Practice Plus Group

Quality Account

2024-2025

Contents

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.

Part 1

Is a statement on quality from our chief executive, Jim Easton.

Part 2

We have included details of the six priorities for improvement that we intend to deliver during 2025/26.

There are also several 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 2024/25, together with performance against key national priorities for organisations delivering NHS care.

Annex 1

Includes feedback on the draft Quality Account from Practice Plus Group Secondary Care's key stakeholders.

Part 1: Statement on quality
from the Chief Executive

This year has been characterised by continuous improvement and growth for Practice Plus Group hospitals and surgical centres.

Our private healthcare brand, Wellsoon, has been attracting increasing numbers of people facing long NHS waiting lists for the life-changing surgery they need, and our NHS volumes have remained high as we continue our efforts to help reduce waiting lists.

We have increased our footprint, with our new Birmingham hospital now open and receiving excellent feedback from patients, as well as a new fixed site ophthalmology centre at Bamber Bridge to provide NHS treatment of Adult Macular Degeneration (AMD), and new mobile sight-saving clinics in Stockport, Preston, Lancs, and Nursling, Hampshire.

We have also introduced new services at selected sites this year, including bariatric surgery, varicose vein treatment, vitro-retinal eye surgery and private GPs.

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:

- Six hospitals
- Three surgical centres
- Two urgent treatment centres.

In the year from April 2024 to March 2025 we carried out:

- 69,980 day-case procedures.
- 12,429 inpatient procedures.
- 297, 070 outpatient consultations, including telephone consultations.

Our consistently high quality measures have remained high during this year of growth; we have retained our high-quality metrics and gained some additional ones.

All of our hospitals and surgical centres remain rated ‘good’ or ‘outstanding’ by the Care Quality Commission (CQC). Our Portsmouth Surgical Centre welcomed a CQC inspection in August 2024 and I am pleased to say were given a clean sweep of ‘good’ ratings across all themes.

Our Shepton Mallet and Barlborough Hospitals achieved Gold and Silver accreditation respectively by the Aseptic Non-Touch Technique (ANTT) patient protection accreditation for the first time, demonstrating their commitment to patient safety and infection prevention.

All Practice Plus Group hospitals retain National Joint Registry (NJR) quality data provider status, recognising excellence in supporting the promotion of patient safety standards through compliance with the mandatory NJR data submission quality audit process, and all endoscopy services remain JAG-accredited.

In the national friends and family test, 98% of our workforce said they would recommend us as a care provider to friends and family, well above the national average of 94%.

We have made significant progress against the priorities we set out to achieve this year:

Priority 1: Review and evaluate PSIRF implementation

All sites now hold weekly meetings at which all open incidents are reviewed to ensure that the required learning responses are being completed, in line with the Patient Safety Incident Response Plan (PSIRP) and 99% of incidents are reviewed within three working days.

Priority 2: Achieve quality standards for imaging

We have signed up to the Royal College of Radiologists (RCR) Quality Standard for Imaging (QSI) and have started work to bring together all aspects of operating practices for the service.

Priority 3: Enhance the perioperative pathway

Our perioperative review programme has made great strides in helping us adapt and respond to increasing demands from a growing and ageing population and open up access for patients to get the treatment and care they need.

Priority 4: Evaluate annual site quality visits

Our self-assessment tool is being widely utilised, with all quality visits reports and regulatory inspections updated, monitored and audited centrally.

We have set six priorities for 2025-26:

Priority 1: Co-Production and Communication of Learning from Harm with Patients and Families

Priority 2: Achieve Quality Standard in Imaging.

Priority 3: Enhance the perioperative pathway

Priority 4: Surgical Site Infection Risk Assessment

Priority 5: Participation in the National NHS Foundation Pharmacist Training Programme

Priority 6: Utilisation of Point of Care Testing

I am confident that with the skilled and experienced teams we have in place we will continue on our growth journey and successfully unlock access to both NHS and private healthcare for those who need it. Looking ahead, we will be approaching 2026 with a focus on building our offer for private medical insurers and their members to help future-proof the business and be a long-term, sustainable partner to the NHS in the areas we operate.

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 2025/26

Priority 1: Co-production and communication of learning from harm with patients and families

Why have we chosen this priority?

We have chosen this priority to ensure that patients and families are not only involved in patient safety incident investigations but are also able to see how their experiences contribute to learning and meaningful change. This enhances transparency, promotes trust, and fosters a culture of partnership in safety improvement.

How will we improve?

We will improve by embedding patient and family voices at every stage of the learning process; before, during, and after investigations. By using our patient safety partner to engage with families post-investigation, we can measure their understanding and satisfaction, and ensure their feedback informs continuous improvement. We will also co-design solutions and visibly communicate the outcomes of safety learning back to patients and carers.

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

The percentage of patient safety incident investigations with documented patient/family involvement in the learning response will be 80% by March 2026.

Feedback will be sought by our patient safety partners from all patients/families involved in patient safety incident investigations on the clarity and value of their involvement and scores, with a target of 90% report feeling “informed” or “very informed”.

There will be at least three co-produced actions implemented per quarter in response to patient safety incident investigations.

“You said, we did” communications will be issued in response to patient and family feedback, with a target of 85% positive engagement.

How will we report and monitor our progress?

Progress against each of the targets described above will be monitored on an ongoing basis by the central governance team at the fortnightly stand-up datix meeting, and reported quarterly to the quality and governance assurance committee.

Priority 2: Quality Standard in Imaging (QSI)

Why have we chosen this priority?

Practice Plus Group is committed to providing high quality imaging services to patients and QSI, as a developmental standard underpinning imaging service providers’ investment in continuous improvement, reflects this commitment.

How will we improve?

We will provide a framework for delivery of high-quality, patient focused care within all Practice Plus Group imaging services. Achieving the QSI mark will provide independent recognition of the quality of Practice Plus Group imaging services.

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

We are in contact with the Royal College of Radiologists and are waiting to be assigned a quality review partner. We will then proceed to the assessment stage and aim to be fully accredited by end of March 2026.

How will we report and monitor our progress?

We will continue to upload documents and information to the QSI Hub to drive our development towards achieving QSI accreditation.

Priority 3: Perioperative pathway

Why have we chosen this priority?

We are undertaking the review of the perioperative pathway to adapt and respond to increasing demands from a growing and ageing population, and to conform to best practice protocols. This work is already underway and was included as a priority last year, for completion in the coming year.

How will we improve?

The following workstreams are to be reviewed and progressed:

Pharmacy perioperative review work

- To ensure pharmacy teams are provided with adequate information to support with decision making and avoid cancellations prior to the day of surgery.
- Ensure patients are referred into pharmacy immediately after pre assessment to ensure appropriate timings for decision making.

Framework and guidance for management of patients who

- Decline blood components.
- Are diabetic.
- Are hypotensive.
- With a BMI over 40 having bariatric or non-bariatric surgery or procedures.

Pre-assessment in maxims

- System alignment across all services.
- Green / amber / red pathways.
- Question reviews.
- Integrated care plan accuracy and tidy up.

Pre-assessment

- Pathology samples alignment.

Development of clinical cancellations alignment reporting

Pre-operative preparation guide for patients undergoing regional or general anaesthesia with respect to fasting of solids and fluids

- Develop a standardised fasting standard operating procedure based on best practice guidance which includes information on sip to send, isotonic drinks and weight loss injections.
- Review and standardise fasting patient resources/ information.

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

The central operations team have scheduled individual monthly implementation meetings with all Secondary Care hospitals starting April 2025 to support with implementing the work within their sites. This provides hospitals with the opportunity to showcase the work that has already been implemented, commit to a timeline of implementation and opportunity to request for additional support. We aim to complete the review by April 2026.

How will we report and monitor our progress?

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.

Reporting will be via:

- Quarterly perioperative pathway review with all relevant leads across the organisations to review progress and decide next steps which the head of nursing and medical director attend.
- Bi-weekly communications sent directly to heads of nursing, heads of clinical services and hospitals directors for each hospital.
- Regular slot for senior leadership meetings, quality review meetings and a standing agenda item on the company's quarterly away days to keep all relevant parties updated where reports are provided to all meetings.

Priority 4: Surgical site infection risk assessment

Why have we chosen this priority?

This priority has been chosen so that all patients that are having hip and knee arthroplasty are risk assessed prior to surgery for the potential of developing a surgical site infection post operatively. This will ensure that we taken appropriate action to safeguard the occurrence which will have better outcomes for the patient.

How will we improve?

We will ensure that every patient that is having hip or knee arthroplasty at one of our sites has a completed surgical site risk assessment completed at pre-admission and on the day of surgery and implement the necessary actions to prevent surgical site infections in those identified as at risk.

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

We will undertake audits of patients' documentation to ensure that a surgical site infection risk assessment has been completed at both stages of the patients' journey. The target will be 95% of patients will have the completed risk assessment within their documentation. Also, we will monitor how many of those patients deemed as high risk develop a surgical site infection.

How will we report and monitor our progress?

We will report quarterly on our progress at two meetings: the surgical site infection working group and the infection prevention and control committee meeting. Each site will be asked to undertake an audit prior to the surgical site infection working group and the audit results will be discussed at this meeting. A report will be produced which will be presented at the infection prevention and control committee meeting. Also, any identified surgical site infections will be monitored to ensure that a surgical site risk assessment has been undertaken and if risks were identified and acted on and this will be reported on at both meetings.

Priority 5: Participation in the national NHS foundation pharmacist training programme

Why have we chosen this priority?

In 2025/26, Practice Plus Group Secondary Care pharmacy will take part in the national NHS foundation pharmacist training programme for the first time, hosting seven foundation pharmacist trainees across our hospitals. This marks a milestone for both Practice Plus Group and the independent healthcare sector. The initiative supports our long-term workforce strategy, enabling us to develop a pipeline of highly trained, competent pharmacists who are equipped to deliver high-quality, patient-centred clinical services across our sites.

How will we improve?

We will establish robust frameworks to deliver structured training in collaboration with NHS England and higher education institutions. Each foundation trainee pharmacist will have a designated supervisor, protected learning time, and the opportunity to rotate through a variety of clinical settings.

Crucially, we will work in partnership with other healthcare organisations across the hospital and community sectors to provide a multi-sector experience. This will enable foundation trainee pharmacists to gain a broad understanding of patient care at the interface between secondary and primary care, equipping them to deliver an holistic and integrated clinical pharmacy service. This approach will strengthen the quality and scope of care provided to our patients and support the development of well-rounded, system-aware pharmacy professionals.

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

- A higher-than-national-average fill rate for foundation pharmacist training posts.
- 100% of foundation pharmacist trainees assigned both a designated supervisor and a designated prescribing practitioner, with locally structured training plans in place.
- Successful progression of all trainees through key programme milestones, with a registration assessment pass rate exceeding the national average in England.
- Improved service continuity through reduced reliance on temporary staffing.
- Positive feedback from trainees and supervisors, gathered via national and local training surveys, reflecting satisfaction with the training experience and support provided.

How will we report and monitor our progress?

The Secondary Care pharmacy senior leadership group will provide strategic oversight, reviewing training outcomes, supervision standards, and site readiness. Regular reporting will be submitted to the Secondary Care quality governance committee to provide assurance that delivery is aligned with national expectations and internal workforce priorities. Progress will also be monitored through the central governance team assurance visits and local site self-assessments, ensuring the quality of training provision and the effectiveness of programme delivery.

We will also provide regular updates to NHS England and other external stakeholders through established reporting channels, including data on trainee outcomes, supervision quality, and training site development.

Priority 6: Utilisation of Point of Care Testing (POCT)

Why have we chosen this priority?

We have chosen this as a priority to increase the profile for Point of Care Testing (POCT) within Secondary Care. POCT are used at the patient bedside to provide rapid clinical results for clinicians to be able to make treatment plans for the patients without having to wait for laboratory results.

How will we improve?

We have established a national POCT committee with designated POCT Leads at all sites to account for all POCT activities at site level. We have established robust frameworks and a national policy to ensure that we have the required assurance of quality within the testing that is carried out. We will work towards the ISO quality standards of 15189:2022 which incorporate POCT testing.

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

We will measure our improvements via many different ways, some of which are:

- National POCT committee meetings chaired by the national POCT lead.
- Local POCT committee meetings chaired by the local POCT lead at each site.
- POCT audits in place on safety culture, our electronic audit management system.
- On-site inspections from national lead.
- Internal quality controls and external quality assurance schemes in place.
- Self-assessments on safety culture focusing on ISO15189:2022 standards for POCT.

How will we report and monitor our progress?

We will report and monitor effectiveness via these methods:

- Committee meetings, local and national will focus on the outcomes of audits against ISO15189:2022.
- Local committees feed into national committees and raised to central governance meetings as and when required.
- Audit findings will be investigated with corrective actions and reported to the central governance teams.
- Progress will also be monitored through the central governance team assurance visits and local site self-assessments.

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 2024/25 Practice Plus Group Secondary Care provided and/or subcontracted relevant health services in ten 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 2024/25 represents 100% of the total income generated from the provision of relevant health services by Practice Plus Group for 2024/25.

2.2.2 Clinical audit

During 2024/25 four national clinical audits and zero national confidential enquiries covered relevant health services that Practice Plus Group provides.

During that period Practice Plus Group participated in 50% national clinical audits and zero national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. There were no qualifying incidents for submission to the Serious Hazards of Transfusion (SHOT).

The national clinical audits that Practice Plus Group was eligible to participate in during 2024/25 are identified in table one.

The national clinical audits that Practice Plus Group participated in, and for which data collection was completed during 2024/25 are listed in table one 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.

