider systems we operate in.

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 2024/25

Priority 1: Review and evaluate PSIRF implementation

Why have we chosen this priority?

Practice Plus Group transitioned to the Patient Safety Incident Response Framework (PSIRF) in April 2024 (see section 3.2 for further details). We want to ensure that the framework is embedded and we are maximising the learning opportunities that can be derived from patient safety incidents to inform improvements to patient safety.

How will we improve?

Stand-up Datix meetings will be introduced to review all incidents that have been reported/need to be reported, agree the appropriate learning response in accordance with the learning response algorithm, monitor progress with learning responses and share learning and improvements made. Standard terms of reference and an agenda will be agreed for these meetings.

Plans for local site actions to maintain effective compliance will be agreed in conjunction with the central governance team and the heads of nursing/heads of clinical services.

An escalation call, including site staff and the central governance team, will be convened to agree the appropriate response and actions to be taken whenever:

- There is uncertainty about the appropriate learning response.
- CQC reporting is indicated.
- There has been a cluster of similar incidents.
- A suspected Never Event has occurred.
- A patient has died within 30 days of treatment.
- A patient has suffered a Surgical Site Infection (other than those that are classified as superficial infections) or endophthalmitis (an infection in the eye following cataract surgery or injections).

Power BI dashboards are currently been designed to demonstrate learning responses undertaken, to inform improvement focus and internal and external reporting and to enable benchmarking between sites.

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

Within the next six months all sites will be holding effective stand-up Datix meetings that are consistent with the terms of reference and agenda. Power BI dashboards will be operational, accessible and used by all sites. Average compliance with incident management key performance indicators will increase as follows:

- Incidents are reported within 24 hours of identification – from 82% to 90%.
- Incidents are reviewed within three working days – from 90% to 100%.
- Incidents are investigated within the timescales set out in the PSIRP – from 70% to 90%.

All sites will demonstrate patient safety incident improvements made in response to learning from incidents on a monthly basis and there will be evidence of patient engagement in all incidents relating to our patient safety priorities.

How will we report and monitor our progress?

Sites will monitor whether the appropriate learning response, as defined in the Patient Safety Incident Response Plan, has been completed for incidents relating to our six patient safety priorities by means of a series of Datix and Power BI dashboards and address any issues identified (Datix is our incident management system). They will report their progress to the central governance team during the monthly quality review meetings.

Implementation of learning responses, the learning derived from incidents and the patient safety improvements subsequently made, will be reported to the quarterly Clinical Governance and Assurance Committee, and the Healthcare Clinical Quality and Compliance Committee, a sub-committee of the Board.

Priority 2: Achieve quality standards for imaging

Why have we chosen this priority?

- Recognised quality indicator for imaging services.
- Compliance with regulation and guidance.
- Networking opportunities and sharing good practice with other imaging services within Practice Plus Group and outside the group.
- Provides a detailed framework for delivering high quality and patient focused care.
- Supports building teamwork and collaboration across the whole business.
- High level of service user satisfaction and confidence.
- Improves and assures efficiency and validity of services.
- Independent recognition 'badge of quality'.
- Enables continuous quality improvement.
- Offers assurance of the service – both internally and externally CQC.
- Improved staff retention and recruitment.
- Potential market advantage when bidding for contracts and insurance work.

How will we improve?

All aspects of the imaging department are inspected to ensure compliance with the rigorous quality standard produced by the Royal College of Radiologists (RCR) and the College of Radiographers. A new quality management system is introduced to ensure all aspects of the department have evidence of continued improvement and are audited via Safety Culture or the yearly quality visits and in person and remote RCR inspectors.

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

Our target is endorsement with the RCR standard to guide continual improvement of a high-quality, safe service. Adoption of the developmental QSI standard that underpins the colleges' vision for all providers of imaging services be invested in a continuous quality improvement journey. QSI will allow our service to evaluate their performance and develop where needed to continually improve patient experience and outcomes.

Improvement will be measured via evidence held in the QMS and staff behaviours. These will be audited via the RCR inspectors, Safety Culture internal audits and the yearly quality visits.

How will we report and monitor our progress?

The QSI lead endeavours to work with all imaging managers and leads to develop the QMS for each site though a staged approach. Collaboration is encouraged to set a staged review process with regular QSI lead support sessions. This approach has been successful at the trial site.

At present the standard imaging QMS document is ready for site allocation and to be made to fit each site unique workflows. This has been trailed successfully at Emerson's Green hospital and reviewed by the managers at Barlborough and Plymouth. Fiona Nelson, Imaging Lead, has set an accreditation target date of the end of 2024 depending upon the RCR inspectors' availability.

Priority 3: Enhance the perioperative pathway

Why have we chosen this priority?

Practice Plus Group have decided to focus on this priority during the next year as we feel that there is opportunity to review our current perioperative pathways using the GIRFT model as our analysis template. Our aim is to ensure that we are as inclusive as possible with our patients. This involves the progression of supportive pre-operative pathway enhancements so we are able to ensure that patients are seen quicker in their preparation for elective surgery.

How will we improve?

We have 10 work streams set up with multidisciplinary teams reviewing perioperative assessment topics which focus on delivering a perioperative pathway fit for the future.

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

The GIRFT pathway, along with several other resources, will provide our measurements against the pathway development. We will continually monitor the newly developed pathways to ensure that they are safe, effective and efficient for all patients across all payor routes.

How will we report and monitor our progress?

The individual work streams will come together each quarter to ensure that we are progressing and aligned to the overall aims and objectives. We will complete a readiness tracker to ensure we have safe delivery in our new pathway. We will ensure that audit of the perioperative process is effective to provide the assurance.

Priority 4: Evaluate annual site quality visits

Why have we chosen this priority?

To evaluate sites effectively at the annual quality reviews, self-assessment tools have been developed centrally for heads of departments to complete prior to the visit. The self-assessment audits are a standard question set for each area and offer assurance that sites are safe, effective and up to date.

How will we improve?

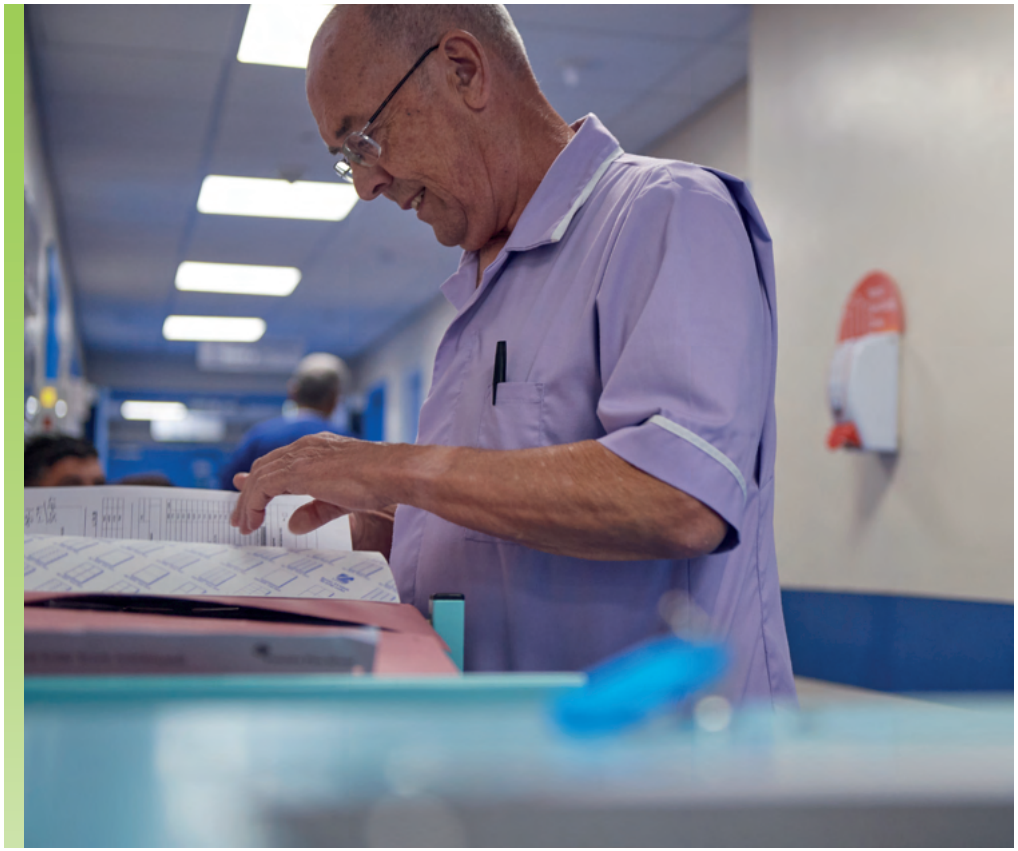
We are developing the next stage of our self-assessment tools. These will include point of care testing (POCT), pathology, endoscopy, resuscitation and blood transfusion.

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

Improvement will be measured by the outcomes of the self-assessments, annual quality visit reports and any regulatory inspections. Our targets are that all sites and departments are compliant with all of the required standards set out in the self-assessment tool.

How will we report and monitor our progress?

Sites will keep their self-assessments up to date and progress by sites will be monitored on Safety Culture, the Practice Plus Group audit platform by the central team. This will be reported on monthly in the quality reviews. The content of the self-assessment tools will be regularly reviewed by the central team and updated as required to keep them current and evidence based.



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 2023/24 Practice Plus Group Secondary Care provided and/or subcontracted relevant health services in 10 main specialties.

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 2023/24 represents 100% of the total income generated from the provision of relevant health services by Practice Plus Group for 2023/24.

2.2.2 Clinical audit

During 2023/24 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 2023/24 are identified in table 1.