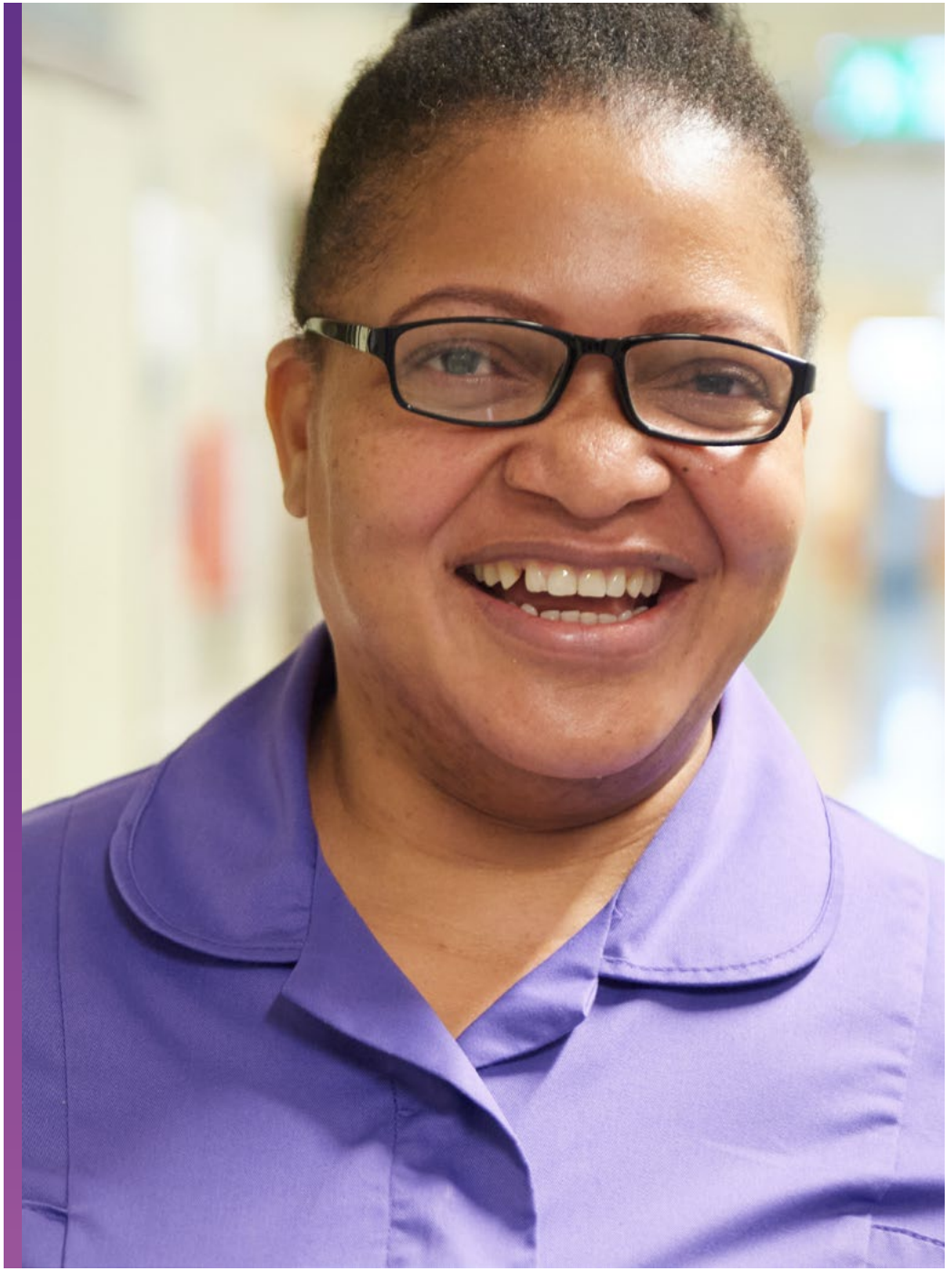


Table 1: Participation in national clinical audits and national confidential enquiries

National Clinical Audit	Eligible to participate	Participated	Comments
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
Emergency Medicine QIPs: a. Care of Older People; b. Adolescent Mental Health c. Time critical medications:	No	-	Practice Plus Group does not provide these services
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	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
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, Newborn and 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 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 Pulmonary Hypertension Audit	No	-	Practice Plus Group does not provide these services
National Bariatric Surgery Registry	No	-	Hosted service for bariatric surgery
National Cancer Audit Collaborating Centre (NATCAN)	No	-	Practice Plus Group does not provide these services
National Cardiac Arrest Audit (NCAA)	Yes	x	The frequency of cardiac arrests within our services does not 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	No	-	Practice Plus Group does not provide these services
National Early Inflammatory Arthritis Audit (NEIAA)	No	-	Practice Plus Group does not provide these services
National Emergency Laparotomy Audit (NELA)	No	-	Practice Plus Group does not provide these services
National Joint Registry (NJR)	Yes	✓	See Part 4: Local quality updates for local site participation details

National Clinical Audit	Eligible to participate	Participated	Comments
National Major Trauma Registry	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 Obesity Audit (NOA)	No	-	Practice Plus Group does not provide these services
National Ophthalmology Database (NOD) Audit a. Age-related Macular Degeneration Audit b. Cataract Audit	Yes	✓	See table 2 for overview
National Paediatric Diabetes Audit (NPDA)	No	-	Practice Plus Group does not provide these services
National Perinatal Mortality Review Tool	No	-	Practice Plus Group does not provide these services
National Respiratory Audit Programme (NRAP)	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
Perioperative Quality Improvement Programme	No	-	Currently NHS providers only
Prescribing Observatory for Mental Health (POMHUK)	No	-	Practice Plus Group does not provide these services
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	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 Benchmarking Audit (SAMBA)	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
Society for Acute Medicine Benchmarking Audit (SAMBA)	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

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

The report of one national clinical audit was reviewed by the provider in 2024/25 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

National clinical audit report	Actions in response to report recommendations
National Ophthalmic database (NOD) Up to and including 31/03/2023	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.

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

The reports of two local clinical audits were reviewed by the provider in 2024/25 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

Local clinical audit report	Findings / actions
Emergency response audit	All services must partake in a 'planned' emergency scenario every three months and at least one unplanned emergency scenario annually. The scenarios are based on the following: • Cardiac arrest • Major haemorrhage • Difficult airway (per DAS guidance) • Collapse in mobile unit All emergency scenarios are seen as learning exercises and all the outcomes shared with the entire team, regardless of whether they were present during the scenario or not.
Medicines management audits	All medicine related audits have been reviewed, updated and tested by the pharmacy teams across all sites to provide a comprehensive medicines management audit schedule which offers robust assurance SC - Controlled Drugs SC - Non medical prescribing Pathways SC - VTE pathway audit SC - Safe and secure handling of medicines in clinical areas SC - Inpatient medication chart documentation SC - Antibiotic Stewardship audit SC - Pharmacy interventions SC - Pre-labelled TTO medication audit

2.2.3 Research

The number of patients receiving relevant health services provided or subcontracted by Practice Plus Group in 2024/25 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 2024/25 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 (CQC)

Practice Plus Group is required to register with the Care Quality Commission (CQC) 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, Birmingham	Not inspected yet
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 and 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

The Care Quality Commission (CQC) has not taken enforcement action against Practice Plus Group during 2024/25.

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

2.2.6 Secondary uses service

Practice Plus Group submitted records during 2024/25 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.
- Not applicable for accident and emergency care.

2.2.7 Information governance

Practice Plus Group's 2024/25 annual Data Security and Protection (DSP) toolkit submission achieved 100% standards exceeded.

We also obtained cyber essentials plus certification recertification in July 2024, demonstrating our high standards in cyber security posture.

Practice Plus Group completed the full migration from ISO 27001:2013 to ISO 27001:2022 standards in October 2024.

During the period, Practice Plus Group has processed over 7,000 subject access requests and over the same period we have had no data breaches or enforcement actions from the regulators.

2.2.8 Payment by results

Practice Plus Group was not subject to the payment by results clinical coding audit during 2024/25 by the audit commission. Practice Plus Group's 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 in line with the Data Security and Protection Toolkit (DSPT), Data security standard one data quality and NHS digital clinical coding audit methodology.

Practice Plus Group have exceeded the terminology and classifications delivery service standards for both primary and secondary diagnoses and primary and secondary procedures.

2.2.9 Data quality

Practice Plus Group has taken the following actions to improve data quality:

Practice Plus Group has updated and published the following policies:

- The Practice Plus Group information request policy.
- Subject access request redaction guidance.
- Subject access request translation guidance.

We published the audio and video recording by service users' policy, to ensure effective staff guidance for managing such requests from service users.

Practice Plus Group has also enhanced the cyber security incident response plan by engaging an external consultant, to support the organisation in the planning and management of cyber incidents.

Practice Plus Group updated and enforced the requirement for all Practice Plus Group cloud-based systems to all have Multi Factor Authentication (MFA) in place in compliance with the cyber essentials plus standards.

Additionally, Practice Plus Group has implemented network controls to only allow UK-based access to our systems as a general rule and deployed an updated international access request process for rare occasions when international access is required.

2.2.10 Learning from deaths

During 2024/25 eight patients died within 30 days of care provided by a Practice Plus Group Secondary Care site. This comprised the following number of deaths which occurred in each quarter of that reporting period:

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

By 8th April 2025, six case record reviews and three investigations have been carried out in relation to 75% of the deaths included above.

In three cases a death was subjected to both a case record review and an investigation. In relation to the death occurring the fourth quarter, a case record review has been completed. This will be followed by a full investigation to inform a complaint response once the coroner's report has been issued.

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.
- One in the third quarter.
- One in the fourth quarter.

One case in the second quarter and another in the third quarter occurred more than 30 days after care was provided by a Practice Plus Group site and post mortem revealed the causes of death to be unrelated to the care provided. Consequently, neither case was reviewed further.

Zero representing 0% 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.

In relation to each quarter, this consisted of:

- Zero representing 0% for the first quarter.
- Zero representing 0% for the second quarter.
- Zero representing 0% for the third quarter.
- Zero representing 0% for the fourth quarter.

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 Network (AHSN) in Yorkshire and Humber and in the West of England.

The actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period include:

- A review of the prescription of medication to take out to include laxatives in cases where the patient was on codeine-based medication prior to admission, if they do not have laxatives already prescribed.
- Recording of observations for all patients seen at an Urgent Treatment Centre regardless of the presenting complaint.

Two case record reviews and investigations were completed after April 2024 which related to deaths which took place before the start of the reporting period.

Neither, representing 0%, of the two patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has 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 Network (AHSN) in Yorkshire and Humber and in the West of England.

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 score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	98.7%	68.4%	92.2%
England	96.8%	70.6%	89.7%

Average adjusted health gains - total **knee** replacement

	Oxford knee score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	97.2%	56.2%	81.4%
England	94.4%	61.2%	82.2%

Data source: NHS digital, patient reported outcome measures

January 2024 - January 2025 data

Health gains

Average adjusted health gains - total **hip** replacement

	Oxford hip score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	96.45%	67.80%	89.95%

Average adjusted health gains - total **knee** replacement

	Oxford knee score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	93.92%	62.70%	81.49%

Data source: Pathpoint

National comparative data have not been published since 2021/2022.

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

- The response rate for full completion of PROMS data (pre- and post-op) is 76% of eligible patients, which provides us with a significant sample size.
- We are able to triangulate this data against other metrics of patient safety and outcome, including National Joint Registry (NJR) data, revision rate, infections and returns to theatre.

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

- Analysis of outcomes across the sites, to identify interventions which are resulting in particularly good health gains.
- Continuing to work with sites with lower completion rates for the PROMS data to improve participation rate.

2.3.2 Emergency readmissions.

	2022/23	2023/24	2024/25
Practice Plus Group (local data)	0.80%	0.16%	0.20%

Data source: Datix incident reporting module / Harvest

National comparative data are not available.

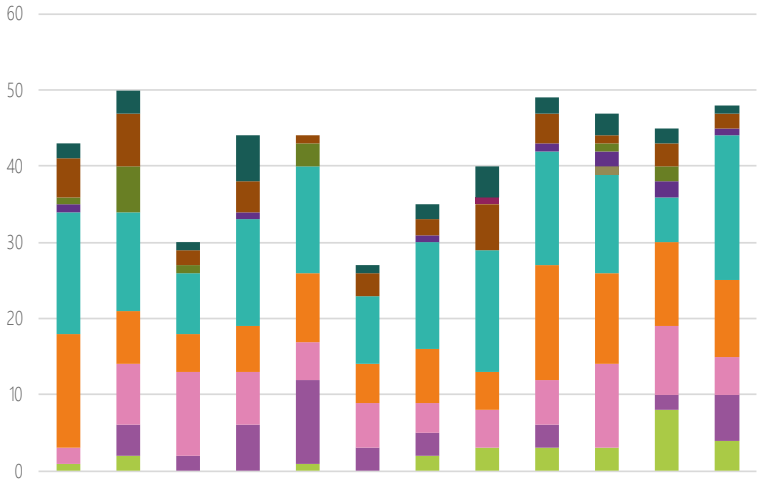
Practice Plus Group considers that this data is as described for the following reasons:

The data used to inform the rate are taken from the datix incident reporting module and Harvest data warehouse. The calculation is based on the number of emergency readmissions to Practice Plus Group sites and the NHS (68) as a percentage of the total number of patient admissions during the reporting period (12,429).

Practice Plus Group is taking the following actions to improve this rate, and so the quality of its services, by including unplanned readmissions as one of the patient safety priorities in the current Patient Safety Incident Reporting Plan (PSIRP). All patients who are readmitted following a procedure undertaken by Practice Plus Group Secondary Care have a review of the index admission care to determine whether there were any issues that could have been addressed or anticipated and thereby avoided the need for subsequent readmission. Where any issues are identified, a Patient Safety Incident Investigation will be undertaken. Remedial actions to improve the quality and safety of the care offered will be identified, implemented and monitored accordingly.

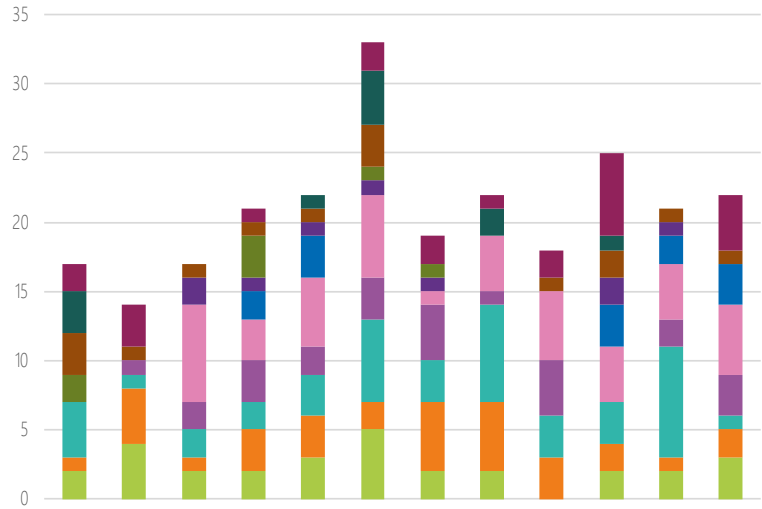
2.3.3 Responsiveness to the personal needs of patients

Number of compliments received by each site



	2024									2025		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emerson's Green Hospital	1	2			1		2	3	3	3	8	4
Ilford Hospital		4	2	6	11	3	3		3		2	6
Plymouth Hospital	2	8	11	7	5	6	4	5	6	11	9	5
Shepton Mallet Hospital	15	7	5	6	9	5	7	5	15	12	11	10
Southampton Hospital	16	13	8	14	14	9	14	16	15	13	6	19
Birmingham Hospital										1		
Devizes Surgical Centre	1			1			1		1	2	2	1
Gillingham Surgical Centre	1	6	1		3					1	2	
St Mary's Surgical Centre	5	7	2	4	1	3	2	6	4	1	3	2
Southampton UTC								1				
St Mary's Portsmouth UTC	2	3	1	6		1	2	4	2	3	2	1

Complaints received by each site



	2024									2025		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emerson's Green Hospital	2	4	2	2	3	5	2	2	0	2	2	3
Shepton Mallet Hospital	1	4	1	3	3	2	5	5	3	2	1	2
Southampton Hospital	4	1	2	2	3	6	3	7	3	3	8	1
Ilford Hospital	0	1	2	3	2	3	4	1	4	0	2	3
Plymouth Hospital	0	0	7	3	5	6	1	4	5	4	4	5
Barlborough Hospital	0	0	0	2	3	0	0	0	0	3	2	3
Devizes Surgical Centre	0	0	2	1	1	1	1	0	0	2	1	0
Gillingham Surgical Centre	2	0	0	3	0	1	1	0	0	0	0	0
St Mary's Surgical Centre	3	1	1	1	1	3	0	0	1	2	1	1
St Mary's Portsmouth UTC	3	0	0	0	1	4	0	2	0	1	0	0
Southampton UTC	2	3	0	1	0	2	2	1	2	6	0	4

Responsiveness to the personal needs of patients

A total of 250 complaints were received during the reporting period, 239 (96%) of which provided the complainant with a satisfactory resolution from the initial investigation and response at stage one. 11 complaints (i.e. 4% of complaints received during the reporting period) were escalated to stage two, whereby the complaint was not resolved to the complainant's satisfaction at stage one and a review of the complaint was requested by the managing director. One of the complaints received during the reporting period were escalated to the Parliamentary and Health Service Ombudsman (PHSO) as a stage three complaint.

77% of complaints (192/250) were acknowledged within three working days, while 38% (88/234) of complainants received a response with the outcome of the investigation within 20 working days.

22% of complaints received during the reporting period were not upheld, 40% were partially upheld and 38% were upheld.

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 the management of complaints, at stages one and two:

- Introducing code of practice for complaints management training provided by the Independent Sector Complaints Adjudication Service (ISCAS).
- Encouraging staff who manage complaints to undertake the Parliamentary and Health Service Ombudsman (PHSO) complaints standards training.
- Offering greater support at stage one of the Practice Plus Group complaints process to ensure that local level resolution is the main outcome for complaints.

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:

	2022/23	2023/24	2024/25
Practice Plus Group	44*	95%	91%

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

Whilst our rating has slightly reduced it continues to be favourable (and exceeds the comparable metric in the NHS - 64% according to the 2024 NHS staff survey) due to our on-going focus on patients, good governance, and the safe delivery of care.

*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.

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

- The Over to You survey is administered and analysed by an external, independent agency.

Practice Plus Group intends to take the following actions to improve this indicator, and so the quality of its services, by continuing our organisational focus throughout all our sites and services on patient care and a cycle of continuous improvement in terms of our related clinical governance processes, systems, functions, and frameworks.

2.3.5 Venous thromboembolism risk assessment

	2022/23	2023/24	2024/25
Practice Plus Group (local data)	97.9%	93.8%	95.9%
Best performance nationally	*	*	100%
National average	*	*	90%
Worst performance nationally	*	*	14%

Data source: NHSE at: Statistics » VTE risk assessment 2024/25

*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 2022/23 and 2023/24. National data collection resumed in April 2024.

The national quality requirement in the NHS standard contract for 2024/25, sets an operational standard of 95% of inpatients (aged 16 and over at the time of admission) undergoing risk assessments each month.

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

- VTE training as part of the mandatory training for all healthcare professionals.
- Systematic emphasis on the importance of VTE prevention at clinical governance meetings.
- Working group on VTE prevention, with a sub-group specifically working on making the electronic VTE assessment forms on the Electronic Patient Record (EPR) more user friendly (with direct support of IT team).

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

- Continuing putting VTE prevention at the forefront by assessing on all eligible patients for the risk of VTE and bleeding.
- Moving forward by focusing on the quality of prescribing of anti-thrombotic medication used and their choice tailored to the patient's specific needs.

2.3.6 C. difficile infection

	2022/23	2023/24	2024/25
Practice Plus Group (local data)	0	0	0
Best performance nationally	0	0	0
National average	115.8	135	Data not available till July 2025
Worst performance nationally	416	545	Data not available till July 2025

Data source: 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:

There have been no reported incidents of C.difficile infection in patients at Practice Plus Group.

2.3.7 Patient safety incidents

Patient safety incidents that...	2022/23		2023/24		2024/25	
...resulted in severe harm	7	0.51%	6	0.31%	3	0.10%
...resulted in death	1	0.07%	0	-	8	0.28%
...were classified as never events	1	0.07%	1	0.05%	9	0.31%
...were classified as serious incidents requiring external reporting	9	0.66%	9	0.47%	25*	0.86%*
Total number of incidents reported	1,370		1,923		2,904	

2.3.7 Patient safety incidents

*Due to the transition to the Patient Safety Incident Response Framework (PSIRF) in April 2024, the number of Patient Safety Incident Investigations (PSIIs) undertaken by the Secondary Care services are included here, since the classification of “serious incidents” has been superseded.

A review of organisational patient safety data was undertaken in April 2025 in response to the recent increase in the number of never events. The review sought to determine whether the increase in Never Event reporting indicates a patient safety issue that requires remedial action, or whether it simply reflects an improvement in reporting.

The review was undertaken using The framework for measurement and monitoring of safety, exploring the following five dimensions which should be included in any safety and monitoring approach to give a comprehensive and rounded picture of an organisation’s safety:

- Past harm: this encompasses both psychological and physical measures.
- Reliability: this is defined as ‘failure free operation over time’ and applies to measures of behaviour, processes and systems.
- Sensitivity to operations: the information and capacity to monitor safety on an hourly or daily basis.
- Anticipation and preparedness: the ability to anticipate, and be prepared for, problems.
- Integration and learning: the ability to respond to, and improve from, safety information.

A similar review of organisational patient safety data using this framework was undertaken in July 2023 to identify the patient safety priorities which would form the focus of the Practice Plus Group Secondary Care patient safety incident response plan.

There has undoubtedly been an increase in the reporting of both the number and rate of never events, incidents, escalation calls being held and the severity of incidents over recent years. Due to several variables, there is nothing to suggest that there is a correlation between the increase in incidents being reported (not just never events) and a decline in patient safety. It is more likely indicative of an improved incident reporting culture. This is reinforced by NHSE in their commentary on National Reporting and Learning System (NRLS) reporting, superseded by Learning from Patient Safety Events (LFPSE):

Increases in the number of incidents reported generally reflect an improved reporting culture and should not be interpreted as a decrease in the safety of the NHS. Equally, a decrease cannot be interpreted as an increase in the safety of the NHS.

It can be argued that staff are more likely to report incidents if it is perceived that improvements will be made in response to reporting.

Although there has been a slight increase in the ratio of harm/no harm incidents, since summer 2024 it has been reiterated that returns to theatre, transfers out and readmissions should be reported as incurring moderate harm, as a minimum, in accordance with the CQC definitions. The inclusion of these incidents as patient safety priorities appears to have resulted in further increases in reporting.

It is worth noting that the type of never events that have been reported by Practice Plus Group Secondary Care, i.e. wrong site surgery, wrong implant/prosthesis and retained foreign object post procedure, are all recognised as not having “strong systemic barriers”. This is because their prevention is reliant on administrative and behavioural controls, known to afford less effective barriers in the hierarchy of controls.

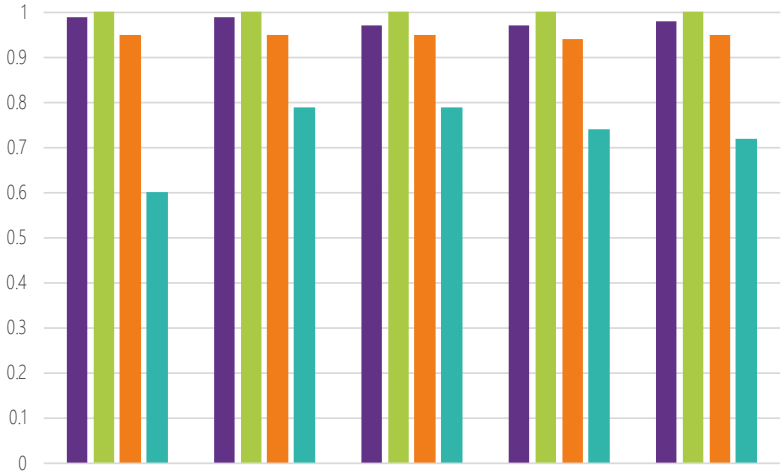
Practice Plus Group considers that this data is as described for the following reasons:

- 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 all aspects of the incident, including the severity of harm and categorisation, are recorded accurately.
- All incidents that will potentially require a patient safety incident investigation are reviewed by a panel led by the medical director and chief nurse.

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

- Involvement of a patient safety partner in the review of patient safety incident investigations.
- All clinical staff completing module one of the national patient safety syllabus as part of mandatory training.
- Repeating the patient safety culture survey to determine progress since the last survey and identify any further action.

2.3.8 Friends and family test



	Jan-21	Jan-22	Jan-23	Jan-24	Jan-25
Practice Plus Group	**99%**	**99%**	**97%**	**97%**	**98%**
Best performance nationally	100%	100%	100%	100%	100%
National average	95%	95%	95%	94%	95%
Worst performance nationally	60%	79%	79%	74%	72%

Data source: NHSE at NHS England » friends and family Test.

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

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

Practice Plus Group data is averaged across our sites and taken as at the same month end as was published for the NHS in recent years.

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

- Review of all FFT survey questions to ensure they are clear, concise and easy to understand.
- All sites have reviewed the means for recording patient experience data.

2.3.10 Freedom to Speak Up (FTSU)

Practice Plus Group are committed to Freedom to Speak Up (FTSU) within our organisation. We believe that safety is paramount for our patients, relatives and colleagues. When things go wrong, we need to make sure that lessons are learnt, and things are improved. If we think something might go wrong, it's important that we all feel able to speak up to stop potential harm.

Even when things are good, but could be even better, we should feel able to say something and be confident that our suggestion will be used as an opportunity for improvement.

We formally implemented the Freedom To Speak Up initiative in April 2024 and have now have a full network of trained FTSU guardians (one per division) and champions within all sites in the divisions of our business. Each quarter we hold a FTSU champion event to ensure our colleagues feel supported in their roles and also to provide any additional training or learning that would help our colleagues grow in their remit of FTSU champions.

Practice Plus Group ensures that we are reporting the mandatory information to the National Guardians Office on a quarterly basis. We also provide the same information to the board on a six monthly basis.

We look forward to April 2025 when we will be holding a special celebration event for all our FTSU guardians and champions across Practice Plus Group. During the coming year we will be focusing on EDI and sexual safety training for our FTSU network.

Part 3:
Other information

3.1 Performance against the priorities set for 2024/25

Priority 1: Review and evaluate PSIRF implementation

We said we would:

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 monthly and there will be evidence of patient engagement in all incidents relating to our patient safety priorities.

What we have achieved:

All sites are now holding weekly stand-up datix meetings at which all open incidents are reviewed to ensure that the required learning responses are being completed, in line with the Patient Safety Incident Response Plan (PSIRP), in a timely manner. A datix dashboard has been produced to support efficient management of these meetings. Corresponding improvements are reflected in the compliance with the incident management key performance indicators:

- Incidents are reported within 24 hours of identification - 86%.
- Incidents are reviewed within three working days - 99%.
- Incidents are investigated within the timescales set out in the PSIRP - 86%.

These improvements are not quite in line with the ambitious targets that were set this time last year, but are not far short.

Power BI dashboards are still under construction due to delays caused by further upgrades to the datix incident management system to enable capacity to report directly to the national LFPSE database (Learning from Patient Safety Events) that has superseded the National Reporting and Learning System (NRLS). It is anticipated that further improvements in the incident management key performance indicators will be realised once the power BI dashboards are fully operational and sites can access their real-time performance data.

The patient safety incident improvements made in response to learning from incidents by each site are demonstrated in the local quality updates, part four. A process of local site approval of all draft patient safety incident investigation reports, followed by the central governance team approval of the reports, is supported by assessment and feedback against the Health Services Safety Investigations Body (HSSIB) learning response review and improvement tool. This tool rates the report against the following eight criteria, informed by a research study which identified the “traps to avoid” in safety investigations and report writing, and supports consistent and high-quality reports:

1. People affected by incidents are meaningfully engaged and involved.
2. The systems approach is applied.
3. ‘Human error’ is not considered as a symptom of a system problem.
4. Blame language is avoided.
5. Local rationality is considered.
6. Counterfactual reasoning is avoided.
7. Safety actions/recommendations are effective.
8. The written report is clear, easy to read and anonymised.

Priority 2: Achieve Quality Standards for Imaging (QSI)

We said we would:

We had set achieving QSI as a priority for previous years but due to a strategic change between UKAS and the RCR we have had to pause our pathway to accreditation while UKAS and the RCR completed both QSI offers. We chose to align to the RCR QSI mark as they are the diagnostic imaging subject matter experts and now that the standard has been launched, we have signed up with the RCR QSI team.

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.

What we have achieved:

Practice Plus Group has now achieved the “Working towards QSI accreditation” mark from the Royal College of Radiologists which celebrated the fact that our services are over 60% of the way towards achieving full accreditation.

This achievement recognises Practice Plus Group’s commitment to quality and patient safety in our diagnostic imaging services and the hard work of our imaging teams in getting this far.

Moving forward we will continue to work with the Royal College of Radiologists QSI team and, at the point of writing, are at the 90% completion point for full QSI accreditation across all services.

Priority 3: Enhance the perioperative pathway

We said we would:

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 pay or routes.

What we have achieved:

A gap analysis was undertaken against the GIRFT pathway, alignment of perioperative care pathway NICE and alignment of perioperative care pathway - Centre of Perioperative Care (CPOC). Key gaps were identified, and an action plan was put in place to align with the relevant guidance. From the guidance we mapped out the priorities, as below.

- Optimisation of clinical resources in the delivery of administrative processes.
- Broaden clinical acceptance criteria to allow us to see more patients.
- Safely accommodate the treatment of increasing numbers of higher acuity patients.
- Maintain continuity of our internal care pathways supported health optimisation and diagnostics.
- Reduce waste and minimise late cancellations of surgery.

The perioperative pathway review has been divided into workstreams from the gaps identified which have been led by clinical experts, had heavy engagement from all our Practice Plus Group hospitals and gone through high level ratification forums. The below covers the workstreams and the outcome of the review:

Acceptance criteria

- Widening our acceptance criteria using national guidelines.

Referral screening

- Allowing clinical staff more time to focus on clinical decisions by utilising administrative colleagues to triage or screen patients.

Monitored beds framework

- Written guidance and readiness tracker produced on how our hospitals can care for patients who require higher levels of monitoring than expected on a routine ward, but who don’t require admission to critical care.

Anaemia protocols

- Guidance and process to detect anaemia at the earliest opportunity and to start treatment for the most likely cause (iron deficiency) as soon as possible, to reduce delays.
- Patient information reviewed and updated.

Joint school

- To help patients get fit for joint surgery and reduce the risk of cancellations.
- Patient information reviewed and updated.

Introducing weekly Multi-Disciplinary Teams (MDTs) principles and guidance

- Readiness tracker developed alongside guidance to ensure joint decision-making on treating patients who may have co-morbidities or other illnesses such as dementia.
- Patient information reviewed and updated.

Skin integrity guidance

- To avoid skin lesions and cuts causing last minute cancellations.
- Patient information reviewed and updated.

Consenting

- Updating on the consenting guidance to be able to deliver gold standard best practice consenting for surgical procedures in line with the GMC guidelines for consent.

Health optimisation

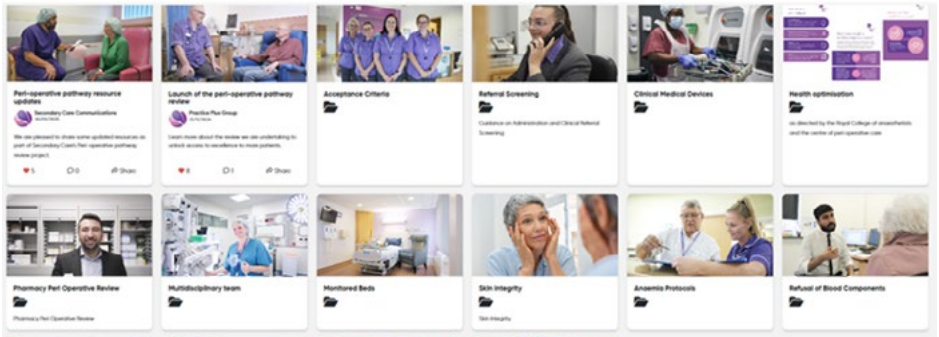
- Patient information reviewed and updated for smoking, alcohol and anxiety

Patient Passport

- Guidance for our hospitals on use of the patient passport in Practice Plus Group hospitals, surgical centres and MSK services.

The benefits of these changes will open access for patients to the treatment and care they need. All workstreams have worked alongside our business systems team to update relevant process in maxims.