The national clinical audits that Practice Plus Group participated in, and for which data collection was completed during 2023/24 are listed in table 1 alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

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

National Clinical Audit	Eligible to participate	Participated	Comments
Adult Respiratory Support Audit	No	-	Practice Plus Group does not provide these services
BAUS Nephrostomy Audit	No	-	Practice Plus Group does not provide these services
Breast and Cosmetic Implant Registry	No	-	Practice Plus Group does not provide these services
British Hernia Society Registry	No	-	Currently exploring the possibility of participating in the future
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 (CRANE)	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 a. Care of Older People; b. Mental Health (self-harm)	No	-	Practice Plus Group does not provide these services
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12)	No	-	Practice Plus Group does not provide these services
Falls and Fragility Fractures Audit programme (FFFAP)	No	-	Exploring the possibility of participating in the future - Currently NHS Trusts only
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR)	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
National Adult Diabetes Audit (NDA)	No	-	Practice Plus Group does not provide these services
National Asthma and COPD Audit Programme (NACAP)	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 in Primary Care (CVDPrevent)	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 (NAD)	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 but will explore participating in the future
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	No	-	Practice Plus Group does not provide these services
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	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
National Cardiac Audit Programme (NCAP)	No	-	Practice Plus Group does not provide these services
National Child Mortality Database	No	-	Practice Plus Group does not provide these services
National Clinical Audit of Psychosis (NCAP)	No	-	Practice Plus Group does not provide these services
National Comparative Audit of Blood Transfusion	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 Gastro-Intestinal Cancer Audit Programme (GICAP)	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 (NNAP)	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
National Obesity Audit (NOA)	No	-	Practice Plus Group does not provide these services
National Ophthalmology Database (NOD) Audit	Yes	✓	See table 2 for an overview
National Paediatric Diabetes Audit (NPDA)	No	-	Practice Plus Group does not provide these services
National Prostate Cancer Audit	No	-	Practice Plus Group does not provide these services
National Vascular Registry	No	-	Practice Plus Group does not provide these services
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	No	-	Practice Plus Group does not provide these services
Paediatric Intensive Care Audit Network (PICANet)	No	-	Practice Plus Group does not provide these services
Perinatal Mortality Review Tool	No	-	Practice Plus Group does not provide these services
Perioperative Quality Improvement Programme	No	-	Currently NHS providers only
Prescribing Observatory for Mental Health (POMHUK)	No	-	Practice Plus Group does not provide these services
Sentinel Stroke National Audit programme (SSNAP)	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 (SAMBA)	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 Renal Registry Chronic Kidney Disease Audit	No	-	Practice Plus Group does not provide these services
UK Renal Registry National Acute Kidney Injury Audit	No	-	Practice Plus Group does not provide these services

The reports of five national clinical audits were reviewed by the provider in 2023/24 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) Up to and including 31/03/2022	Published results show that all Practice Plus Group sites are within accepted limits for posterior capsular rupture and visual loss. Low post-operative complications reported and no outliers.

The reports of three local clinical audits were reviewed by the provider in 2023/24 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 and re-audit	The initial audit identified that the Practice Plus Group policy that relates to prophylactic antibiotic administration needed a review. It also showed that some sites were following Practice Plus Group guidance and others were following local Trust guidance. The re-audit is being completed as the relevant policy has been reviewed, ratified and had time to embed.
Consent audit	The consent audit was a one-off deep dive audit to assess that all sites are following the two-stage consent process appropriately. There were some areas identified for improvement so this audit has now been agreed as a quarterly audit to be added to the mandator audit schedule.
IPC audits	The consent audit was a one-off deep dive audit to assess that all sites are following the two-stage consent process appropriately. There were some areas identified for improvement so this audit has now been agreed as a quarterly audit to be added to the mandator audit schedule.

2.2.3 Research

The number of patients receiving relevant health services provided or subcontracted by Practice Plus Group in 2023/24 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 2023/24 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:

Site	CQC Status
Practice Plus Group Hospital, Plymouth	Good
Practice Plus Group Hospital, Shepton Mallet	Good
Practice Plus Group Hospital, Barlborough	Good
Practice Plus Group Hospital, Emerson's 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, St Mary's Portsmouth	Good
Practice Plus Group Surgical Centre, Devizes	Good
Practice Plus Group Surgical Centre, Gillingham	Good
Practice Plus Group Urgent Treatment Centre, Southampton	Good

Practice Plus Group has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Practice Plus Group Secondary Care services during 2023/24.

Practice Plus Group Secondary Care 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 2023/24 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;
  100% for outpatient care; and
  N/A for accident and emergency 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 2023/24 annual Data Security and Protection (DSP) toolkit submission achieved Standards Exceeded.

We also obtained our Cyber Essentials Plus Certification recertification in July 2023, demonstrating our high standards in Cyber Security posture.

We have completed the first Phase of the migration from ISO 27001:2013 to ISO 27001:2022 standards and we are scheduled to complete the full migration in October 2024.

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 have met 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 will be taking the following actions to improve data quality:

- Practice Plus Group has published an Artificial Intelligence Policy which outlines how requests to use AI within Practice Plus Group should be handled. It details
  how employees must ensure that their behaviour when using AI is not harmful to Practice Plus Group.
- Practice Plus Group commenced consultations with all Patient Administration Systems (PAS) vendors on implementing Electronic Records Retention and Archiving procedures on their systems to ensure compliance to the NHS Records Management Code of Practice.
- Practice Plus Group has fully implemented the Electronic Data Subject Access Requests system that enables patients and representatives to submit and receive their SAR request online, ensuring that all SARs are processed, managed in a timely manner with central management oversight.
- Practice Plus Group implemented the electronic Privacy and Compliance system to manage the compliance to GDPR and Information Security certifications, ensuring centralised accuracy of Records of Processing Activities (ROPA), Data Protection Impact Assessments (DPIAs), Information Sharing agreements repository, Vendor Management and Assessments as well as operational sites Information Governance self-assessments.

2.2.10 Learning from deaths

During 2023/24 eight of Practice Plus Group NHS patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Two in the first quarter;
Two in the second quarter;
Three in the third quarter;
One in the fourth quarter.

By April 2024, eight case record reviews and one investigation have been carried out in relation to eight of the deaths included above.

In one case 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:

Two in the first quarter;
Two in the second quarter;
Three in the third quarter;
One 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.

These numbers have been estimated using a review tool adapted from the Royal College of Physicians' National Mortality Case Record Review Programme and the regional work carried out by the Academic Health Science Networks (AHSN) in Yorkshire and Humber and in the West of England.

The investigation of one case, where a patient died from pulmonary embolism almost seven weeks after a total hip replacement, concluded there were no omissions of care. In addition to the individual case investigation, a thematic review of all instances of venous thromboembolism (VTE) during the reporting period was undertaken by our VTE Lead. This provided assurance that the thromboprophylaxis policy adopted across our services provides good protection against VTE.

There were no case record reviews and no investigations completed after April 2023 which related to deaths which took place before the start of the reporting period.

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.

2021/22 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 2021/22 data shown above, with no date at which publication will be resumed announced at this present time.

2.3.2 Emergency readmissions

	2021/22	2022/23	2023/24
Practice Plus Group (local data)	0.67%	0.80%	0.16%

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

National comparative data are not available.

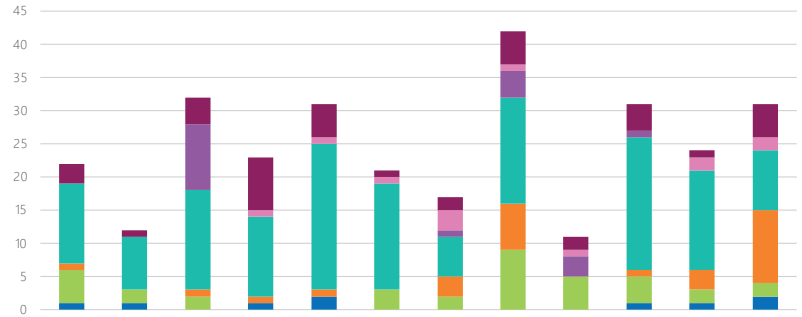
Practice Plus Group considers that this data is as described for the following reasons:

- The data are taken from the Quality Governance Indicator report, which informs the monthly Board report.

Practice Plus Group has taken the following actions to improve this percentage, and so the quality of its services, by including unplanned readmissions as one of our patient safety priorities for 2024/25. This will improve the investigation data available for all unplanned readmissions and thereby enable quality improvement work to focus on any themes and trends identified.