An intranet page has been created for all perioperative work, pictured below.



Priority 4: Evaluate annual quality site visits

We said we would:

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 the required standards set out in the self-assessment tool.

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. 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.

What we have achieved:

All of the self-assessments have been reviewed based on use and feedback. Changes have been made to ensure there is no duplication and the questions align to the required standards. The POCT, endoscopy, resuscitation and medical governance self-assessments have also been developed.

The self-assessments are ready to share with all sites for completion for Q3 24/25.

3.2 National Joint Registry (NJR) quality data provider awards

All Practice Plus Group hospitals were awarded NJR quality data provider status for 2023/24 after successfully completing a national programme of local data audits.

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

The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers. The registry collects high quality orthopaedic data 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 achieve the award, hospitals are required to meet a series of six ambitious targets during the audit period 2023/24. One of the targets which hospitals are required to complete is compliance with the NJR’s mandatory national audit aimed at assessing data completeness and quality within the registry.

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

- Barlborough hospital (gold award).
- Emerson’s Green hospital (silver award).
- Ilford hospital (silver award).
- Plymouth hospital (gold award).
- Shepton Mallet hospital (bronze award).
- Southampton hospital (sliver award).

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 2024/25

Priority 1 - Partially achieved

We said we would:

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 we have achieved:

- 2023/24 25% utilisation.
- 2024/25 47% utilisation.

With the introduction of bariatrics and laparoscopic procedures, theatre one utilisation has increased by 22%. Ophthalmology continues to grow, and referrals are increasing. We will continue to build on this and our review of acceptance criteria should help with this.

Priority 2 - Achieved

We said we would:

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 we have achieved:

In 2023/24 we delivered 591 procedures and this has slightly increased to 611 procedures in 2024/25 with referrals continuing to increase. The revenue generated from private healthcare allows us to reinvest in key areas such as:

- Staff training and development.
- Improving facilities.
- Upgrading equipment.
- Employee benefits.

This enables us to deliver the best care to all our patients, both NHS and private, and to ensure staff are able to do their jobs to the best of their ability.

Priority 3 - Achieved

We said we would:

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

What we have achieved:

We continue to work closely with our local trusts and are currently supporting them with patients who are over 52 weeks.

In 2024/25 we have had 444 orthopaedics and general surgery referrals from local trusts (Chesterfield and Derby hospitals).

Local outcomes

Barlborough	#	%	Comments
NJR submission	2317	100	NJR Quality Data Provider Awards 2024 - Gold level
VTE risk assessment	3033	100	
VTE incidents	16	0.52%	All reviewed and no issues with care
Transfers to NHS trusts	14/4062	0.34%	SWARM completed for all transfers
Readmissions and/or return to theatre	24/4062	0.59 %	6 readmissions, 6 returns to theatre, 12 both
Surgical Site Infections (SSIs)	28		1 deep, 4 Joint space, 24 superficial
Endophthalmitis	0	n/a	None
Delay in diagnostic/treatment pathway	0	n/a	None
Incidents relating to patient harm	172/390	44.1%	
Patient Safety Incident Investigations (PSIIs)	3/172	1.74%	3 never events - 2 retained wire, 1 wrong side block
Complaints received	13/4062	0.32%	Total of 390 patient safety incidents reported. 218 were associated with no harm; 135 were associated with low minimal/ harm; 34 were associated with moderate/short-term harm. 3 Deaths
Complaints upheld/partially upheld	5/9	38%	2 partially upheld, 3 upheld, 4 still pending as being investigated

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

3 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- Staff should feel confident to raise concerns and these concerns should be taken seriously.
- Professional behaviour, open communication and teamwork are of the highest importance in maintaining a safe working environment.
- X-ray to be done in theatre before closure if there is any doubt about a retained object.

The patient safety improvements made in response to the reviews included:

- Civility saves lives training for all staff.
- Human factors training for all clinical staff.
- Wider staff involvement in patient safety incident investigations / reviews to gain a better understanding of never events and serious incidents.

14 Emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Reviews to be completed in a timely manner to ensure relevant people have input.
- Patients need to be transferred appropriately and should only be transferred if they cannot be managed safely at Barlborough.
- Patients should be followed up appropriately by the responsible consultant.

The patient safety improvements made in response to the reviews included:

- Acute Life-threatening Events Recognition and Treatment (ALERT) training for key staff.
- SLA with local trust has now been formalised and we have better communication between local trust consultants to ensure we are updated about patients progress.
- Emergency transfer grab bag is now available.

16 unplanned readmission reviews

The key learning from these reviews included:

- Investigations found there were no key themes in relation to surgeon performing the surgery or length of stay.
- All pre assessment risk assessment were completed.
- Datix need to be investigated, and readmission section completed in a timely manner.

The patient safety improvements made in response to the reviews included:

- Continuous monitoring of returns to theatre through on-going data analysis and regular reviews to identify any emerging patterns or areas for improvement.
- Surgeons need to be more involved when their patients are readmitted.

18 unplanned return to theatre reviews

The key learning from these reviews included:

- There has been an increase in post operative dislocations which may be linked to the absence of hip precautions. Thematic review underway.
- Duty of candour is completed and recorded in maxims but not always recorded on the datix.
- There are no themes identified in relation to surgeon, surgical approach, patient demographics.

The patient safety improvements made in response to the reviews included:

- Continue to report on datix and return to theatre review should be completed in a timely manner with input from orthopaedic lead.
- Duty of candour to be recorded and added to datix.
- NJR monthly reporting to capture patients who have been readmitted / returned to theatre at other providers.

16 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- VTE policies were adhered to and any discrepancies were documented with a clear explanation.
- There were no themes or trends identified on review of all reported VTE incidents.
- VTE risk assessments are always completed.

The patient safety improvements made in response to the reviews included:

- Further audit of VTE cases to explore the correlation between VTE and the use of tranexamic acid.
- Escalate to central governance team and review of current VTE policy.

5 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- All patients received prophylaxis antibiotics, however in some cases the correct dosage was not given in relation to the patients weight.
- Patients are not always to access their GP and are reluctant to return to the hospital if they are not local. This can sometime result in delays or patients redressing wounds themselves.
- Patient who are readmitted to other providers for wound issues are not routinely swabbed and undergo treatment without having a confirmed infection.

The patient safety improvements made in response to the reviews included:

- Pharmacy manager has delivered a training session for the anaesthetists around correct antibiotic prophylaxis at the last clinical governance day.
- Laminated posters of the antibiotic metric displayed in each anaesthetic room.
- More dressing clinics in outpatient's department to capture those patients who are struggling to see their GP.
- Establishing better communication with local trusts so that we are informed if patients are seen at other providers. Patients are also encouraged to contact us in the first instance so that we can advise on the best treatment plan.

24 Superficial SSI thematic reviews

The key learning from these reviews included:

- Wound swabs are done in OPD for leaking wounds where there is no other clinical signs of infection. This is potentially giving a false positive as staph aureus could just be normal skin flora and not an infection.
- All patients with wound issues are seen regularly and progress notes are added to datix.
- We have seen an increase in patients in OPD as many patients are unable to get an appointment with their GP.
- SSI risk assessments are always completed at pre assessment.

The patient safety improvements made in response to the reviews included:

- Review of dressings used in theatre.
- Antibiotic prophylaxis audits to ensure compliance.
- Information given to patients about wound care.

Learning from local patient safety priorities

Five adverse clinical outcomes (e.g. hip dislocations, leg length discrepancies) associated with the same surgeon in a six month period will prompt a thematic review.

The threshold for this local patient safety priority has not been met during the reporting period.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- Expand acceptance criteria to enable more complex patients to access the services we provide. This will improve theatre utilisation and enable us to better support our NHS partners, while continuing to provide excellent care.

What will success look like?

- Increase in referrals / conversion rates from more complex patients.
- Better theatre utilisation.

How will we monitor progress?

- Number of referrals and conversion rates.
- Theatre productivity.

Priority 2

What are we trying to improve?

- Increase reporting and investigations into post operative complications to identify themes and trends. Ensure all complications are reported on datix, even when no harm occurs and this is a recognised post op complication. Thematic reviews are to be completed where we have high instances.

What will success look like?

- Reduction in avoidable post operative complications.
- Increased reporting and investigation.
- Increased discussion at clinical governance meetings including lessons learned.
- Consultant involvement in investigations.

How will we monitor progress?

- Datix reports.
- Audit reports.

- Monthly NJR report on revisions.
- Monthly KPI dashboard which identifies post op complications - dislocations, LLD, foot drop, infections, fractures.

Priority 3

What are we trying to improve?

- Continue to empower our workforce to deliver exceptional care to all our patients in a safe environment. We are committed to increasing and upskilling our workforce in order to support Priority 1. We have introduced Acute Life-threatening Events Recognition and Treatment (ALERT) training, Nurse apprenticeship training and anaesthetic nurse training. More staff are ALS trained and we have invested resources in upgrading clinical equipment and infrastructure.

What will success look like?

- Staff will have the confidence to manage more complex patients.
- Fewer patient transfers.
- Improve staff retention (although this is already very good).
- More complex patients will have access to our services.

How will we monitor progress?

- Staff survey.
- Patient satisfaction.
- KPIs - patient transfers, readmissions, returns to theatre.
- Reputation.

Patient stories

To all the staff,

I would like to thank all the staff at Barlborough Hospital from the gentleman who took my bag up to the ward, to the ward staff, the theatre staff, reception staff, the tea lady and the receptionist who went to find my daughter because she had not got a signal.

The MRI scanner staff who looked after me very well, the surgeon who listened to me and was able to help me understand my problems - everyone!

Treatment with kindness helps and that is what I got. I don't think the queen could have got better treatment.

Thank you all so much.

To everyone at Barlborough Hospital,

Just wanted to say a huge thank you to all the staff who looked after me during my stay for a total knee replacement in December. I was really scared as it's the first time I have been in hospital but I really shouldn't have worried. All the staff were lovely and put me at ease straight away. The surgeon and anaesthetist were kind and patient with me and made sure I understood everything that would happen to me.

All the staff in theatres and on the inpatient ward really looked after me and nothing was too much trouble. I would highly recommend this hospital to anyone who needs surgery.

Thank you for everything.

Dear All,

I am writing to express my heartfelt gratitude for the exceptional care and expertise provided during my recent hip replacement surgery.

I have been deeply impressed by everyone's professionalism, kindness and dedication throughout the whole process. The surgery has been truly life changing and I am already experiencing significant improvement in my mobility and comfort, and I am optimistic about fully returning to my daily activities.

Thank you for your unwavering commitment to improving the lives of your patients. I feel incredibly fortunate to have been under your care and will always be grateful for the positive impact you have had on my health and wellbeing.

With heartfelt appreciation and kind regards.

Birmingham Hospital

Practice Plus Group Hospital, Birmingham has been operational for less than 12 months. During this time, we have identified several priorities and areas of improvement in addition to our local outcomes.

Local outcomes

Birmingham	#	%	Comments
NJR submission	36	100%	
VTE risk assessment	79	98.75%	1 patient did not have VTE assessment
VTE incidents	0	0	
Transfers to NHS trusts	0	0	
Readmissions and/or return to theatre	0	0	
Surgical Site Infections (SSIs), excl. superficial SSIs	0	0	
Endophthalmitis	0	0	
Delay in diagnostic/treatment pathway	0	0	
Incidents relating to patient harm	0	0	
Patient Safety Incident Investigations (PSIIs)	0	0	
Complaints received	0	0	
Complaints upheld/partially upheld	0	0	

Priorities for 2025/26

Priority 1

What are we trying to improve?

As a team, we are committed to ensuring all patients who require a VTE assessment are identified at the earliest opportunity. A thorough assessment should be completed during a patient's stay and any interventions or treatment should be provided at the point of assessment.

What will success look like?

Our current compliance is 98.75% which equates to one out of 79 patients not having a complete VTE assessment in place. Our priority is to ensure this figure is 100%. Whilst the tolerance level is above 95%, based on proportionality we will focus on the number of patients requiring an assessment and not the percentage compliance in isolation. Success will ultimately achieve 100% compliance however where this has not been possible, it should be clear for each incomplete assessment what the associated actions are and the rationale. Each incomplete VTE assessment should also trigger completion of a datix incident report.

How will we monitor progress?

Progress will be monitored through our monthly quality governance committee where scrutiny and assurance will be applied to track progress and accountability and form part of the committee work plan.

Priority 2

What are we trying to improve?

We are committed to improving our theatre utilisation and increasing our productivity whilst monitoring opportunities for efficiencies.

What will success look like?

It is intended that our utilisation would increase overall meaning an increase in the flow of patients through outpatients, theatres and the ward areas.

How will we monitor progress?

Utilisation and activity are monitored weekly at the activity planning meeting. A summary report will be added to the monthly quality governance committee.

Priority 3

What are we trying to improve?

Our private healthcare manager and coordinator are working hard to convert outpatient appointments into admissions. Our current performance is healthy, given our stage of mobilisation however there are opportunities to further improve. Our current conversion rate is 66% and our target conversion is 70%.

What will success look like?

Ultimately success will be demonstrated by achieving the target conversion rate. In is also anticipated that this will be reflected in our patient feedback surveys to support continuation of service provision or identify areas of improvement to further enhance operational delivery.

How will we monitor progress?

Progress will be monitored through the monthly senior leadership team board meeting, as a standing agenda item for the operations manager. This is the appropriate forum for scrutiny and assurance to be applied and accountability to be demonstrated in relation to this priority.

Patient stories

Joint sufferers willing to travel over 100 miles to a hospital to beat NHS surgery lists

A patient from North Wales, drove 103 miles over the border to Birmingham for hip surgery.

A new hospital in Birmingham is astounded by how far patients are willing to travel to get hip and knee surgery since it opened last year - and is seeing a rise in Welsh patients tired of long NHS waiting lists in the country.

Figures from the hospital show surgery patients have travelled a collective 2,228 miles for private orthopaedic treatments since its' theatres opened in January, coming from as far as North Wales (103 miles) and further south in Norwich (137 miles).

Its current lack of waiting list at the hospital is a big draw for both its private and NHS patients. However, under Welsh NHS rules, patients living in Wales are unable to be treated in English hospitals on the NHS, so it is seeing a rise in Welsh patients crossing the border to pay for faster access to orthopaedic surgeries such as hip and knee replacements.

The patient from North Wales, knew their wait time in North Wales for hip surgery on the NHS would amount to around two years, they bit the bullet and opted to pay for private surgery with Wellsoon at the new Practice Plus Group Hospital, Birmingham. They self-financed their hip replacement using some savings as a deposit and has arranged to pay the balance off with an interest free loan via Chrysalis Finance from the healthcare provider.

The patient's GP in North Wales had refused to refer her for a hip replacement as it was not deemed 'severe' enough, despite her complaining of "nauseating pain". Commenting on their decision to skip the Welsh NHS waits and go private, they said: "My job is really physical. For up to ten hours a day I am on my feet helping people and often pushing a wheelchair - which as you can imagine is torturous with tremendous hip pain. By last summer I'd had enough. My GP sent me for X-rays which showed there was some level of osteoarthritis deterioration, but he didn't feel I was a candidate for surgery. Instead, he suggested I do certain exercises to help ease my hip. I felt deflated as I wanted a more long-term solution to the pain."

The patient thought about taking matters into their own hands, but didn't have a clue where to start with choosing a private healthcare provider. But as luck would have it, she saw a leaflet for a private health service and was inspired to seriously think about private surgery option.

"Seeing a leaflet for Wellsoon private healthcare from Practice Plus Group really spurred me on and I felt hopeful that there was an option for quicker hip surgery out there. Even though I'd have to pay privately and travel some distance, I felt it would be worth it to get my life back."

The patient first travelled three hours by train to Birmingham for a consultation at its Birmingham hospital which was the closest to her home. After a successful consultation there, she later arranged for friends to ferry her by car to the hospital and back after staying in the hospital overnight for her hip replacement surgery. She comments:

"The journey home after my surgery was a little uncomfortable, but weighing that up with the prospect of waiting months for surgery was totally worth it. I'm so glad I went private rather than rely on the NHS. I loved the clear pricing too. I paid exactly what they said I would at the start and there were no hidden extras. I know some hospitals charge this for X-rays and that for extra tests, but with Wellsoon it really was as it said on their website. I chose to put down a deposit upfront and pay off the balance over the next 12 months interest-free. It's brilliant - it means I can keep my savings in my bank for longer."

Taking the initiative to go private has worked well for the patient. Despite the long distance to the hospital, they feel they're getting their life back. "Now I'm recovering I can start to think about the difference the surgery will make to my life," says the patient. "Not only will it help me day-to-day at work, but it will also give me my freedom and social life back. I'd recommend the team at Wellsoon to anyone."

Sam Doubleday, Hospital Director at the new Practice Plus Group Hospital, Birmingham, says, "We're seeing patients travel to us from all over the country since we opened our theatres in January. NHS waiting lists in some parts of the country can be arduous, especially for hip and knee surgery. Patients just want a fast, expert solution to their hip or knee troubles and often have one simple goal to enjoy life fully again without the pain its causing. It's little wonder that we're seeing private patients like this one coming from parts of Wales as its NHS lists are unfortunately amongst the longest in the UK. However, we feel hopeful that with our lack of waiting lists for both private and English NHS patients we're able to improve life for many joint pain sufferers much sooner. We're dedicated to providing the best outcomes for our patients and delighted that this one, and our other patients like them, have been pleased that they looked at alternative options rather than be stuck on a list."

Wellsoon from Practice Plus Group, offers fast access to surgery in as few as 4-6 weeks of seeing a consultant. Initial consultations cost £95 and include x-rays, bloods and swab tests. Visit practiceplusgroup.com. NHS patients in England can ask their GP for a referral to the hospital.

Devizes Surgical Centre

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would:

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

What we have achieved:

Our theatre manager has run several NatSSIPs2 sessions and will continue to run sessions and implement changes as NatSIPPs2 continues to be updated.

Our theatre manager has also created a new SOP relating to NatSIPPS2 which will come to our documentation forum for ratification shortly. We have also completed a NatSIPPS2 compliance audit in which we achieved 87% compliance.

Priority 2 - Achieved

We said we would:

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.

What we have achieved:

Within Devizes we have reported zero infections this year. IPC has been a focus of ours this year with a dedicated IPC lead supporting both Devizes and Emerson's, as well as an IPC champion based at Devizes. We have improved our accuracy in administration of medicines to take home, by reducing our incidents from 10 in 23-24, to only two in the last year 24-25.

Although our transfers appear to have increased from 0 to three, upon review and investigation this appears to be related to both improved reporting, as well as being able to take on more complex cases and being able to accept more patients with a wider range of medical conditions by expanding our suitable for surgery criteria.

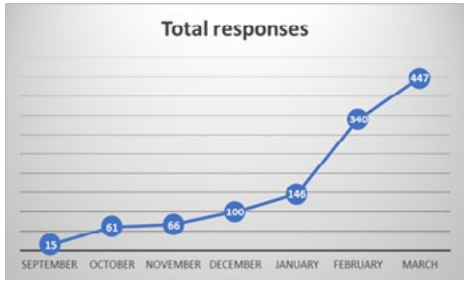
Priority 3 - Achieved

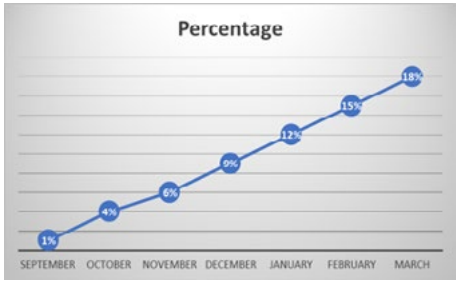
We said we would:

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.

What we have achieved:

We have created a Quality Initiative project (QI) for friends and family responses. Towards the latter half of 2024 we identified all equipment we had for the survey responses, what equipment needed replacing, upgrading and what departments had equipment gaps, and ensured by January that all departments had the necessary tools to obtain this feedback. We have increased our feedback from one percent in September, with only 15 responses for Devizes, to 18% in March, with 447 responses. We will continue to work towards our goal of 20% response rate.





We have also set up an Equality, Diversity and Inclusion (ED&I) committee which meets quarterly, and received ED&I training at our clinical governance day by our head of equality, diversity and inclusion.

Local outcomes

Devizes	#	%	Comments
Transfers to NHS trusts	3	0.04%	6,618 patients seen
Readmissions and/or return to theatre	1	0.02%	1 return to theatre
Surgical Site Infections (SSIs)	0	0%	
Endophthalmitis	0	0	None
Delay in diagnostic/treatment pathway	6	0.09%	
Incidents relating to patient harm	10/48	21%	8 Low harm 2 Moderate harm 38 No Harm
Patient Safety Incident Investigations (PSIIs)	0	0	
Complaints received	8	12%	
Complaints upheld/partially upheld	8	12%	3 upheld 5 Partially upheld

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

3 emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Staff showed the ability to promptly recognise the onset of atrial fibrillation and managed the patient appropriately.

The patient safety improvements made in response to the reviews included:

- Ensuring the staff were comfortable with the escalation process in relation to contacting the onsite anaesthetist, or they are unavailable, the on-call anaesthetist to immediately review the patient and transfer in appropriate timeframe.
- Creating a contract with Bristol ambulance as a backup to transfer patients if the NHS are not able to respond within a reasonable timeframe.
- Appointed a deputy resus lead to work with the anaesthetists to ensure we have the correct skills and equipment.

1 unplanned return to theatre review

The key learning from this review included:

- Post operative bleeding is a known complication with dental surgery and staff were aware of the signs and appropriate actions to be taken.

The patient safety improvements made in response to the reviews included:

- Empowering staff to be able to raise concerns with other colleagues, clinical lead or consultants when required.
- Ensuring staff have the correct skills and knowledge to deal with complications in Recovery and escalate when required.

Learning from local patient safety priorities

Two incidents of wrong TTA medication given to patients on discharge from the same department will prompt a thematic review and process mapping.

No incidents of wrong TTA medication given to patients on discharge from Devizes. All incidents are reviewed by our head of quality before approving, therefore multiple incidents would be identified. Our head of pharmacy is also aware of all pharmacy related incidents and will identify any trends or causes for concern.

Priorities for 2025/26

Priority 1

What are we trying to improve? Improve recording and quality of patient safety incidents

- Improve reporting of patient safety incidents by ensuring they are added to the datix reporting platform, as well as improve accuracy and quality of the reported patient safety incidents.

What will success look like?

- 95% of all incidents reported within 24 hours.
- 95% of all incidents reviewed within three days.
- 100% of investigation incidents reviewed within 20 days.

How will we monitor progress?

- Monthly reporting will allow us to identify the timeframes in which incidents have been reported and reviewed, as well as the number of incidents reported.
- Daily 10@10 huddles to discuss if any unplanned events occurred and ensure they are added to datix, as well as offer support if necessary.

- Twice weekly checks of clinical outcome on maxims to ensure relevant outcomes have been reported and added to datix if necessary.
- Weekly review of clinical cancellations to ensure avoidable incidents have been added to datix.
- Weekly standing datix meeting to review quality of datix reviews and any reoccurring issues or themes.

Priority 2

What are we trying to improve?

- ANTT compliance and training.

What will success look like?

- Bronze accreditation (as a minimum).
- 95% or higher in ANTT training compliance.
- 100% of all relevant staff trained in ANTT.

How will we monitor progress?

- ANTT Quarterly audits.
- ANTT training compliance reviewed monthly in LMS.
- Monthly review of ANTT progress in our quality review meeting.
- Quarterly review and support discussions in our IPCC meeting.

Priority 3

What are we trying to improve?

- To continue to improve our response rate from friends and family surveys (FFT) with a minimum of 30% response rate by 2026.

What will success look like?

- Consistent monthly response rate of 30% minimum.

How will we monitor progress?

- Weekly reports of departmental devices, with departments being informed when their devices were last switched on and last submitted data, as well as those highlighted if not used within two weeks.
- Weekly review of how many responses received for the hospital and the departments.
- Monthly departmental breakdown report of the amount of responses received vs the footfall in each department, with an accompanying response percentage per department for the hospital. This report is shared at HODs meeting a week prior to month end to identify any departments which require support.

Patient stories

Letter received:

“Nose is 100% better being able to breathe for the first time in 11 years is incredible! Cannot thank my doctor and the amazing staff enough for making me feel completely safe and comfortable.

This procedure has changed my life for the better.

I would recommend to anyone who asked about the practice plus group!”

Letter received:

“From start to finish the process - FANTASTIC! Mr. Gendy and his support team showed personal touch explaining the process through being attentive and responsive to any questions. The team in Devizes were helpful and accommodating, polite and thorough. After 23 years in the military this is great to think the support is there!

Thank you! Thank you! Thank you!!”

Emerson's Green Hospital

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would:

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

What we have achieved:

Our Theatre Manager has run several NatSSIPs2 sessions and will continue to run sessions and implement changes as NatSIPPs2 continues to be updated.

Our Theatre manager has also created a new SOP relating to NatSIPPS2 which will come to our Documentation Forum for ratification shortly. We have also completed a NatSIPPS2 compliance audit in which we achieved 87% compliance.

Priority 2 - Achieved

We said we would:

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.

What we have achieved:

Within Emerson's Green we have reported 11 infections this year compared to 20 the previous year.

We have appointment two IPC facilitators at Emerson's Green led by our IPC Lead.

We have been consistent in our accuracy in administration of medicines to take home, by not increasing our incidents this year.

Although our transfers appear to have increased from 11 to 15, upon review and investigation this appears to be related to both improved reporting, as well as being able to take on more complex cases and being able to accept more patients with a wider range of medical conditions by expanding our suitable for surgery criteria.

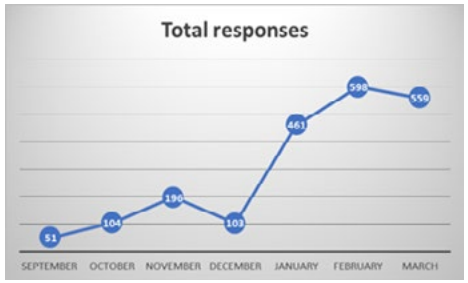
Priority 3 - Achieved

We said we would:

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.

What we have achieved:

We have created a Quality Initiative project (QI) for friends and family responses. Towards the latter half of 2024 we identified all equipment we had for the survey responses, what equipment needed replacing, upgrading and what departments had equipment gaps, and ensured by January that all departments had the necessary tools to obtain this feedback. We have increased our feedback from 1% in September, with only 51 responses for Emerson's Green, to 10% in March, with 559 responses. We will continue to work towards our goal of 20% response rate.



We have also set up an Equality, Diversity and Inclusion (ED&I) committee which meets quarterly, and received ED&I training at our clinical governance day by our head of equality, diversity and inclusion. We have also completed training with the Ward teams regarding effective and appropriate patient communication.

Local outcomes

Emerson's Green	#	%	Comments
NJR submission		97-98%	Silver award received
VTE risk assessment	9833	92%	
VTE incidents	3	0.2%	3 against 1,457 inpatients
Transfers to NHS trusts	15	0.1%	15 against 13,429 total NHS patients
Readmissions and/or return to theatre	20	0.1%	4 unplanned readmissions resulting in a return to theatre 7 unplanned readmissions 9 unplanned returns to theatre
Surgical Site Infections (SSIs)	11	0.08%	
Endophthalmitis	1	0.06%	
Delay in diagnostic/treatment path-way	8	0.06%	
Incidents relating to patient harm	91	47%	
Patient Safety Incident Investigations (PSIIs)	4	4%	
Complaints received	29	22%	
Complaints upheld/partially upheld	25	86%	2 - not upheld 17 - upheld 8 - Partially upheld 2 - Open pending investigation

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

4 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- Extended stay in hospital should have been considered for patients whose surgery is complex or having trouble with effective pain management.
- Documentation was not always accurate or complete to a required or expected standard.
- Communication can be a concern and staff need to feel empowered to be able to challenge any member of staff or question any concerns they may have around patient safety or correct processes.

The patient safety improvements made in response to the reviews included:

- Empowering staff to escalate concerns and challenge if they feel necessary.
- Created a SOP which confirmed length of stay before discharge with an option for extended length of stay where surgery has been either complex or pain management is required.
- Ensure patients are kept informed of progress in referrals and updates in their care.
- DisCo team to chase referrals when consultants are absent.
- Documentation importance reminders given to all staff, specifically theatre teams to be aware the importance of accurate documentation.

15 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Patient bathroom doors opening inwards created a risk to patient safety when a patient fell against the door blocking access.
- Newly upgraded call bell system has not always worked which has caused delays in achieving an emergency response from those required to support and attend.
- Folder on department specifically designed to support with emergency situations was found to be incredibly supportive, especially for those staff who were new or less experienced in emergency transfers.

The patient safety improvements made in response to the reviews included:

- All patient bathroom doors now open outwards to allow forced access if required.
- Any issues identified with the call bell system is noted on the daily 10@10 meeting and immediate back up processes put in place. Discussed with the providers and further upgrades to take place.
- On the morning huddle it is now identified who will be responsible for each role during an emergency situation.

11 Unplanned readmission reviews

The key learning from these reviews included:

- Correct clinical decisions made in the best interest of the patients.
- Patients readmitted the same day they called with concerns.

The patient safety improvements made in response to the reviews included:

- 24-hour post op line covered by registered nurses and not HCAs to ensure best advice given.
- Patients booked for call backs if the Doctor is unavailable to take the call at the time.

13 unplanned return to theatre reviews

The key learning from these reviews included:

- Incorrect or substandard dental advice given on the 24-hour helpline.
- Calls to the 24-hour helpline were not answered.
- Where a return to theatre was identified, patients were seen promptly.

The patient safety improvements made in response to the reviews included:

- Dental triage support given to staff on the 24-hour helpline including written advice for staff to review to
- 24-hour helpline held by registered nurses and it is identified in the morning 10@10 briefing who is responsible for the helpline that day, as well as any staffing concerns.

3 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- Patients were adequately identified as being high risk.
- Patients at extreme body weights should be considered for a more aggressive form of anticoagulation.

The patient safety improvements made in response to the reviews included:

- Work being done on ensuring the VTE assessments and incidents are always fully completed and with accurate information.

Post Infection Reviews (PIRs)

The key learning from these reviews included:

- Patients requiring extended courses of antibiotics, especially IV antibiotics should be considered for transfer for more appropriate care and monitoring as well as access to more specialist dressing.
- Staff to be aware of patients presenting with infections months after orthopaedic procedures.

The patient safety improvements made in response to the reviews included:

- Orthopaedic team reviewing wound processes and looking at alternative suture options over the use of clips.
- Improved infection reporting.
- Improving the quality of PIR reports.

1 Endophthalmitis-Specific PIR (E-PIR)

The key learning from these reviews included:

- Good compliance with WHO checklist.
- Good compliance with hand hygiene.