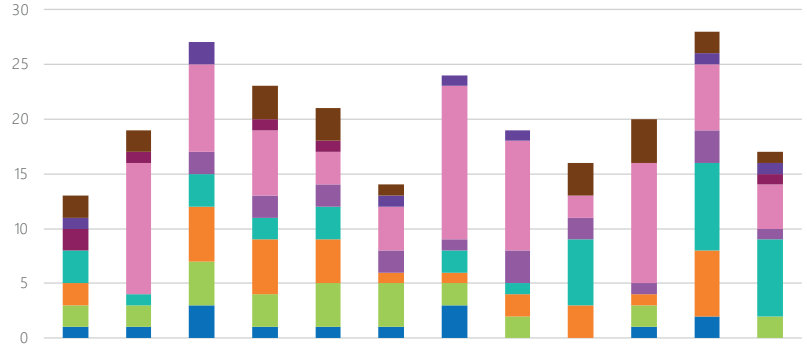
2.3.3 Responsiveness to the personal needs of patients

Number of compliments received by each site



	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Emerson's Green Hospital	1	1	0	1	2	0	0	0	0	1	1	2
Ilford Hospital	5	2	2	0	0	3	2	9	5	4	2	2
Plymouth Hospital	1	0	1	1	1	0	3	7	0	1	3	11
Shepton Mallet Hospital	12	8	15	12	22	16	6	16	0	20	15	9
Southampton Hospital	0	0	10	0	0	0	1	4	3	1	0	0
Devizes Surgical Centre	0	0	0	1	1	1	3	1	1	0	2	2
St Mary's Portsmouth Surgical Centre	3	1	4	8	5	1	2	5	2	4	1	5

Complaints received by each site



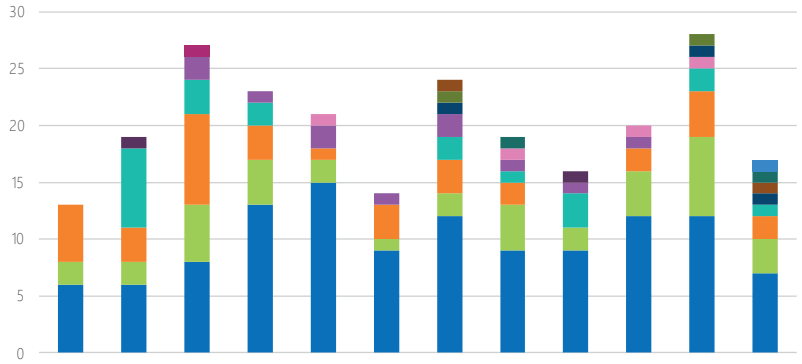
	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Barlborough Hospital	1	1	3	1	1	1	3	0	0	1	2	0
Emerson's Green Hospital	2	2	4	3	4	4	2	2	0	2	0	2
Ilford Hospital	2	0	5	5	4	1	1	2	3	1	6	0
Plymouth Hospital	3	1	3	2	3	0	2	1	6	0	8	7
Shepton Mallet Hospital	0	0	2	2	2	2	1	3	2	1	3	1
Southampton Hospital	0	12	8	6	3	4	14	10	2	11	6	4
Devizes Surgical Centre	2	1	0	1	1	0	0	0	0	0	0	1
Gillingham Surgical Centre	1	0	2	0	0	1	1	1	0	0	1	1
St Mary's Portsmouth Surgical Centre	2	2	0	3	3	1	0	0	3	4	2	1

A total of 241 complaints were received during the reporting period, 222 (92%) of which provided the complainant with a satisfactory resolution from the initial investigation and response at stage 1. 13 complaints (i.e., 5.4% of complaints received during the reporting period) 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. Six (2.5%) of the complaints received during the reporting period were escalated to the Parliamentary and Health Service Ombudsman as stage 3 complaints.

78% of complaints (188/241) were acknowledged within three working days, while 44% (90/203) of complainants received a response with the outcome of the investigation within 20 working days.

28% of complaints received during the reporting period were not upheld, 36% were partially upheld and 36% were upheld.

Subjects of complaints received



	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Clinical treatment	6	6	8	13	15	9	12	9	9	12	12	7
Communication (oral)	2	2	5	4	2	1	2	4	2	4	7	3
Staff attitude/behaviour	5	3	8	3	1	3	3	2	0	2	4	2
Date for appointment	0	7	3	2	0	0	2	1	3	0	2	1
Communication (written)	0	0	2	1	2	1	2	1	1	1	0	0
Failure to follow agreed procedures	0	0	0	0	1	0	0	1	0	1	1	0
Staff competence	0	0	0	0	0	0	1	0	0	0	1	1
Consent to treatment	0	0	0	0	0	0	1	0	0	0	1	0
Date of admission/ attendance	0	0	0	0	0	0	1	0	0	0	0	1
Patient privacy/dignity	0	0	0	0	0	0	0	1	0	0	0	1
Personal records	0	1	0	0	0	0	0	0	1	0	0	0
Outpatient and other clinics	0	0	1	0	0	0	0	0	0	0	0	0
Patient property/expenses	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 percentage of 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	2023/24
Practice Plus Group	49*	-	44*	95%

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

* Prior to the 2023/24 survey, the responses were calculated using the Net Promoter Score. All respondents were categorised as either detractors or promoters and the Net Promoter Score calculated by subtracting the percentage of detractors from the percentage of promoters. The 2023/24 data analysis was modified in line with that used by the NHS staff survey.

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 reasons:

- The *Over to You* staff survey is administered and analysed by an independent agency.

Each site develops an action plan in response to their individual *Over to You* survey findings and an overarching Secondary Care plan is also developed and implementation monitored.

2.3.5 Venous thromboembolism risk assessment

	2020/21	2021/22	2022/23	2023/24
Practice Plus Group (local data)	98.9%	99.1%	97.9%	93.8%

Data source: Harvest (Practice Plus Group data warehouse).

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 for this measure. National data collection restarted in April 2024.

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

- All sites record data for this measure for reporting in the monthly Board report.
- The introduction of electronic reporting resulted in an initial, temporary decrease in VTE risk assessment records due to the change in practice and accessibility. Measures have been taken to address this through a quality improvement project, which has led to further training and modifications to the electronic patient record. Compliance has improved since and will be monitored closely to ensure that this improvement is sustained.

2.3.6 C. difficile infection

	2020/21	2021/22	2022/23	2023/24
Practice Plus Group (local data)	0	0	0	0
Best performance nationally	0	0	0	0
National average	22.2	44.04	115.28	135
Worst performance nationally	140.5	138.4	416	545

Data source: https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure.

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

- They are taken from the national statistics available online and collected by the UK Health Security Agency health surveillance and reporting programmes.
- We are a group of short-stay elective surgery hospitals and surgical centres.
- Our cohort of patients are ASA 3 and below with minimal co-morbidities.

2.3.7 Patient safety incidents

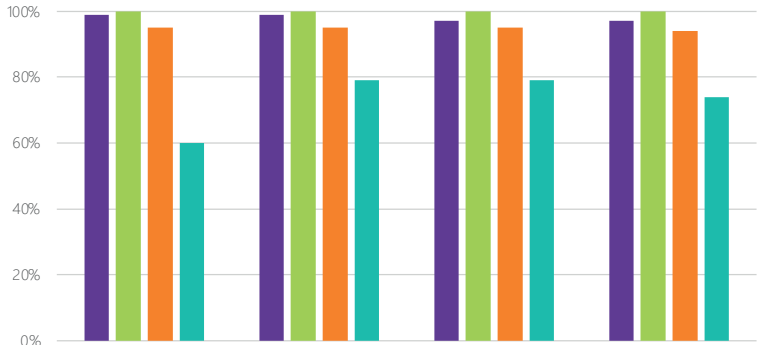
Patient safety incidents that...	2020/21		2021/22		2022/23		2023/24	
	#	%	#	%	#	%	#	%
...resulted in severe harm	0	-	8	0.41%	7	0.51%	6	0.31%
...resulted in death	0	-	2	0.10%	1	0.07%	0	-
...were classified as Never Events	0	-	1	0.05%	1	0.07%	1	0.05%
...were classified as serious incidents	5	0.59%	12	0.61%	9	0.66%	9	0.47%
Total number of incidents reported	854		1,970		1,370		1,923	

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 incidents that potentially require external reporting, Never Events, patient deaths within 30 days of treatment, surgical site infections (apart from superficial infections), clusters of incidents or any other cases requiring escalation to the central governance team, are discussed and a plan of action and appropriate learning response are agreed.

Practice Plus Group has now transitioned from the Serious Incident Framework (SIF) to the Patient Safety Incident Response Framework (PSIRF). It is anticipated that this will improve incident reporting and management and so the quality of the services. Section 3.2 covers this in more detail.

2.3.8 Friends and family test



	Jan 21	Jan 22	Jan 23	Jan 24
Practice Plus Group (local data)	99%	99%	97%	97%
Best performance nationally	100%	100%	100%	100%
National average	95%	95%	95%	94%
Worst performance nationally	60%	79%	79%	74%

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

FFT-AE-data--January-2024.xlsm (live.com)

National data submission and publication for the Friends and Family Test restarted for acute and community providers from December 2020, following the pause during the response to COVID-19.

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

- Data is based on inpatient data to be consistent with NHS publications.

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

- Monitoring the Friends and Family test data monthly at site level quality reviews. All sites' feedback is reviewed centrally for trends and themes and any sites that see a drop in response rates or a drop in related scores are supported, by the central team and *We Love Surveys* (the external company that administers and analyses the data), to develop an action plan to address the issues.

2.3.9 Freedom to speak up

Practice Plus Group are committed to ensure that Freedom to Speak Up (FTSU) is well embedded and remains actively promoted and discussed to support the culture in relation to the way we speak up, listen up and follow up. There is a good Freedom to Speak Up network across Practice Plus Group. We have three central FTSU guardians in place and a good number of FTSU champions in both central functions and local level sites, with a least one FTSU champion in each location. All members of the FTSU network align to the expected values for our organisation and for the National Guardians Office expectations.

Our Freedom to Speak Up policy has recently been updated. We have developed this policy using the guidance tool from the National Guardians Office and we have had the policy reviewed by a number of colleagues in different roles to ensure it reads well and creates the correct support to our colleagues who would go to this policy for guidance, either for raising a concern or responding as a champion or guardian to a concern. It is important to note that the policy includes the legal protection information in relation to the Public Interest Disclosure Act (1998), protecting those that 'make a disclosure in the public interest'. Local sites communicate the FTSU champions available in the building during their morning safety huddles. This helps to continually promote Freedom to Speak up on a daily basis.

The recording mechanisms that are in place are via a dedicated module in Datix that provides a robust, confidential way of recording and also aids Practice Plus Group to submit a report of themes raised to the National Guardians Office. Practice Plus Group offer supervision sessions for all Champions and this is held a minimum of quarterly and also on a one-to-one basis as required.