The patient safety improvements made in response to the reviews included:

- Theatre complete weekly cleaning audits.
- Introduction of post op calls, especially in regard to ophthalmology.
- Training for the Remote Doctor to support improved recognition of eye emergencies.

Learning from local patient safety priorities

Two incidents of wrong TTA medication given to patients on discharge from the same department will prompt a thematic review and process mapping.

Threshold for the patient safety priority not met. All incidents are reviewed by our Head of quality before approving, therefore multiple incidents would be identified. Our head of pharmacy is also aware of all pharmacy related incidents and will identify any trends or causes for concern.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- Improve quality and timeliness of data and investigations round reporting of SSIs and PIRs.

What will success look like?

- All PIR to completed within 20 working days.
- All PIR to be added to the relevant datix.

How will we monitor progress?

- Monthly reports to check how long PIR took to complete, as well as any outstanding.
- Head of quality to approve any incident requiring a PIR to ensure good quality. review and uploaded to datix.

Priority 2

What are we trying to improve?

- ANTT compliance and training.

What will success look like?

- Bronze accreditation (as a minimum).
- 95% or higher in ANTT training compliance.
- 100% of all relevant staff trained in ANTT.

How will we monitor progress?

- ANTT quarterly audits.
- ANTT training compliance reviewed monthly in LMS.
- Monthly review of ANTT progress in our quality review meeting.
- Quarterly review and support discussions in our IPCC meeting.

Priority 3

What are we trying to improve?

- To continue to improve our response rate from friends and family surveys (FFT) with a minimum of 30% response rate by 2026.

What will success look like?

- Consistent monthly response rate of 30% minimum.

How will we monitor progress?

- Weekly reports of departmental devices, with departments being informed when their devices were last switched on and last submitted data, as well as those highlighted if not used within two weeks.
- Weekly review of how many responses received for the hospital and the departments.
- Monthly departmental breakdown report of the amount of responses received vs the footfall in each department, with an accompanying response percentage per department for the hospital. This report is shared at HODs meeting a week prior to month end to identify any departments which require support.

Patient stories

Testimonial from a Welsh patient

I will first explain that for the last twelve years of my working life at Withybush General Hospital in Pembrokeshire Wales I was an occupational therapy technician working on the trauma and orthopaedic ward. My role included participating in the joint replacement schools, explaining any preparation of the home environment required to allow safe discharge, assessing for and issuing equipment, and fitting adaptations. I worked closely with the physio team to ensure the patient met the requirements for safe discharge and arrange for support if needed.

My first good news was a telephone call from Hywell Dda University health board offering me the opportunity to have my operation carried out by yourselves. This was followed up with a telephone call from Practice Plus Group confirming if I was prepared to travel to Bristol for the procedure, which I gladly confirmed I would.

Several phone calls followed with forms to complete and information leading to a pre op appointment. There was an opportunity to meet the consultant and to discuss any concerns I may have. All of the calls I received were patient focussed, polite, informative and friendly.

On arrival at Emerson's Green the reception staff were welcoming and friendly and the pre op process was carried out by a well coordinated team with a professional, friendly and reassuring approach. When I left your centre I knew I would be in good hands.

The following phone calls leading to the operation were again polite, informative and friendly and I welcomed the advice of the physio to book an additional night at the Travelodge in case my discharge was delayed.

Jill and I travelled from Pembroke the day before the operation and we stayed at the Travelodge overnight to remove any anxiety of late arrival. The reception staff at Practice Plus Group welcomed me and I was then taken to the ward to settle in. I was seen by the nurse who checked that all previous information that I had given was still current and accurately recorded my medication. She was very reassuring and her friendly attitude reduced any anxiety that I had, and the surgeon popped by to say "hello".

At the surgery waiting area I met the surgeon, anaesthetists and other support staff who were all friendly, relaxed and reassuring. The anaesthetist's assistant held a very friendly conversation up until the sedative had its effect.

I remember waking up in recovery and being fully awake back in the ward. I was surprised I enjoyed the sandwich and tea so much so soon after the operation,

I had a pain free evening and the night staff were very considerate, friendly and efficient.

The morning routines were carried out by friendly staff and the food was served with a friendly attitude. Introductions were made to the physio who would enable and assess me and the ward round was assuring and that all went well.

The physio interventions were friendly, timely and encouraging and after the check x-ray had been seen by the surgeon, discharge was planned.

I left Practice Plus Group around 2.30pm and took advantage of the extra night at the Travelodge. The long corridor there is ideal for walking practice and we left for home at about 11.00am the following day.

Since arriving home I have reduced my medication in line with advice given by the nurse, sleeping well, doing the rehab exercises and virtually pain free.

I did not expect such a well organised friendly professional team prior to being contacted by yourselves, but you exceeded any expectations that I had.

The travelodge being so close was a big bonus for us and it also accepts dogs.

You should be proud of the team and facilities you have at Practice Plus Group and please pass on my thanks to all who were involved in my journey.

Google Review

"My autistic brother recently had a wisdom tooth out at Emerson's Green dental hospital and received an outstanding service. The whole team could not have done more to support us. Excellent communication with his family/carers and a desire to make any adaptations necessary to ensure a successful experience for him. They exceeded all my expectations: this team is truly committed to providing a high standard of healthcare for people with additional needs."

Ilford Hospital

Performance against the priorities set for 2024/25

Priority 1 - Not achieved

We said we would:

Improve VTE assessment completion rate to 98% at all stages of the patient pathway.

What we have achieved:

In March 2025 97% of VTE assessments were completed and we achieved above the national target of above 95%. We will continue with monitoring actions that are in place to show an upward trajectory.

Priority 2 - Partially achieved

We said we would:

Year on year increase in number of incidents reported:

- 2022-2023 111.
- 2023-2024 158.
- 2024-2025 383.

- 98% reported within 24 hours.
- 98% reviewed within three working days.
- 95% investigated within 20 working days.

What we have achieved:

We achieved 95% in investigating our incidents within 20 working days. We were one percent away from achieving the 98% target of reporting incidents within 24 hours and reviewing incidents within three working days.

- 97% reported within 24 hours.
- 97% reviewed within three working days.
- 95% investigated within 20 working days.

We achieved our target of increasing our incident reporting. We reported 383 incidents in 2024-2025. A growth of 142% since the previous year. Our incident reporting has increased significantly through workshops, discussions and staff training, allowing a positive reporting culture.

Local outcomes

Ilford	#	%	Comments
NJR submission	725	99.72%	Practice Plus Group, Ilford was awarded the NJR Silver Award last year
VTE risk assessment	7290/ 8290	95.04%	
VTE incidents	8/8290	0.097%	8290 patients required a VTE assessment, and we have had 8 VTE related incidents against
Transfers to NHS trusts	3/8594	0.03%	
Readmissions and/or return to theatre	8/8594	0.09%	
Surgical Site Infections (SSIs)	7/8594	0.08%	7 Superficial Infections
Endophthalmitis	0	N/A	
Delay in diagnostic/treatment path-way	3/8594	0.03%	
Incidents relating to patient harm	44/383	11.4%	Total of 383 Incidents 35 were associated with low minimal/ harm 9 were associated with moderate/short-term harm 339 were associated No harm 0 Deaths
Patient Safety Incident Investigations (PSIIs)	4/44	9%	There were 4 incidents that we undertook patient safety investigations for. Three of which are currently being investigated. 1 investigation is complete.
Complaints received	27/8594	0.31%	26 x Stage 1 complaints 1 x Stage 3 complaint
Complaints upheld/partially upheld	15/27	55.5%	7 Upheld 8 Partially Upheld 12 Not Upheld All but one complaint received during the reporting period have provided the complainant with a satisfactory resolution from the initial investigation and response at stage 1. One complaint was escalated to stage 3. 100% of complaints (27/27) were acknowledged within 3 working days, 96% of complainants received a response with the outcome of the investigation within 20 working days

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

4 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- The need to improve communication within team brief.
- Missed opportunities, during the perioperative period, to refer the patient to NHS haematology clinic.
- Communication failure at multiple levels.
- Staff undertaking PSII need training on how to complete PSII.

The patient safety improvements made in response to the reviews included:

- SOP introduced for escalation of abnormal blood results.
- Raising awareness among current resident doctors of the importance of discharge letters to GP.
- Virtual anaesthetist clinic slot is created every Friday, on a rolling basis, in maxims.
- Staff have been signposted to training.

3 emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Staff communication with colleagues has been of a good standard.
- The communication between the hospital and local trust has been good and patients have been transferred in a timely manner.
- Where patients clinical condition has become a concern escalation has taken place appropriately.

The patient safety improvements made in response to the reviews included:

- Ensure good working relationships with our local trust/adjoining hospital.
- Ensure we continue to monitor patients closely post operatively and transfer them as soon as the need is identified.
- Have key members are present at SWARM.

8 unplanned readmission reviews

The key learning from these reviews included:

- Patients were not contacting us in the first instance, and we were being made aware of the patient's readmission to another trust during their post op phone call.
- The learning response has not always been completed within the timescales due to the delay in obtaining all the information for readmissions at other trusts.
- 88% of our readmissions were to a local trust, of these 29% were accident and emergency attendances.

The patient safety improvements made in response to the reviews included:

- Patients are given information on the 24-hour helpline at discharge and know how to contact us with concerns. All contact is being documented.
- The time scale of the learning responses is shared with the investigator ensuring that progress notes are made clearly highlighting any delays with completion. This is also monitored at weekly datix meetings.
- All patients receive a post operative phone call to try and anticipate these issues.

8 unplanned return to theatre reviews

The key learning from these reviews included:

- Patients are contacted following a return to theatre at another hospital and duty of candour is undertaken.
- Deficiencies in documentation.
- Clinical care provided was in line with best practices.

The patient safety improvements made in response to the reviews included:

- Verbal duty of candour to be documented clearly in the notes.
- We monitor returns to theatre regularly to look for any themes and trends emerging.
- Regular audits conducted to monitor adherence to documentation standards.

8 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- Patients had the required VTE thromboprophylaxis but we need to improve our VTE risk assessment screening to 98% from 96%.
- Quarterly audits are undertaken and shared with all staff on governance away days.
- The VTE assessment is not always signed at all stages of the assessment.

The patient safety improvements made in response to the reviews included:

- Improve the number of VTE risk assessments completed.
- Our audits have shown a consistent improvement during each quarter. In April 2024 we had achieved 90% compliance in our audit. The last audit undertaken in January 2025 showed 96% compliance.

- Individuals and teams are spoken with when identified to not be signing VTE risk assessment.

Post Infection Reviews (PIRs)

The key learning from these reviews included:

- Flu vaccine less than 72 hours before surgery a potential factor.
- Wound care advice given at discharge.
- ANTT and infection control measures were followed.

The patient safety improvements made in response to the reviews included:

- Literature has various timescales between surgery and vaccines.
- Staff updated that following any vaccine seven days should have passed prior to the patient's procedure.
- Infection risk assessment to be completed for all patients to identify high risk patients.

7 superficial SSI thematic reviews

The key learning from these reviews included:

- Completion of risk assessment in pre-operative assessment.
- Infection control lead communicated with all patients.
- Discharge instructions and teaching, wound care instructions not documented clearly.

The patient safety improvements made in response to the reviews included:

- SSI risk assessment checklist to be prepared and added in pre-operative assessment and to be completed for each patient during pre-op assessment.
- Wound swab should be taken before prescribing antibiotics to find out sensitivities.
- Patients given advise on infections at discharge and all staff to document advise given clearly.

Endophthalmitis-specific PIRs (E-PIRs)

There have been no cases of endophthalmitis during the reporting period.

Learning from local patient safety priorities

Five or more avoidable cancellations in any one month will prompt a thematic review

- We hold monthly cancellation meetings where we assess all cancellations with the heads of service. We examine themes and trends and learnings.
- Temperature and humidity has been a regular trend seen. This is being addressed with repairs. We also found that pooling patients effected avoidable cancellations resulting in a difference of opinions. We have increased in one stop appointments to prevent avoidable cancellations.
- We have seen some avoidable cancellations due to kit issues. The process for ordering kit along with timelines has been reiterated.

Delayed MDT input will prompt a SWARM huddle- we have not had a delayed MDT.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- We will increase our flu vaccination uptake.

What will success look like?

- Two thirds of our staff will be vaccinated.

How will we monitor progress?

We will hold a record of all staff that have been administered the vaccine

Priority 2

What are we trying to improve?

- PROMs data collection to improve.

What will success look like?

- 95% of PROMS will be completed.

How will we monitor progress?

- We will monitor this through the data portal.

Priority 3

What are we trying to improve?

- One stop clinics.

What will success look like?

- Patients will have a smoother pathway, a better patient experience and the wait time for nurse led appointments will decrease.

How will we monitor progress?

- The number of patients awaiting nurse led appointments will decrease.

Patient stories

Patient 1 feedback

“Sorry I cannot remember everybody names but I wish to thank the service and medical staff and bed service was excellent and couldn’t have been better. If I wasn’t married I would marry all of you, I wish you all well in everything you do”.

Patient 2 feedback

“I just wanted to say thank you to everyone who has supported me during my stay. Your support and understanding have meant everything to me. Thank you for being such an important part of my life”.

Patient 3 feedback

“Just wanted to say how very nice all the staff was and I was so worried, all the staff nurses and consultants was understanding how I was but I do want to say 100% caring nurses and doctors, great staff, I would also come here as I trust all of the staff and fantastic care they given me. PS I would always recommend this hospital”.

Patient 4 feedback

“I just want to thank you all for looking after me on 17th July 2024 for my arm/shoulder operation. Every staff member I encountered was exceptional in standard and how they helped me. I have never had such a thorough explanation of everything from Reception to assessment team, to consultant being onboarded into the ward with nurse and the team as well as in turn the consultants and surgeons then doing the operation to then being discharged in all my visits to hospital this has been such a pleasant procedure even though it’s not for the greatest of reasons, I’m very thankful to everything you all have done for me to help me. I’m not in great spirits right now due to pain but I’m so glad it’s been done quickly. I truly wish you and all the departments the best in your roles as you are all very nice to have come into contact with. I work as an operations Manager for 14+ years in recruitment, so I understand what goes into making a great team and what I expect from my own staff, really impressed with everything you all do.”

Plymouth Hospital

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would:

Optimise patients to decrease long waiters in the wider health community.

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

What we have achieved:

98 patients have been seen in our BMI clinic with 87% having a completed surgery and the other remain on active monitoring whilst they lower their weight.

Our diabetic nurse is utilised regularly with requests to review patients Hb1c results. She reviews their medical notes, and provides guidance on how to control there condition and supports them until they are deemed fit for surgery. It is often that these patients have other co-morbidities but having this service reflects the comprehensive care we are providing at Practice Plus Group Hospital, Plymouth.

276 Cornish patients have had a successful surgery within Practice Plus Group significantly reducing the long wait lists for Cornwall ICB patients

To support these priorities we have implemented a Referral to Admission (R2A) team, enhancing our pre-operative pathway with additional resources. The initiative has helped patients prepare for surgery while ensuring continuous monitoring and improved communication for those awaiting investigations or results before proceeding with surgery.

Priority 2 - Achieved

We said we would:

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

- Scrub to Surgical First Assistant (SFA) training at Plymouth University.
- Nurse apprenticeship programme / diabetic specialist nurse training / operating department practitioner apprenticeship
- Acute Life-threatening Events Recognition and Treatment (ALERT) training and programme implemented and scenario-based learning.

What we have achieved:

We have recently expanded our team with two newly qualified surgical first assistants, two new anaesthetic practitioners, three ongoing apprenticeships and we are supporting one for OPD and one for RN.