The priorities for the coming year are to ensure that we can create richer information for themes and trends and the continual awareness to encourage trust in the process and in turn hopefully reduce the anonymous version of concerns raised as teams start to trust in the process and support of Freedom to Speak Up.

Part 3
Other information

3.1 Performance against the priorities set for 2023/24

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:

- We have employed a dedicated QSI Lead to support services. We have taken the QSI standards on board as we have reviewed our audit schedules and meeting structures. We have developed a Quality Manual for diagnostic imaging services which we are embedding on a site-by-site basis.

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

We said we would:

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

What we have achieved:

- A single HIS has now been rolled out across all Secondary Care services so we are developing standardised content for all diagnostic imaging test including the details required on imaging referral forms. The HIS in use allows for live worklists to be developed to enable easier monitoring of the referral pathways in use, for example a worklist is available to show all requested studies with no report available on the HIS.

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

We said we would:

- 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.

What we have achieved:

- Our quality improvement model has been adapted, based on feedback and data, to fit with capacity at sites and to ensure the structured approach we are using is integrated with PSIRF methodology. A quality framework to embed this is in draft form.
- We have a well-attended Clinical Audit and Effectiveness Group that provides an excellent space for sharing quality improvement projects for implementation across sites.
- Quality improvement is on the agenda at all site quality reviews and achievements are celebrated.

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

We said we would:

- 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.

What we have achieved:

- We have piloted the surgical site infection risk assessment tool in two localities and have made some minor adjustments following feedback from staff. The tool is now being used in all localities throughout Practice Plus Group where major orthopaedic procedures are undertaken and is under constant review to ensure that it fulfils the requirements to ensure patient safety.

3.2 PSIRF implementation

The NHS Patient Safety Strategy was published in 2019 and described the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework.

The Serious Incident Framework (or "SIF") defined criteria for establishing which incidents resulting in severe harm or death should be classified as "serious incidents", and their subsequent reporting and investigation requirements.

PSIRF, by contrast, removes the "serious incident" classification and advocates a less prescriptive, proportionate approach to incident management. With the exception of a small number of nationally-determined requirements, the response to the majority of incidents is determined by individual organisations, informed by the patient safety priorities they have identified. The framework places greater emphasis on the learning to be derived from incidents that can change systems and cultures, rather than on producing a large number of detailed investigation reports.

Patient safety data from the last five years was analysed, in conjunction with the existing patient safety improvement programme, to identify six patient safety priorities for 2024/2025.

The six patient safety priorities identified for 2024/2025

Emergency transfer	Unplanned return to theatre	Readmission
Venous thromboembolism	Surgical site infection	Delays in the diagnostic treatment pathway

The Secondary Care Patient Safety Incident Response Plan formalises our response to these priorities and other patient safety incidents and, following consultation with stakeholders, approval by our lead ICB and ratification, has been published on our website. The accompanying, group-wide policy will be published alongside this once it has been approved by all of the lead ICBs.

A suite of templates, specific to each of the six priorities, was developed to guide and record the learning response. These have been piloted across secondary care since December 2023 and the final question sets were integrated within our electronic incident management system, Datix, to coincide with the formal PSIRF launch on 02 April 2024. This enables consistently thorough recording of learning responses, the generation of far richer incident analysis than previously and facilitates thematic reviews.

3.3 National Joint Registry (NJR) Quality Data Provider Awards

All Practice Plus Group hospitals were awarded NJR Quality Data Provider status for 2022/23, which included:

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

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.

To gain Quality Data Provider (QDP) status for 2022/23, hospitals were required to meet the targets for best practice; increase engagement and awareness of the importance of quality data collection and embed the ethos that thorough and accurate data ultimately enables the NJR to develop improved patient outcomes.

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.

Part 4
Local quality updates

Barlborough Hospital

Performance against the priorities set for 2023/24

Priority 1 - achieved

We said we would:

- Continue to grow our private healthcare and insured service.

What we have achieved:

- Private healthcare continues to grow at a steady pace. Private Self-pay Apr'22 to Mar'23 was £4.0M. Increased in Apr'23 to Mar'24 to £4.7M.

Priority 2 - achieved

We said we would:

- Ophthalmology service growth.

What we have achieved:

- Ophthalmology service is up and running and we now have a contract with the ICB for cataracts.
- Referrals are on the up and clinics are starting to fill up. We have one regular consultant on board and are looking to employ a second consultant. GA ophthalmology lists starting in April. First patients have already been pre-assessed and booked. We are supporting Chesterfield Royal Hospital by taking long waiting cataract patients from them.

Priority 3 – achieved

We said we would:

- Introduce PSIRF.

What we have achieved:

- Clinical governance manager and head of nursing have completed PSIRF engagement leads training. Medical director is booked to attend in March 2024. Key staff have completed investigation training and the learning response algorithm has been implemented across departments. To be monitored by SMT and clinical governance manager.

Local outcomes

Barlborough	#	%	Comments
NJR submission		100%	NJR submission and upload to the NJR database successful. Data Quality Gold award presented to the hospital for 2022/2023.
VTE risk assessment	4036/ 4036	100%	
VTE incidents	13/4036	0.32%	13 VTE incidents. Investigation completed for all incidents and no issues with care found.
Complaints received	14/3229	0.43%	
Complaints upheld/partially upheld	5/11	45%	2 upheld. 3 partially upheld. 6 not upheld. 3 still ongoing. 10 Complaints received during the reporting period have provided the complainant with a satisfactory resolution from the initial investigation and response at stage 1, 1 has been escalated to stage 2 with the stage 1 response upheld but this is now at stage 3 - Parliamentary and Health Service Ombudsman. 100% of complaints (14/14) were acknowledged within three working days, while 100% (14/14) of complainants received a response with the outcome of the investigation within 20 working days unless an extension was agreed with the complainant.
Incidents relating to patient harm	111/321	34.58%	92 Low harm. 17 Moderate Harm. 2 patient deaths (1 within 30 days).
Serious patient safety incidents	1/111	0.90%	Unexpected death of a patient – Coroner confirmed due to natural causes and not related to surgery.

Priorities for 2024/25

Priority 1

What are we trying to improve?

- Improve utilisation of theatre one (non-laminar flow) with the introduction of laparoscopic procedures and bariatrics, growing ophthalmology and identifying orthopaedic lists that could run in theatre one.

What will success look like?

- Laparoscopic procedures and bariatrics up and running.
- Increase in ophthalmology procedures.
- Increased number of orthopaedic lists in theatre one.
- Theatre one in use six days per week.

How will we monitor progress?

- Increased activity in theatre one.
- Increase in revenue.
- Quality outcomes and high patient satisfaction.

Priority 2

What are we trying to improve?

- Continue to grow private self-pay healthcare and insured service. Concierge service has now started and our private healthcare manager is working closely with our business development manager to look at further initiatives – signature moments.

What will success look like?

- Increase in private self-pay healthcare and insured referrals.
- Increase in revenue.
- Excellent patient satisfaction.

How will we monitor progress?

- Referrals.
- Patient feedback.
- Revenue.

Priority 3

What are we trying to improve?

- Continue to support the local trusts with orthopaedic and ophthalmology to build relationships and reduce wait times.

What will success look like?

- Increase in referrals from the local trust.
- Better working relationships with the local trust.
- Increase in revenue.
- Theatres and clinics full.
- SLA in place local trusts for ophthalmology and orthopaedics.

How will we monitor progress?

- Theatre utilisation.
- Referral numbers.
- Revenue.
- Feedback from ICB.
- Feedback from patients.

Patient stories

Feedback from patient one

We have used the services at Barlborough Hospital for many years, starting when outpatient consultations were conducted at Pilgrim Hospital which resulted in a knee replacement by Mr Mersich. In 2023 Mr Minhas replaced patient's left and right hips. Every aspect of the treatment and services can only be described as excellent. Every level of staff performed superbly. Medical, nursing, administration, X-ray, operating theatre, ward, catering, in fact all staff in every area of the hospital have been excellent. No reason to complain about anything or anybody. 100% rating all round. Thanks for everything.

Patient stories

Feedback from patient two

I would like to say thank you for all the care and attention given to me during my two hip replacements last year. My surgery in December went very well and I was soon out and about walking. I started a virtual challenge on 1st January and have already completed 170 miles of my journey from John O'Groats to Land End. From the nurses to the catering staff, office personnel and surgical team I saw nothing but kindness and caring. You have a wonderful group of people all working together as a happy team. Thanks again.

Other

- Several staff have now completed Freedom to Speak up training.
- Excellent links with local universities and colleges. We have several student nurses and physios some of which go on to work here when qualified.
- Students from ***Access to Nursing*** programme.
- Pharmacy manager has completed prescriber's course.
- Staff development – five health care assistants are currently on apprenticeship schemes to be healthcare professionals.

Emerson's Green Hospital and Devizes Surgical Centre

Performance against the priorities set for 2023/24

Priority 1 –partially achieved

We said we would:

- Patient optimisation aims to reduce perioperative morbidity and mortality, reduce length of stay, unplanned critical care admissions and hospital re-admissions. It aims to support efforts to increase the proportion of patients who are identified as suitable for day case surgery, avoiding an inpatient stay.

What we have achieved:

- Across our outpatient and booking teams we updated our inclusion and exclusion criterions and updated our nurse and anaesthetic pre-assessment processes with the latest standards from the Preoperative Association. This ensures people attending Emerson's Green and Devizes are in the best health to undergo surgery.
- In 2023 three patients died within 30 days of surgery compared to one in 2022. The first died of natural causes. The second, as a result of heart failure, a condition unrelated to their surgical procedure. And the third person died due to an unrelated event.
- Our overall length of stay fell from 1.13 days to 1.03 days with significant improvements achieved in orthopaedics with a reduction from 1.66 to 1.26 days.
- We transferred out eight patients to higher level care compared to five in 2022 although the total volume of people treated was much higher.

Priority 2 – partially achieved

We said we would:

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

What we have achieved:

- We have obtained mobile translators for both Emerson's Green and Devizes sites available to all patients whose first language is not English including British Sign language.
- QR codes are supplied to all appropriate patients to give feedback about their experience, with access to paper feedback forms if requested.
- Around both the hospital and surgical centre posters are displayed supporting breastfeeding awareness and what we can offer to support nursing mums, as well as a dedicated display linked to men's mental health and the support available to them.
- We had wanted to obtain more demographic information to be able to customise our focus of potential inequalities faced at our sites, however we have not been successful in this and will make it a quality project next year.

Priority 3 – achieved

We said we would:

- Our commitment to a clean and safe environment.

What we have achieved:

- We have implemented the National Cleaning Standards in both our sites with individualised cleaning standards in every clinical department.
- We have systematically reviewed our cleaning products to reduce variation and optimise cleaning.
- Diversey Cleaning have trained our on-site housekeeping and theatre teams on the process to follow to ensure the optimal effectiveness of the cleaning process.
- We have implemented a clinical IPC lead to review our practices and have a number of IPC champions across our departments.

Local outcomes

Emerson's Green & Devizes	#	%	Comments
NJR submission		100%	Award won.
VTE risk assessment	18777	93.34%	99% Devizes. 90% Emerson's Green.
VTE incidents	2	0.0099%	Based on 20116 patients.
Complaints received	68	0.34%	
Complaints upheld/partially upheld	53	78%	35 upheld. 18 partially upheld. 3 still under investigation.
Incidents relating to patient harm	74	44.6%	74 harm incidents against 166 patient related incidents in total.
Serious patient safety incidents	6	8.1%	6 out of the 74 incidents relating to patient harm.

We were honoured to receive an award for 100% data submission from the National Joint Registry. It recognised the precision and completeness of the information uploaded by ward nursing staff and ensured the NJR's results were a robust assessment of surgical effectiveness and of the quality of care received for patients undergoing orthopaedic procedures.

Priorities for 2024/25

Priority 1

What are we trying to improve?

- The overall safety of patients undergoing surgery by helping to achieve the triple goals of improved safer surgery, better team-working and enhanced efficiency.

What will success look like?

- We will implement the second and updated version of the National Safety Standards for Invasive Procedures, known as NatSSIPs2. We will have better compliance with the WHO safety checklist, fewer theatre-related patient safety incidents and improved theatre through put.

How will we monitor progress?

- We will review the effectiveness of the WHO safety audits, monitor patient safety incidents and the overall cases per session.

Priority 2

What are we trying to improve?

- Provide a safer patient environment. We will reduce the incidence of post-operative wound infections, improve the safety of take-away medication and reduce the incidence of urgent transfers to the local acute hospital.

What will success look like?

- There will be fewer superficial wound infections, greater accuracy in the administration of medicines to take home and fewer patients transferred out to the local acute hospital.

How will we monitor progress?

- We will continue to train staff in aseptic non-touch technique (ANTT), implement the findings to any post-infection review and review the method of wound closures currently used. We will also provide additional training to staff and implement any learning from future administration errors.

Priority 3

What are we trying to improve?

- Improve the capturing our patient demographic information to be able to identify and focus on areas of potential inequality or support.

What will success look like?

- Improved Friends and Family responses/compliments.
- Have no complaints linked to inequality or protected characteristics.
- Further customised training sessions, support documents and access to services.

How will we monitor progress?

- Patient feedback.
- Complaints monitoring.
- Shared learning and training sessions on clinical governance days.
- Demographic data monitoring.

Patient stories

I had an endoscopy this morning at Emerson's Green in Bristol, and just wanted to leave some feedback as I don't think positive things get said enough, The team (I apologise I cant remember the names after sedation) were absolutely incredible with me, I was very nervous as this was the first ever procedure or anything like this in my life and they made me feel extremely comfortable, reassured me through the whole process and just genuinely felt there was a lot of care involved. I cannot speak highly enough and really glad I was in such safe hands throughout. I hope the feedback can reach the team and they just realise how amazing they actually were. Many Thanks.

Patient stories

Thanks you so much to Practice Plus Group.

Very clean environment, super friendly staff and great consultant. I am very happy with the treatment I received and the result of my procedure.

Informative the whole way through, lovely staff over the phone who take payment. I like how I received reminders and updates about my appointments and upcoming payments. I think Practice Plus Group is an affordable, great value for money private clinic - changed my life for the better.

Patient stories

The treatment process form the initial assessment through the first treatment process and then the operation was excellent. Information booklet was provided post each visit all my questions had been answered and at no point did I feel unsure of what was going to happen next. The operation itself went very smoothly and at no point did I feel that my personal care wasn't a priority. The attention I received post procedure was excellent and my recovery process was explained to me in great detail.

The treatment and service that I have received from start to finish has been at the highest quality.

Ilford Hospital

Performance against the priorities set for 2023/24

Priority 1 – partially achieved

We said we would:

- Improve our Datix Incident reporting investigation timescales.

What we have achieved:

- 97.5% of incidents were reported within 24 hours of the incident taking place.
- 97% of the reported incidents were reviewed within three working days.
- 92.5 % were investigated within 20 working days.

Priority 2 - partially achieved

We said we would:

- Reduce infection rates to zero.

What we have achieved:

- In 2023-2024 we have had 10 superficial incisional infections which were reported via post discharge leaflets so these wounds were not able to be reviewed and one deep tissue infection.

Priority 3 - achieved

We said we would:

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

What we have achieved:

- We logged 26 complaints last year and 30 complaints for the same period this, but we have had an increase in our attendances so our rate of complaints has reduced.

Local outcomes

Ilford	#	%	Comments
NJR submission	931	100%	NJR submission and upload to the NJR database successful. This year the GOLD Data Quality award was presented to Practice Plus Group Ilford.
VTE risk assessment	7086/ 7555	94%	There was a new IT system installed in May 2023 and this resulted in a dip in VTE assessment completion. This has been rectified now and this remains a priority for 2024 as a result.
VTE incidents	2/7555	0.03%	The two VTE incidents were one deep vein thrombosis related incident post knee replacement and one Pulmonary Embolus incident following a knee arthroscopy. Both patients had received anti thrombolytic treatment.
Complaints received	30/ 42,080	0.07%	
Complaints upheld/partially upheld	13/30	43%	7 upheld. 6 partially upheld. 17 not upheld.
Incidents relating to patient harm	21/158	13.29%	Total of 158 incidents relating to patients (increase from 111 last year). 18 Low minimal harm. 3 Moderate short-term harm. 137 No harm.
Serious patient safety incidents	0	0%	

Priorities for 2024/25

Priority 1

What are we trying to improve?

- VTE assessment completion at all stages of the patient pathway. A new IT system was installed in May 2023 and this resulted in a dip in VTE assessment collation. This has been rectified now.

What will success look like?

- The expectation is that we will be reporting a completion rate of 98% to Unify 2.

How will we monitor progress?

- Monthly reporting via our Harvest Reporting IT system.

Priority 2

What are we trying to improve?

- We are trying to increase our incident reporting numbers and investigating timescales.

What will success look like?

- Year on year increase in number of incidents reported:
  - 2022-2023 111.
  - 2023-2024 158.
  - 98% reported within 24 hours.
  - 98% reviewed within three working days.
  - 95% investigated within 20 working days.

How will we monitor progress?

- Monthly reporting via KPIs.

Patient stories

Last year on 10th June you replaced my left knee at Practice Plus Group, Ilford. Prior to the operation you told me you had the easy job to replace my knee, making it work was more difficult. I took on board your advice. My knee has been a total success and now almost as flexible as my normal knee. At the beginning of May, 11 months after the operation, I cycled from Lands' End to John O Groats, some 900 plus miles in nine days. There were no problems at all from my knee I would like to thank you and your team for a wonderful job. Very well done.

Patient stories

I had my right foot operated on yesterday morning, (13th February) and felt I must write to thank all your lovely staff who assisted me. Everybody who talked to me was friendly, courteous and helped me feel confident about my operation. There are so many occasions when us older folk feel that we're being a nuisance if, for example, we ask someone to repeat something, because we couldn't hear. Your staff were the complete opposite, and I would like you to convey my thanks to them all. They are a credit to Practice Plus Group, including reception, the porters, the nurses, and the surgical staff, and I was given excellent after-care advice, which I'm following to the letter.

Patient stories

The colonoscopy team were fantastic, I have received from all of them a nice welcome, they kept me well informed throughout the procedure and they have been very nice and caring. The nurse advised me to go with gas and air first and if I needed it I would receive sedation, however I was able to manage with gas and air only and that to me is very convenient as I need to pick up my child. Thank you all for being so caring.

Plymouth Hospital

Performance against the priorities set for 2023/24

Priority 1 – achieved

We said we would:

- Increase the number of day hip, knee and uni-knee replacements.

What we have achieved:

- 2022/2023 – Hip: 4 Knee: 3 Uni Knee: 0
- 2023/2024 – Hip: 17 Knee: 8 Uni Knee: 11
- We have tripled the total amount this year.

Priority 2 - achieved

We said we would:

- Improve patient access to treatment.

What we have achieved:

- **Created a BMI clinic** – This has seen 50 patients, 37 became fit for surgery and five end of cared. This has an 88% success rate which means that 37 more patients were offered their surgery during this period.
- **Patient Initiated Digital Mutual Aid System (PIDMAS)/ Long waiters** – NHS England initiative to offer all patients on lists with an NHS provider who have waited over 40 weeks, the option to be transferred to another provider who can treat them quicker. We have accepted over 200 from RCHT and 20 from UHP.