Our diabetic nurse has completed training and is now regularly seeing and advising diabetic patients. Additionally, two nurses have attended a three-day pre-operative assessment foundation course, with two more scheduled for later in the year, with the aim for all pre assessment nurses to complete the course over the next year.

To support workforce development, we have trained multiple staff as trainers in Moving and handling, venepuncture and cannulation, BLS, and ILS. We have also implemented the ALERT course, with 35 staff trained, covering 80% of our ward team.

We have a structured clinical governance day programme that takes place for a full day on alternate months. This provides all staff with the opportunity to receive essential core training relevant to their roles and departments.

Furthermore, we have recruited a clinical educator to ensure clinical competence across all departments. These initiatives demonstrate our commitment to staff development and continuous professional growth.

Priority 3 - Achieved

We said we would:

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

- Implementation of regular monthly meetings for specific groups including environmental, water, medical devices, health and safety.
- Creating terms of references for each group.

What we have achieved:

We have fully established our environmental, health and safety, medical devices, IPC and resuscitation committees, each supported by clear terms of reference.

Local outcomes

Plymouth	#	%	Comments
NJR submission		99.8%	NJR submission and upload to the NJR database successful. Gold award presented to the Hospital.
VTE risk assessment	6674/ 6802	98.11%	
VTE incidents	6/2427	0.65%	
Transfers to NHS trusts	14/6115	0.22%	
Readmissions and/or return to theatre	38/6115	0.62%	Both unplanned re-admissions resulting in return to theatre - 12 Unplanned re-admission - 23 Unplanned return to theatre - 3
Surgical Site Infections (SSIs)	43/5473	0.78%	Superficial - 40 Deep - 3 Joint - 0
Endophthalmitis	0/699	0%	
Delay in diagnostic/treatment path-way	12/6115	0.19%	
Incidents relating to patient harm	143/429	33%	Total of 429 patient safety incidents reported. 286 were associated with no harm; 116 were associated with low minimal/ harm; 26 were associated with moderate/short-term harm. 1 was associated with death.
Patient Safety Incident Investigations (PSIIs)	1/193	0.51%	
Complaints received	44/6115	0.71%	
Complaints upheld/partially upheld	41/44	93%	17 upheld, 24 partially upheld, 3 not upheld. 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 4 being escalated to stage 2. 100% of complaints (44/44) were acknowledged within 3 working days, while 91% (4/44) of complainants received a response with the outcome of the investigation within 20 working days.

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

1 Patient Safety Incident Investigation (PSII)

The key learning from these reviews included:

- A structured induction process ensures that new medical theatre staff are adequately prepared before engaging in clinical work.
- Professional behaviour and teamwork in theatres are crucial for maintaining a safe and respectful working environment.
- The anaesthetic checklist is a critical safety tool used in each theatre to verify that essential equipment and processes are ready before a procedure.

The patient safety improvements made in response to the reviews included:

- A formalised induction process should be established. A clinical educator has been recruited and will support the embedding of all induction processes.
- Staff should not participate in clinical duties until they have completed and signed off on all minimum mandatory requirements.
- Deliver further human factors and civility training to reinforce positive behaviours, enhance teamwork, and promote a culture of safety and respect in the operating theatre.
- Additional checklist columns on anaesthetic machines should be added to enhance accountability.
- All checks completed must be signed off with full signature and not just ticked.

14 Emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Timely patient reviews.
- Improved relationships and communication with neighbouring trusts.
- Timely escalation of concerns for patient deterioration.

The patient safety improvements made in response to the reviews included:

- Daily face to face ward round with all multi-disciplinary team (including surgeon, anaesthetist, resident doctor, ward manager, shift lead, physio lead) to ensure all patients are seen daily and care plan implemented.
- For any patients that remain in the hospital for three days or more must be reviewed by an MDT to ensure a plan is implemented.
- Relationship and contact details updated to ensure the consultant to consultant roles handover is always conducted and documented clearly to the receiving trust.
- ALERT course fully implemented for ward staff with 80% attended and the remainder booked on. All learning from transfers have been shared with medical teams to ensure they understand the importance of attending any request for review of patients.

38 unplanned readmission reviews

The key learning from these reviews included:

- 12/34 = 34% of re-admissions are due to wound oozing, on reviewing the themes it is notable that the majority are following knee surgery.
- Further investigation found there were no key themes in relation to surgeon performing the surgery or length of stay.
- Due to the implementation of the pre-operative assessment course, the standard of pre-operative assessment and documentation has been excellent.

The patient safety improvements made in response to the reviews included:

- A review of the Tranexamic Acid (TXA) policy is being conducted.
- Review of the post-operative instructions for patients, to ensure they understand the importance of elevation, ice therapy and physiotherapy.
- All registered nurses carrying out pre operative assessment will complete the three day pre-operative assessment training course.

15 unplanned return to theatre reviews

The key learning from these reviews included:

- While evidence has shown that hip precautions are not needed for most patients that have elective hip replacements, in some cases these precautions are appropriate and should be implemented to reduced risk of dislocation.
- The review of returns to theatres revealed no clear direct themes, as the cases varied in causes, surgical procedures and diagnoses.
- All patients had appropriate review by the medical reviews, ensuring duty of candour was completed.

The patient safety improvements made in response to the reviews included:

- Hip precautions session to be delivered to staff in outpatients, to ensure there is an understanding when hip precautions are appropriate and to inform the physio team. Continuous monitoring of returns to theatre through on-going data analysis and regular reviews to identify any emerging patterns or areas for improvement.
- When it is deemed necessary for a return to theatre, all departments must be aware, including the administrative team to ensure the appropriate slot is booked for the patient.

6 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- Our VTE policy is adhered to, and any discrepancies are clearly documented with a rationale.
- A review of all reported VTE cases found no clear pattern or correlations between VTE diagnosis and the primary surgery performed.
- While compliance of completing the VTE assessments is very good, there can be discrepancies with the risk rating.

The patient safety improvements made in response to the reviews included:

- Regular distribution of the VTE policy, for new starters including surgeons and residential doctors.
- Quarterly VTE audits are conducted to monitor compliance. The most recent audit scored 98% compliance rate, with a slight reduction due to variations in VTE assessment rating across different departments. The findings, along with key learnings and actions, were shared with the relevant departments.

3 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- All patients received prophylaxis antibiotics, however in some cases there are discrepancies in dosage of the antibiotics.
- 24 hour helpline and ward attender clinic is being heavily utilised, and patients are being invited for review quickly and care planned at the time of visit.
- Patients out of area, for example more than 30 minutes where less likely to contact the hospital and therefore there were delays in us being informed of the patient have any complications.

The patient safety improvements made in response to the reviews included:

- Antibiotic prophylaxis policy discussed heavily at our clinical governance managers days.
- Laminated cards of the antibiotic policy was printed and given to all anaesthetics and situated around the theatre department.
- Prophylaxis antibiotics to be given in our Day Surgery Unit (DSU) prior to going through to theatre.
- All staff in DSU have been listed to attend venepuncture and cannulation to support the theatre team.
- Governance contacts utilised at all surrounding trusts to ensure if a patient is admitted following surgery from Practice Plus Group Hospital, Plymouth, they will inform us in a timely manner.

40 Superficial SSI thematic reviews

The key learning from these reviews included:

- All patients received antibiotics, however in some cases there are discrepancies in dosage of the antibiotics.
- If there was a deviation from policy surrounding the dosage of antibiotics used, was limited documentation evidencing why this occurred.
- Patients consistently complete our Surgical Site Infection (SSI) questionnaire following surgery and report that they are prescribed antibiotics when visiting their GP. However, our investigation has revealed that GPs are not consistently taking a wound swab to confirm infection prior to commencing antibiotics.

The patient safety improvements made in response to the reviews included:

- Laminated cards of the antibiotic metric printed and given to all anaesthetics and situated around the theatre department.
- SSI statistics was reviewed and presented at our clinical governance day, the importance of documentation surrounding a deviation from policy on dosage was discussed to support our SSI investigation.
- We have ensured that our patient information is clear and concise, advising patients to contact us first for a wound review if they have any concerns. Additionally, we have provided feedback to the GPs.

Learning from local patient safety priorities

Medical cancellation of patient will prompt a structured case note and pathway review

All medical cancellations must be signed off by a member of the Senior Management Team (SMT) on the day of cancellation. These cancellations are then recorded in the datix system, which automatically initiates an investigation.

Recurring themes in medical cancellations are reviewed and discussed during our clinical governance day. Key issues identified include:

- Incorrect BMI documentation.
- Patients not receiving ‘stop medication’ letters.
- Incomplete review of past medical history before being deemed fit for surgery.
- To address these challenges, we have implemented a referral to admission team, which has significantly improved the process and reduced occurrences of these issues.

Ophthalmic complications will prompt a structured review of each complication and a thematic review over three months

All ophthalmic complications undergo a structured review by our optometrist and outpatient ophthalmology nurses. Any complications are documented in Datix, and appropriate investigations are conducted. Our governance assurance processes are robust, and reviewing the last years data, we have had no moderate harm incidents since establishing our patient safety priorities.

Medical devices and theatre set/kit issues will prompt a thematic review

Thematic reviews were conducted in response to ongoing issues related to theatre set and kit availability. We ensured regular reporting to our external Theatre Sterile Servicing Unit (TSSU) has been maintained, with improved compliance through the use of non-conformance forms. To enhance diligence in theatre, measures are being reinforced to ensure missing kit is not added inappropriately.

Additionally, scrub counting training has been implemented in alignment with National Safety Standards for Invasive Procedures (NatSSIPs) to improve adherence to safety protocols. Regular recurrent meetings with TSSU have been conducted to facilitate the sharing of learning and information. We are in the process of establishing our own TSSU on site, with implementation planned for late 2025.

Clinical deterioration of a post-operative patient will prompt an after-action review and PSII if deficiencies identified

All incidents requiring further investigation due to deviations in care are reviewed alongside Datix submissions.

We have implemented the Acute Life-threatening Events Recognition and Treatment (ALERT) course to train staff in identifying and responding to deteriorating patients. In April 2025, we aim to introduce the (Baseline Emergency Assessment for Clinical Healthcare) BEACH course to equip HCAs with essential skills for recognising and escalating concerns.

MDT ward rounds take place daily, with weekly meetings to discuss complex patients. Any inpatient remaining after three days undergoes an additional MDT review to trigger a tailored care plan.

Priorities for 2025/26

Priority 1

What are we trying to improve?

Referral to admissions - to improve pathway efficiency.

What will success look like?

To reduce the number of appointments and requirements for patients to attend the hospital. Patients should only need to attend the hospital four times. This is dependent on the complexity of the patients needs but the ideal standard would be:

1. First appointment and pre-operative assessment.
2. Surgery date.
3. Post-operative appointment.
4. Physio.

How will we monitor progress?

This will be monitored through a MAXIMs worklist, and an audit conducted quarterly to review the number of patient admissions to the hospital.

Priority 2

What are we trying to improve?

To implement Getting It Right First Time (GIRFT).

What will success look like?

Evidence that we have fully implemented the GRIFT recommendations and received the GRIFT accreditation.

How will we monitor progress?

We will review the implementation action plan and continuous monitoring through quarterly audits.

Priority 3

What are we trying to improve?

Patient information leaflets.

What will success look like?

Continuous reviewing of all current leaflets and prior to rolling out new documentation it will be done in conjunction with our patient forum.

All patients will be contacted within 14 days of pre-operative assessment.

How will we monitor progress?

Continuous discussion at patient forum, reviewing of patient feedback and analysis of patient cancellations to understand if they were due to misunderstanding of our patient information.

Patient stories

Patient 1:

The patient was booked to have a knee replacement, however due to his anxiety he was not able to leave his house to attend the hospital. To help and support him to overcome his anxiety about coming to hospital and having surgery, the physiotherapist team invited him to Joint School' prior to his surgery date and arranged for him to talk to other patients about their positive experiences and made sure he had all the information he needed. He had a look around the ward and staff arranged for him to come in the day before his surgery to get settled and feel comfortable in the hospital. The patient expressed his gratitude of the steps taken:

"Staff really went above and beyond to ease my anxiety!! They helped to arrange for me to come into the hospital early to enable me to settle prior to surgery. I cannot thank them enough! Having had major anxiety that prevented me attending my first operation date the physios suggested coming to joint school to try and ease my anxiety. With their help and determination I have now successfully had my surgery and physio after care."

Patient 2:

Patient had a right total knee replacement and wanted to comment on infection control.

A patient experienced a wound ooze post operatively. This resulted in multiple dressing changes and the patient complimented the nursing team on their care and actions taken to prevent an infection. The patient commented on the cleanliness of the ward and the infection control practices of the staff. The patient expressed her thanks and wanted to show her appreciation of the amazing care she had received.

Patient 3:

Patient had a left total knee replacement and would like to say thank you for the treatment he received at our lovely hospital. Patient had been unable to walk without crutches for four months. Patient is now pain free and feels the surgeon and the team have given him his life back. Patient was able to walk his daughter down the aisle at her wedding four and a half weeks after the operation and would like to thank everyone for making this a reality. Patient would also like to thank the nurses and staff on the ward who were brilliant, and nothing was too much trouble.

Patient 4:

A self-pay patient had left total hip replacement and would like to say thank you for the excellent treatment from Practice Plus Group throughout the whole process. The polite, well organised and highly professional chronology of care was very impressive. The patient would like to thank the surgeon for their expertise, pragmatic approach and carrying out the operation within a tight time frame. Also, to the anaesthetist who explained the benefits of spinal anaesthetic rather than general anaesthetic allaying the fears of a nervous patient and also to the assistant for his expertise politeness and calming influence. Thank you to the nurses and physio. The patient would like to say a special thank you to the private healthcare coordinator who was exceptionally helpful. The patient is a veteran and was impressed with the way we highlight veteran aware and how we lived up to that.

Shepton Mallet Hospital

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would

Improve medication reconciliation

- 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 cancellations and/or last-minute changes to TTAs delaying discharge.
- Create an opportunity to highlight any medicines optimisation issues prior to admission.

What we have achieved:

- Since April 2024 we have achieved 98% or above for the medicines reconciliation compliance. This is due to the pharmacy team seeing all joint arthroplasty patient prior to admission for a consultation to discuss their medications and drug allergies and sensitivities.
- All medicine reconciliations are completed using the summary care records and/or electronic patient record as the first source. The second source is the patient. This provides the patient with excellent contact with the clinical teams and an opportunity for the patient to discuss any concerns and for the pharmacist to identify any individualised prescribing which may be required.
- Medicine optimisation is enabled as the patient is seen face to face with the pharmacist and the pharmacist has the understanding of the intended procedure. Any changes to medication such as changing, stopping or adjusting medications ahead of surgery. Upon admission a nurse will document the number of medicines bought into the hospital. Their regular medications are prescribed on the inpatient drug chart and a clinical screen is performed by the pharmacist. Medicines reconciliation is now complete.

Priority 2 - Partially achieved

We said we would:

Streamline admission of inpatients

- 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.

What we have achieved:

- All patients are fully admitted on the ward, then go downstairs to be seen by the anaesthetists and then will go to theatre once ready. They will have an HCA chaperoning them while waiting before going through to theatre.
- Friends and family scores are at 100%.
- Patients see fewer staff but have longer with each staff member.
- We will roll this Priority into 2025-26. To include redesign of theatre admissions environment.

Priority 3 - Partially achieved

We said we would:

Paper free medical records

- 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.