Priority 3 - achieved

We said we would:

- Improved responses to patient feedback.

What we have achieved:

- Patient complaints and compliments are discussed at all Clinical Governance days with specific focus on any trends.
- Patients are offered an opportunity and encouraged to share their experiences with our staff.
- Patient feedback is shared widely across all the hospitals.
- Complaints are all responded to within the policy timeframe.

What we need to improve:

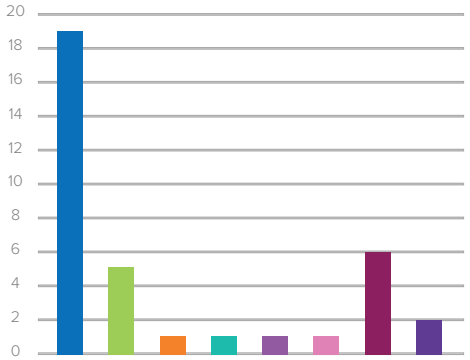
- Issues regarding tablet technology and our surveys. While the feedback we are receiving from the surveys is 99% positive we are not capturing enough of the patients coming through the hospital.
- We have invited 'We love surveys' to come to the hospital to review all our tablets and process to ensure it is not user error.

Local outcomes

Plymouth	#	%	Comments
NJR submission	2271	99.5%	NJR submission and upload to the NJR database successful.
VTE risk assessment	6994	98%	77 missed VTE assessments since Apr 23.
VTE incidents	4	0.18%	
Complaints received	36	0.96%	92% of complaints (26/28) were acknowledged within three working days, while 83% (5/28) of complainants received a response with the outcome of the investigation within 20 working days.
Complaints upheld/partially upheld	28	87%	15 upheld. 13 partially upheld. 4 not upheld. 4 complaints are currently being investigated, therefore the outcome has yet to be determined. All complaints received during the reporting period have provided the complainant with a satisfactory resolution from the initial investigation and response at stage 1, with three being escalated to stage 2.
Incidents relating to patient harm	98	38%	Total of 257 patient safety incidents reported which is 6% of our total NHS patients both inpatient/day case. 158 were associated with no harm. 75 were associated with low minimal/harm. 23 were associated with moderate/ short-term harm.
Serious patient safety incidents	2	0.77%	2 Never Events.

NHS complaints by subject

	Number of NHS complaints by subject
Clinical treatment	19
Communication (oral)	5
Communication (written)	1
Date for appointment	1
HPF issue	1
Patient property/expenses	1
Staff attitude/behaviour	6
Staff competence	2



Priorities for 2024/25

Priority 1

What are we trying to improve?

- Optimising patients to decrease long waiters in the wider health community.

What will success look like?

- Continue using the BMI clinic.
- Create a diabetic clinic.
- Working in conjunction with Devon and Cornwall to reduce the long waiters.
- Reduction in clinical cancellations and decrease patients on active monitoring.

How will we monitor progress?

- Regular reviewing and validation of wait list.
- Attendance and success for BMI/diabetic clinics.
- Monitoring trends of clinical cancellations outcomes.

Priority 2

What are we trying to improve?

- Increasing and upskilling our workforce to support increased activity and acuity.

What will success look like?

- Scrub to Surgical First Assistant (SFA) training at Plymouth University.
- Nurse Apprenticeship Programme/ Diabetic specialist nurse training.
- Acute Life-Threatening Events Recognition and Treatment (ALERT) training and programme implemented and scenario based learning.

How will we monitor progress?

- Completion of courses.
- Reviewing incident management.
- Staff retention and feedback.
- Appraisals/PCR

Priority 3

What are we trying to improve?

- Re-shaping our support infrastructure to support clinical activity, staff and patient safety.

What will success look like?

- Implementation of monthly meetings for specific groups including (Environmental, Water, Medical Devices, Health and Safety).
- Creating Terms of References for each group.

How will we monitor progress?

- Incident reviews relating to non-clinical issues.
- Regularity of staff reporting.
- Minutes and actions from meetings.

Patient stories

Patient one, self-referred into Practice Plus Group Hospital, Plymouth in 2023 after being advised of the long wait time for NHS treatment for her required knee replacement surgery. As a keen walker who has always remained active with keep fit classes and yoga, the pain in her knee was at a point when something needed to be done.

Speaking of her surgery patient one states "I was impressed how professional and efficient the service is. Every member of staff, from the consultant, anaesthetist, doctors and nurses, to the parking attendant and caterer are so friendly and keen to help. I found the environment clean and relaxing and I was reassured all the way."

Patient stories

Patient two, was referred into Practice Plus Group Hospital, Plymouth in 2023, for a hip replacement, after being in pain for a long time unable to fully enjoy every aspect of her life.

Speaking of her surgery patient two states "I am so grateful for your surgery to my hip it has changed my life back to what it was before! Such a smooth operation and a great back up team.

Shepton Mallet Hospital

Performance against the priorities set for 2023/24

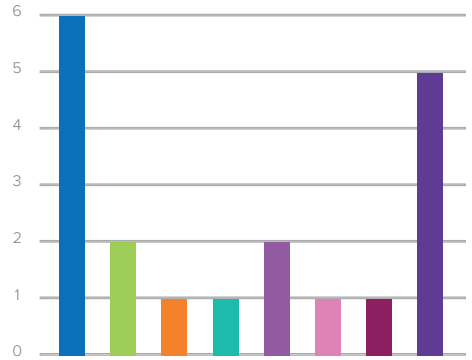
No priorities were set for 2023/24

Local outcome

Shepton Mallet	#	%	Comments
NJR submission	1901	98.7%	This DQP qualified for the Bronze Award
VTE risk assessment	8058/ 8190	98.39%	Of total of admitted patients requiring VTE assessment 8190. Omissions are audited, feedback to teams and checked for any gaps in patient safety.
VTE incidents	5/2039	0.06%	Of a total of 2039 NHS inpatient procedures performed.
Complaints received	19/7330	0.2%	Of 7330 NHS Inpatient and day case procedures performed. Feedback is actively encouraged, learning is sought from complaints and reported through governance processes.
Complaints upheld/partially upheld	11/14	78.57%	3 upheld. 8 partially upheld.
Incidents relating to patient harm	85/214	39.72%	Of the 214 incidents reported relating to patients there were 129 where no harm was identified or avoided. Incident reporting has seen a steady increase over the last 12 months which has occurred alongside the introduction to the PSIRF approach to incidents. Patient safety has been made a key priority for all staff.
Serious patient safety incidents	2/85	2.35%	Incidents were reviewed were found not to be as a direct result of procedures performed at Shepton Mallet

NHS complaints by subject

	Number of NHS complaints by subject
Clinical treatment	6
Communication (oral)	2
Communication (written)	1
Consent to treatment	1
Date for appointment	2
Date of admission/attendance	1
Personal records	1
Staff attitude/behaviour	5



Priorities for 2024/25

Priority 1 – medication reconciliation

What are we trying to improve?

- Prior to undertaking this quality improvement project, the proportion of medicines reconciliations being fully completed by a pharmacist was negligible.
- Nursing staff were completing the drug history page of the drug chart at the time of patient arrival outside of pharmacy opening hours.
- It was questionable if a full and detailed list of all medicines the patients were taking were recorded as the list often reflected only the items which had been bought in.
- The pharmacy team were struggling to find an opportunity in amongst other pharmacy work pressures to catch patients when they aren't in theatre, recovery, undergoing physiotherapy or being seen by other healthcare professionals.
- Patients were not reviewed by the pharmacist until the day after surgery (if at all), which was often too late to make any significant interventions to peri-operative drug management.
- We wanted to provide personal face to face medication reviews with patients to ensure accurate record was made prior to surgery.

What will success look like?

- Increase the number of medicines reconciliations completed by the pharmacy team to above 90% of patients admitted for joint arthroplasty measured during a one-month period.
- Ensure each medicines reconciliation is taken from two sources, with the patient being one of these.
- Identify medication related interventions before admission which previously may have resulted in avoidable on the day cancelations and/or last minute changes to TTA's delaying discharge.
- Create an opportunity to highlight any medicines optimisation issues prior to admission.

How will we monitor progress?

- Monitor through monthly intervention figures which capture the number of medicines reconciliations completed.

Priority 2 – streamline admission of inpatients

What are we trying to improve?

- Patient pathway improvement for major joint surgery.
- Patient experience improvement.
- Utilisation of staff skills.
- More effective utilisation of resources.

What will success look like?

- Single admission for patient and reduced duplication of tasks, whilst maintaining patient safety prior to surgery.
- Improvement in friends and family score.
- Improved continuity of care.

How will we monitor progress?

- Regular project review meetings fed into Quality Governance meetings.
- Patient feedback.
- Staff feedback.
- Reduction in duplication.

Priority 3 - paper free medical records

What are we trying to improve?

- Reduce the amount of paperwork in order to reduce errors with incorrect documentation and misfiling of paper in files.
- Reduction in cost in consumables.
- Sustainability.

What will success look like?

- Reduction in costs of consumables.
- Fewer opportunities for paper records to go missing or be misfiled.
- Majority of patient information will be on the electronic patient pathway.

How will we monitor progress?

- Reduction in Datix incidents relating to documentation.
- Collect feedback from departments via monthly review meetings.
- Evaluate costs.

Patient stories

Thank you so much for my new knee. It took me longer than I thought but, I've made it back to running. Here I am finishing Park Run – Longrun Meadow February 2024. Show this to anyone who won't believe you can run after a TKR. My operation was in August 2022.

Patient stories

From a very happy patient who sent a letter with his photograph he said he only had six more miles of shingles to walk. This is a 10-mile walk considered to be 10/10 hard and takes five hours. This is 363 days after a right hip replacement.

Southampton Hospital

Performance against the priorities set for 2023/24

Priority 1

We said we would:

- Improve the patient pathway through the pre-assessment process.

What we have achieved:

- We have appointed a pre-assessment lead and reconfigured the outpatient department. We have reassigned responsibilities for identification and proactive management of patients with additional needs. We have devised new patient pathways to identify the most appropriate clinical/medical appointment required. We have a training programme for all staff.

Priority 2

We said we would:

- Chronic pain management prior to surgery.

What we have achieved:

- One of our clinicians now offers pain advice throughout Practice Plus Group. We have reviewed our pain pathway leading to a more efficient service which means more patients can be seen each day.

Local outcomes

Southampton	#	%	Comments
NJR submission	989	92%	
VTE risk assessment	10,381	87%	Total admitted 11915. The % assessed fell when the new electronic patient system was introduced in April 2023, this is increasing and was 95% in February 2024.
VTE incidents	2	0.01%	
Complaints received	65	0.5%	
Complaints upheld/partially upheld	67	0.2%	
Incidents relating to patient harm	86	31%	271 no harm.
Serious patient safety incidents	0		

Priorities for 2024/25

Priority 1

We said we would:

- We want to embed the National Safety Standards for Invasive Procedures version two (NatSSIPs2) across the hospital. The standards have been written by clinicians from multiple professions and specialties and re-launches the WHO check list.

What we have achieved:

- NatSSIPs 2 will be in place and we will identify local surgical safety guardians.

How will we monitor progress?

- Through quarterly review and audits reported locally.

Priority 2

What are we trying to improve?

- Prescribing To Take Out (TTO) medicines for inpatients the day before discharge, when patients stay overnight.

What will success look like?

- 90% of patients will have TTOs prescribed the day before discharge.

How will we monitor progress?

- Through auditing prescriptions and reporting locally.

Priority 3

We said we would:

- Improving the post operative advice line. This will mean that patients are aware of who to contact post-operatively and that they are triaged appropriately.

What we have achieved:

- 90% of calls will be responded to within four hours.

How will we monitor progress?

- Through the daily safety huddle and quarterly review locally.

Patient stories

Excerpt from feedback received from patient on 5th February 2024 who underwent hernia repair surgery

"I have always wanted to say thank you very much to the hospital, basically to the staff that helped me there. The surgeons, nurse, healthcare assistants as well and everyone. I had been in so much pain prior to the surgery. Once again, thank you very much and may goodness follow you all the days of your lives."

Patient stories

Excerpt from letter of thanks from patient who underwent Bilateral simple orchidectomy surgery on 25 January 2024.

"Everybody I came into contact with made me feel welcome, at ease and reassured and pretty much as though I was your only patient. The overall level of care was in my view exceptional, the surroundings spotless and difficult to imagine how the standard could have been exceeded.

The Urology consultant is an absolute asset to your clinic. His overall standard of care has been outstanding in every respect, from consultation just before Christmas, up to his pre and post operative advice on the day. I think I can humbly but confidently suggest you are very fortunate to have him as a key member of your team and would do well not to lose him.

St. Mary's Portsmouth Surgical Centre

Performance against the priorities set for 2023/24

Priority 1 – partially achieved

We said we would:

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

What we have achieved:

- Our avoidable cancellations have improved (2186 versus 1295).

Priority 2 – achieved

We said we would:

- Improve staff retention within the surgical centre.

What we have achieved:

- Staff retention has improved across the centre overall.
- During March 2023, surgical centre turnover was 1.82%, and as a comparative, during February 2024, surgical centre turnover was 0%. These figures are reflected in our current advertised positions, which at present, are minimal.

Priority 3 – partially achieved

We said we would:

- Increase accessibility for a wider range of patients to our services.

What we have achieved:

- We regularly facilitate patients with additional needs across all of our services. Such requirements are recorded via the alerts system (via Maxims) and are robustly communicated at our bi-weekly scheduling meeting to ensure our patients are safely and appropriately supported.
- In addition, we have facilitated two training sessions (led by Autism Hampshire) to increase our local understanding of autism and other neurodiverse presentations. We have undertaken an assessment of our environment to understand the sensory impact that it may have, and are currently reviewing the recommendations.
- Furthermore, we have locally ratified a Standard Operating Procedure (SOP) that offers guidance on how we present our written information to ensure that it is in line with British Dyslexia Association recommendations.

Local outcomes

St. Mary's	#	%	Comments
VTE incidents	1	0.00%	
Complaints received	21	0.07%	
Complaints upheld/partially upheld	11/20	55%	One complaint does not have the outcome recorded.
Incidents relating to patient harm	41/259	15.83%	271 no harm.
Serious patient safety incidents	0		

Priorities for 2024/25

Priority 1

What are we trying to improve?

- To reduce the number of received patient complaints; which has identified a requirement to embed a consistent and positive perioperative patient journey. In addition, to improve our response to patient feedback (including the acknowledgement of compliments and positive feedback).

What will success look like?

- A reduction in patient complaints and an increase in patient compliments.

How will we monitor progress?

- We will monitor this monthly via our reporting channels. The Governance team will support further with reviewing received complaints for themes and/or trends.

Priority 2

What are we trying to improve?

- To improve our current post-operative queries/advice process (including out of hours) for our patients to ensure access is easily and robustly obtained where support is required.

What will success look like?

- A comprehensive and robust process which safety-nets our patients; complaint trends would reduce.

How will we monitor progress?

- Sub-committee progress; this will be evidenced by meeting minutes and an accompanying action tracker (where applicable).

Priority 3

What are we trying to improve?

- To improve the communication of pre-operative/pre-procedural information to reduce cancellations (including cancellations related to timings).

What will success look like?

- Reduction in the number of cancellations (particularly on-the-day) from 2024/25.

How will we monitor progress?

- Sub-committee progress; this will be evidenced by meeting minutes and an accompanying action tracker (where applicable). In addition, we will monitor this monthly via our reporting channels.
- Regular audit of our cancellations will be undertaken to establish themes and/or trends.

Patient stories

"My wife and I have had really excellent service for cataract removal in both eyes for which we thank you. This morning I accompanied my wife to St Mary's Portsmouth, for her final post op. We were very early and had over 40 mins before her appointment time. So, I sat for about one hour in reception and was really impressed with the lady on reception. She was sufficiently welcoming, efficient, considerate, and helpful to all arrivals for me to want to write to commend her to you. I also think that she was not feeling very well so that enhances her performance. Thank you."

"I would like to say a very sincere thank you to all of you who took part in doing the above. Right from my first appointment to my discharge. I had politeness, explaining, advice and very good workmanship. My eye sight is so very improved, "delighted". Thank you."

Gillingham Surgical Centre

Performance against the priorities set for 2023/24

Priority 1

We said we would:

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

What we have achieved:

- We achieved a 37% drop in cancellations on the day of surgery. Inclusive of a 48% drop from gastro, 17% for ophthalmology, and a 54% decrease in on the day cancellations for orthopaedics.

Priority 2

We said we would:

- Improve our Datix Incident reporting investigation timeframes.

What we have achieved:

- 14% drop in the 20-day investigation timeframe from the previous year. On a positive note, there has also been a 14% reduction in the records error type in thanks to staff training.

Priority 3

We said we would:

- Achieve theatre start-time compliance of 90%.

What we have achieved:

- Theatre start-time compliance of 89%, however there has been an increase in both our case per session ratio, and number of sessions per day for the Gillingham site.

Local outcomes

Southampton	#	%	Comments
VTE risk assessment	7771	96.62%	
VTE incidents	1	0.012%	
Complaints received	14	0.17%	
Complaints upheld/partially upheld	2	14.23%	1 complaint not upheld. Outcome of others not known.
Incidents relating to patient harm	21/88	23.86%	67 incidents reported resulted in no harm.
Serious patient safety incidents	1/21	4.76%	

Priorities for 2024/25

Priority 1

What are we trying to improve?

- Improve our Datix reporting timescales for incidents reported within 24 hours, reviewed within three days and fully investigated within 20 days to 90%+.

What will success look like?

- Success will be measured via the timely reporting, investigation and management of concerns and incidents raised and closed, through the implementation of learning from actions.

How will we monitor progress?

- This will be monitored through monthly Datix meetings.

Priority 2

What are we trying to improve?

- Reduce our wait lists for general surgery patients below 45 weeks.

What will success look like?

- Patients progressing through general surgery pathways more timely, reducing our current wait times below 45 weeks and with patients providing high satisfaction responses based on excellent outcomes.

How will we monitor progress?

- Through weekly utilisation and planning meeting to manage capacity and optimisation of patients on pathway.

Priority 3

What are we trying to improve?

- We aim to provide our patients and colleagues with a clean and safe environment.

What will success look like?

- Our housekeeping team will complete regular meetings and cleaning charters with HODs, ensuring audits are in place to drive improvements following patient survey and colleague feedback.

How will we monitor progress?

- Internal audits and feedback received through surveys and various stakeholders.

Patient stories

I had a colonoscopy at Practice Plus Group Gillingham. Fantastic and professional service keeping me calm and relaxed. Thanks to nurse Theresa in particular who was very comforting and reassuring throughout the procedure.

Patient stories

Just had my cataract fixed on Friday. I have worked in the NHS as a senior nurse for the past 30 years and know what good care is. Quality building with excellent staff. The care I received was top drawer. Free parking too. Thank you.

Appendix 1
Local clinical audit schedule

Audit	Purpose	Frequency
Emergency Response Audit	All services must hold a 'planned' emergency scenario every three months. It is also good practice to incorporate an 'unplanned' 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, regardless of whether they were present during the scenario or not.	Monthly
Documentation	Supports best practice in clinical documentation and guidance from professional bodies. Various versions according to the department being audited e.g., ward, pre-op, theatre, physio etc.	6-Monthly
Safeguarding Assurance Framework Audit	To ensure that safeguarding concerns are referred and logged, providing assurance that safeguarding responsibilities are discharged.	Quarterly
Accessible Information Standard	The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so they can communicate effectively with health and social care services.	Annually
Site Assurance Tool - Non Facilities	Log of the key people required to comply with legislation.	Annually
Endoscopy Decontamination QMS	To determine whether endoscopy decontamination is undertaken in accordance with policy.	Quarterly
CSSD QMS	To assess compliance with standards for decontamination of reusable sterile equipment.	Monthly
Controlled Drugs	Compliance with the documentation element of Controlled Drugs.	Quarterly
Inpatient Medication Chart Documentation	To ensure compliance with NICE guidance, focusing on reconciliation of medicines.	Quarterly
Antibiotic Stewardship Audit	To reduce the risk of inappropriate antibiotic usage in line with Practice Plus Group policy and national Antibiotic Stewardship guidelines.	6-Monthly
Pre-Labelled TTO Medication Audit	To ensure medication management processes and arrangements are robust and that documentation and audit trails are comprehensive.	6-Monthly
Diagnostics X-Ray Interpretation	Data collection to determine the percentage of correctly-interpreted images to identify trends.	Monthly
Diagnostics Reject Analysis Monthly Data	An overview of the monthly rejection rate from each site.	Monthly
Diagnostics Reject Analysis Monthly Data	An overview of the monthly rejection rate from each site.	Monthly
Diagnostics Reject Analysis Audit	A more in-depth review of the reasons for rejection in order to highlight trends.	Quarterly
Diagnostics DVT Ultrasound Audit	To determine whether referrals are appropriate and completed in a timely manner.	Annual
Diagnostics Clinical Practice Review and Documentation	Assessment of compliance with the diagnostics standards for documentation.	6-Monthly
Diagnostics DRL Audit	To ensure that local dose levels of radiation for common imaging examinations are in line with National Regulatory Dose reference levels.	Annually
Diagnostics Peer Review	A monthly audit of each sonographer's randomly-selected images and reports to review for clinical discrepancies within the report.	Monthly
Diagnostics Clinical Evaluation on Auto-Reported X-Rays	A clinical evaluation of the outcome of medical exposures where there is no formal radiological report.	Quarterly
Diagnostics U/S Guided Injection Documentation Audit	Retrospective audit of documentation for USGI and accurate recording of medicines given and complications.	Quarterly
Health and Safety and Environment Departmental Audit Tool	Routine health and safety inspections of departments and offices by individual department H&S Representatives.	Monthly
Annual Fire Check		Annual
IPC Assurance Tool	Assessment of compliance with the IPC Strategy.	Monthly
Hand Hygiene Technique	Hand hygiene is performed by staff at every appropriate opportunity according to the Five Moments of Hand Hygiene.	Quarterly
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.	6-Monthly
Aseptic Technique	The risk of infection is minimised through implementation of evidence-based practice.	6-Monthly
Peripheral Vascular Devices	Evidence-based best practice is being consistently applied to prevent peripheral vascular device infections.	6-Monthly
Urinary Catheter Care	Evidence-based best practice is being consistently applied to prevent urinary catheter infections.	Annually
Ward environmental Audit Tool	To assess the cleanliness of areas, both clinical and non-clinical.	Quarterly
Theatre, Minor Ops, Endoscopy Environmental Audit	To assess the cleanliness of areas, both clinical and non-clinical.	Monthly
OPD, UTC, Diagnostics and Physio Environmental Audit	To assess the cleanliness of areas, both clinical and non-clinical.	Quarterly
One Together Assessment	Audit of the interventions aimed at reducing surgical site infection.	6-Monthly

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

NHS Kent and Medway
Integrated Care Board

We welcome the Quality Account for Practice Plus Group, Kent and Medway Integrated Care Board (ICB) confirm that this Quality Account has been produced in line with the National requirements and includes all the required areas for reporting.

The Quality Account demonstrates an overview of quality of care in your focus areas, looking at improving the safety, and effectiveness of your services, as well as improving patient experience.

There is an overview of the work that you have undertaken this year with a focus on reducing the number of clinical cancellations on the day of surgery. We commend your efforts to increase theatre start-time compliance.

The report has a clear flow that would be easy to follow for member of the public.

Your report sets out your Quality priorities for 2024/25 which you have provided clear reasoning for and we support your work on reducing your wait lists for general surgery patients below 45 weeks, providing your patients and colleagues with a clean and safe environment and improving your Datix reporting timescales for incidents.

Thank you for your engagement at the Provider performance meetings and the ICB thanks Practice Plus Group for the opportunity to comment on these accounts and looks forward to further strengthening the relationships with the organisation through continued collaborative working.

Ian Brandon
Associate Director of Quality
NHS Kent & Medway ICB

NHS Hampshire and Isle of Wight Integrated Care Board

NHS Hampshire and the Isle of Wight Integrated Care Board (NHS HIOW ICB) would like to thank Practice Plus Group for the opportunity to comment on their Quality Account for 2023/2024. We are satisfied with the overall content of the Quality Account and believe it meets the mandated elements.

We have worked alongside Practice Plus Group to seek assurances that the care provided by them meets the required standards for safe, effective care and that experience is key to those accessing it, taking action for improvement where necessary.

We supported Practice Plus Group's 2023/24 organisational wide quality improvement priorities. It is pleasing to note that significant progress has been made against all four of these priorities and considerable improvements in several areas are evident.

With regards to the local priorities, we are pleased to see the progress made in improving the pre-assessment process and chronic pain management in the Southampton Hospital, along with the reduction of avoidable cancellations and improved staff retention in St Mary's Portsmouth Surgical Centre.

It is recommended that the impact the 2023/24 priorities have had on patient outcomes continues to be monitored during 2024/25 and further progress made on the local priorities that have been partially achieved this year.

NHS Hampshire and the Isle of Wight Integrated Care Board welcomes the 2024/25 priorities outlined in the Quality Account, specifically the review and evaluation of the Patient Safety Incident Response Framework (PSIRF) and quality visits.

For the Southampton Hospital, we are pleased that our agreed area of system improvement regarding National Safety Standards for Invasive Procedures (NatSSIPs2) will be linked to one of your local priorities and look forward to hearing about progress with your post operative advice line.

It is also positive to see that, where relevant, local quality improvement initiatives will be adopted across all sites, ensuring benefit to more patients.

We look forward to Practice Plus Group sharing improvements and examples of best practice/innovation with us during the coming year.

We note that the number of complaints for the Southampton Hospital are higher than the other sites and so we suggest that there should be a particular focus on this during 2024/25.

Next year, it would be good to see information included for the Southampton Urgent Treatment Centre in the local quality update section of your Quality Account.

We would like to thank Practice Plus Group for inviting us to participate in internal quality meetings and quality visits to support our assurances processes. Thank you for supporting local and system quality improvement by being an active, respected, and valued member of NHS Hampshire and the Isle of Wight Integrated Care Board's local Quality Group meetings.

Overall, we are pleased to endorse the Quality Report for 2023/24 and look forward to continuing to work closely with Practice Plus Group during 2024/25 in further improving the quality of care delivered to our population.

Nicky Lucey
Chief Nursing Officer
Hampshire and Isle of Wight ICB

NHS Devon
Integrated Care Board

NHS Devon Integrated Care Board (ICB) would like to thank Practice Plus Group Plymouth for the opportunity to comment on the quality account for 2024/25. Practice Plus Group is commissioned by NHS Devon ICB to provide elective care services in Devon. 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.

The ICB notes the successes outlined in the Account in relation to 2023/24, including implementing a BMI Clinic and improving responses to patient experience.

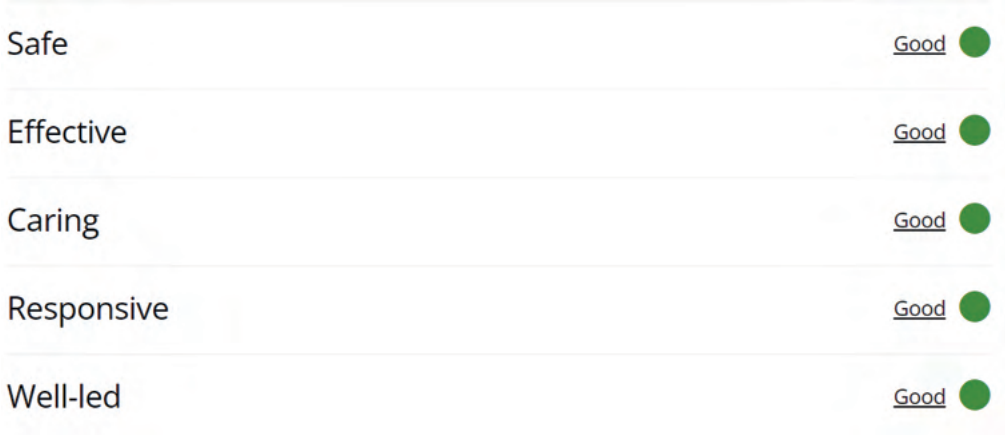
Priorities for 2024

The ICB welcomes the 2024/25 priorities outlined by Practice Plus Group and will look forward to seeing the projected achievements as they aspire for continuous quality improvement, and as commissioners we continue to support their priorities.

Priority 1:	Optimising patients to decrease long waiters in the wider health community.
Priority 2:	Increasing and upskilling our workforce to support increased activity and acuity.
Priority 3:	Re-shaping our support infrastructure to support clinical activity, staff and patient safety.

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).

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.

Sara Wright
Head of Nursing and Quality
NHS Devon ICB