What we have achieved:

- A reduction in paper use is being seen as scanning at source is being introduced. Cost savings will start to show throughout 2025.
- Notes are only made up for a patient at the point of consent. We have reduced the amount of paper records being created therefore working towards reducing the amount of files being stored in medical records. The patient booking team are moving to book from the worklists in the electronic patient record; if patients have had no investigations the files can now go straight from the outpatient's department

to medical records. As there are no personnel in medical records all staff now have the responsibility to track notes.

- The booking form and WHO safety checklist form are now directly in maxims to reduce amount of paper required and reducing the risk of a paper record being misfiled or lost.
- The next phase will scanning documents at source, as an example to procure devices such as ECG machines which will upload directly to the electronic paper record.

Local outcomes

Shepton Mallet	#	%	Comments
NJR submission	1740	98.17%	Bronze award achieved. Going for Gold this year.
VTE risk assessment	8862/ 9060	97.81%	9060 VTE Eligible admissions 8862 had all required VTE stages complete.
VTE incidents	2	0.1%	2 of total 2080 NHS Inpatient Admissions.
Transfers to NHS trusts	8	0.08%	All patients who were transferred out either return to the Shepton site or were discharged home from the NHS Trust.
Readmissions and/or return to theatre	15/9060	0.1%	14 Re-admissions from a total of 9060 Admissions.
Surgical Site Infections (SSIs)	11	0.1%	Superficial 9 Joint 2 PIR in progress 1
Endophthalmitis	0	0/1977	
Delay in diagnostic/treatment path-way	23	0.2%	Delays in reporting communications, recall for surveillance and one due to a late start time for the radiology department.
Incidents relating to patient harm	96	1%	314 incidents reported. 213 were associated with no harm 47 were where low harm 49 moderate harm occurred. 2 Deaths were reported to the hospital but were unrelated to treatment undertaken at the hospital. Reporting of patient safety incidents has been encouraged and is targeted daily at Safety Briefs. Any incident which can potentially cause harm or incident which has caused harm is reported.
Patient Safety Incident Investigations (PSIIs)	5	0.05%	There were 5 incidents which required a Patient Safety Incident Investigation 3 of which were Never Events resulting learning has led to changes in process, 1 delay in reporting a serious finding, 1 delay in surveillance recall from 2016. Further detailed information can be seen in the narrative below.
Complaints received	32	0.35%	97% of complaints received were responded to in 3 working days. 56% Had a response in 20 working days, 28% received a response beyond this time. Delays sometimes due to complainants asking for further questions to be answered or investigations taking longer than the statutory time period.
Complaints upheld/partially upheld	27	84%	10 partially upheld, 17 upheld, 2 not upheld, 3 are still under investigation. All complaints closed after Stage 1 resolution. No stage 2 complaints received.

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

5 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

A prosthetic implant should be checked as part of the WHO checklist process. An implant check/ pause should be completed in a methodical manner during this part of the procedure.

Reviewed and performed a gap analysis for National Safety Standards for Invasive Procedures 2 (NatSSIPs 2) created an action plan and shared this with other Practice Plus Group sites. Utilised the NatSSIPs2 link to guidance and resources: The National Safety Standards for Invasive Procedures (NatSSIPs) | centre for perioperative care.

- WHO safety champions within relevant departments to be identified and trained.
- Further human factors training to be made available particularly for those involved in invasive procedures.
- Peer review WHO audit.

- NJR prosthesis scan/checker implementation.
- Safety pin 'say it out loud' campaign.
- Two consecutive operating days with high volume numbers can cause fatigue for some surgeons, therefore surgeons preferences need to be taken into account in activity planning.
- Verbal transmission of information for writing on a board is at risk of transmission or receptive error.
- 48 hour flash completed and shared with all Practice Plus Group hospitals to learn from the incident.

The patient safety improvements made in response to the reviews included:

- Implant storage removed from inside each theatre.
- NJR prosthesis scan/checker implementation.
- Safety pin 'say it loud' campaign.
- Final check of the prosthesis will be performed just before the insertion.
- SWARM huddles.
- Processes in place to safety net checking of histology results.
- SOP for wording on pathology reports discussed with the pathology service provider and changed to ensure that abbreviations are not used.
- Any urgent referrals which are made to Shepton Mallet are rejected onwardly referred for appropriate management.

8 emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Rapid and prompt action helps prevent patient deterioration. Acting swiftly with the appropriate level of escalation helps facilitate swift transfer to appropriate acute setting.
- A mutually agreed SLA and SOP with the southwest ambulance service for emergency transfer facilitates a smooth collaborative transfer of unstable and or acutely unwell patients.
- Staff who are trained to ALS and ILS level provide excellent effective care to patients who display critical symptoms ensuring that safe interventions are made during a peri-arrest situation prior to onwards transfer to acute facility. Swift review of tests and investigation results ensures appropriate and timely treatment.

The patient safety improvements made in response to the reviews included:

- Improved documentation of critical events.
- All clinical staff undertaking ALERT course to support the ILS training and use of observation beds on the inpatient Ward.
- Where gaps in professional know have been identified, enhanced coaching and training has been provided. Local protocols have been updated and communicated to clinical teams.

14 unplanned readmission reviews

The key learning from these reviews included:

- Multicentre review of results and management plan provides effective and prompt escalation of transfer and treatment.
- Readmissions due to dislocation of total hip replacements and infection of post operative wounds. No themes emerging as to causation of dislocations. No themes emerging for infections-all infections have cultured different bacteria.
- Continue to undertake detailed monitoring of re-admissions.

The patient safety improvements made in response to the reviews included:

- Encourage patients to contact Shepton Mallet as soon as they have any concerns-advise a low threshold for seeking clinical advice.
- Review of readmission relating to gastrointestinal problem has identified that patients must be asked about their bowel habits upon admission.
- Registered nurses must take all the helpline call information and act upon it appropriately.

14 unplanned return to theatre reviews

The key learning from these reviews included:

- Reviews of the preoperative care was good to excellent. No clear themes were identified to suggest causation of dislocations.
- Some events which led to the re admission could not have been predicted.
- One readmission was due to a patient having diverticulitis which was not apparent on the patient's admission to the hospital for their index surgery.

The patient safety improvements made in response to the reviews included:

- Patients are reminded to not have hot showers when they first go home due to the risk of fainting and dislocating.
- Patients are asked when they last had their bowels opened at the point of admission to establish if they may arrive with a problem prior to their surgery.
- Patients are advised and encouraged to have a low threshold for contacting the hospital for advice on any concern relating to their surgery.

2 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- Helpline calls should be taken by register clinical staff and responded to appropriately.
- Patients may not always describe the classic symptoms of a DVT; check that clinical teams question patients' symptoms to avoid under diagnosis.
- Patients with additional risk factors have a higher likelihood of developing a DVT.
- Continue audit for VTE risk assessment - annual compliance for conducting the audit is 98%.

The patient safety improvements made in response to the reviews included:

- Helpline calls are responded to the same day as they are received.
- Helpline staff have awareness raised of the need to err on the side of caution for any pains or swellings which may be a VTE.
- Patients can still develop VTE when on prophylactic anticoagulation; patient awareness of this is very important and is reinforced by the nursing staff and pharmacists when discharge information is provided to the patient.

Post Infection Reviews (PIRs)

The key learning from these reviews included:

- Implementation of the Practice Plus Group surgical site infection risk assessment tool. This is not yet in place. IPC lead is in discussion with the Mölnlycke rep. We now have more information on their SSI risk assessment, and have arranged F2F training for staff in the next few months.

The patient safety improvements made in response to the reviews included:

- Develop a local quick reference guide or standard operating procedure for guidance on dental interventions prior to elective surgery.
- Draft/bullet points has been written and will be taken to the next SSI steering group meeting early 2025.

0 Superficial SSI thematic reviews

0 Endophthalmitis-specific PIRs (E-PIRs)

Learning from local patient safety priorities

More than five patient falls will prompt a SWARM huddle and thematic review.

22 falls occurred to patients who attended the Shepton Mallet site over the last 12 months. 12 falls occurred to patients who had recent major orthopaedic surgery to their hips and knees. Four occurred to patients on the ward following major orthopaedic surgery; in addition one following lower limb surgery and one following a hernia repair. Themes of patients exerting their independence can be seen. Of the eight falls occurring at home four were following total knee replacement and four were following total hip replacement. One resulted in an admission to hospital for re-suturing of wound, one was advised to go to ED following a fall due to a head injury with no obvious trauma. Other incidents included sensitivity to medication, dizziness in shower, tripping over own feet and incorrect use of crutches. Overall, the risk of falls is highest in the major orthopaedic surgery group with a total of 12 falls out of the 22.

More than five medication administration errors will prompt a thematic review

Thematic review undertaken no commonality observed. Resulting in no changes to SOP's processes /procedures. Staff counselling undertaken for all medication errors and additional training provided as required.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- Streamline admission of inpatients.
- Single admission for patient and reduced duplication of tasks, whilst maintaining patient safety prior to surgery.

What will success look like?

- Improvement in friends and family score.

How will we monitor progress?

- Improved continuity of care.

Priority 2

What are we trying to improve?

- We are reviewing endoscopy patient flow from referral to end of care to streamline the pathway. Looking at the electronic patient record as a reliable tool to manage the patient pathway for surveillance, fast track and diagnostics.

What will success look like?

- Reliable surveillance database from the EPR.
- Seamless onward referral where required.
- Effective use of the EPR for booking worklists.
- Having the right people in the right place at the right time; a competent workforce.
- Maintaining JAG accreditation.

How will we monitor progress?

- Maintaining JAG accreditation.
- Incident reporting.
- Patient feedback Staff feedback.
- Audit of patient surveillance database.

Priority 3

What are we trying to improve?

- LEAN project to improve the environment for patients and staff.

What will success look like?

- The premises is clean and tidy.
- The environment is well maintained.
- Improved PLACE scores.
- Everything has a purpose and place.
- Everyone has the right information presented to them in the right way.

How will we monitor progress?

- PLACE audit.
- Environmental audits.
- Implementation of the NHS England National Standards of Cleanliness 2025.

Patient stories

Patient 1: 1000th sight-saving injection at Shepton Mallet Hospital

This week saw the 1000th sight-saving treatment at a local hospital since launching its wet age-related macular degeneration (AMD) service two years ago. Coincidentally, one of the first patients to receive a life-changing injection at Practice Plus Group Hospital, Shepton Mallet, was also the team's 1000th patient - who says without them he'd likely be blind now.

One patient has been visiting the hospital's ophthalmology team once a month for two years to be treated as an NHS patient for wet AMD, after it was spotted in a routine check-up by their optician. Wet AMD is a condition that affects a person's central vision.

The patient says: "I was thrilled to help recognise this fantastic milestone at the hospital. I was one of the first patients to have wet AMD injections at Practice Plus Group Hospital, Shepton Mallet since the service was first offered there. I have since had 43 injections in total and I can certainly say with confidence that if I hadn't started coming for monthly injections I would most likely have lost my sight by now. The team are incredible, and coming in once a month I have come to know and appreciate them well.

"I was relieved that a regular check-up with my high street optician flagged the signs of wet AMD. Originally, I had gone in to be checked for glaucoma, but was told that although there were signs, what was of more concern were some nodules and bumps behind my eyes, which I was told was age-related macular degeneration, and I was referred for treatment immediately!

"At first, I was quite apprehensive about having injections in my eyes, but the team at Practice Plus Group Hospital, Shepton Mallet, put me at ease. It really wasn't as bad as I was expecting! There is a numbing cream applied first, then some iodine drops and finally the injection. It is really as they say, a bit of a sharp scratch, and you can see bubbles as the liquid goes in. Within 24 hours after the iodine has cleared from the eye, it's like nothing has happened at all. I am so grateful to the team. The macular degeneration has stabilised and I am still able to drive and do the things I enjoy.

Patient 2:

"I've struggled for years with arthritis in various parts of my body, but can honestly say that the pain in my thumbs was seriously impeding my life the most, and daily tasks became an agonising experience. I couldn't even pop a pill out of the blister pack for pain relief as I couldn't pinch or push my thumbs without searing pain. Instead I had to cut the pills out with a pair of scissors. I'd also had to invest in various tools to open jars and driving had become almost impossible.

"I first heard of the new thumb joint replacement surgery through my physio based in Somerset. I had heard of the specialist hand surgeon at Practice Plus Group Hospital in Shepton Mallet, and suggested I see my GP for a referral to see them.

''Fortunately, I was an ideal candidate for the surgery and was booked in quickly on the NHS for both of my thumbs to be scanned and assessed. When I met the surgeon, I knew I had made the right decision. I'd explained how bad my thumbs had become and how the tingling pain was starting to affect other fingers, and how constant pain was leaving me feeling exhausted. It's like having the worst toothache type pain in your thumbs all the time. The surgeon showed me the replacement joint which was like a little hinge, and I felt really reassured that this was the right surgery for me.

"My operation went really well and almost immediately I could feel my pain and range of movements improving no end. Seven weeks later I had my right thumb joint replaced too by the same surgeon. Now there is nothing I can't do. I am back to teaching and throwing clay pots. My thumbs look normal with minimal scarring and my range of joint movement is better than ever since there is no pain at all. I didn't require physio which was a blessing and have felt instantly relieved. I've recommended the surgery to other people I know - especially women - who tell me their joints have become affected during the menopause. I was lucky to have my treatment on the NHS but if I'd had to pay it would be worth every penny. The change in my life is marvellous and I don't have to worry anymore about not being able to teach. My career is definitely back on track!".

Patient 3:

One patient has been enjoying Walking Football for seven years, playing for an Axminster-based team. They were worried they'd have to pack it in last year when their hip pain became too much to bear, but then discovered they could have NHS surgery at a local private hospital much sooner than anywhere else. They've now recovered enough to put the new hip to the test this season and says Walking Football is a great solution for those looking to stay active, but don't want the risk injury associated with traditional football as it's a non-contact sport.

The patient says, "My new hip has given me the confidence to get back to my team mates. I was in a lot of pain last year and limping about a lot. I couldn't really play very well as I was in a lot of pain. I'd already had one hip replaced about a year ago, so I suspected I needed my other hip replaced as the pain was starting to become unmanageable.

NHS hospitals nearby had between a 14 month and 18 month wait, where Practice Plus Group Hospital, Shepton Mallet, had only a four-month wait. Even though it's a private hospital they still see NHS patients so I asked my GP for a referral there. Everything went really smoothly and I have been recovering well.

"I have been playing Walking Football in Axminster for a number of years now and I love it. Our team are called AWFUL - Axminster Walking Football League - and I've enjoyed weekly training sessions over the years and have made some great friends. Despite two hip operations now, I am excited to begin training again with the team and glad that I can still get involved.

Patient 4:

I would like to feedback for my two operations, August 2023 and December 2023 for partial knee replacements.

The results have been outstanding. The change to my mobility is unimaginable. Prior to the operations walking was difficult, climbing up and down stairs was painful. Sleeping was regularly interrupted with pain from my knees.

I followed religiously all the pre and post operation exercises given by the physiotherapy team. These were not easy, but I pushed through.

Now I can bend both knees nearly back to how they were years ago. Walking is fine, and in fact I have been walking some to the South West Coastal path, some parts being challenging. Cycling is great , no issues with distance or going up hills.

After sitting a long time I get stiffness when standing up and initially walking is difficult however this is improving slowly.

Thank you, to you and your team.

Patient 5:

I just want to pass on a huge thanks to all the surgeons, consultants and staff etc. at Shepton Mallet hospital. Over the last three years or so I have been a patient at your hospital several times to receive a new hip and two new knees. I cannot thank you all enough for the difference that this has made to my quality of life. Having got to a point where I could not walk 500 yards without being in severe pain, I have just managed to achieve a lifetime ambition of visiting Machu Picchu as well as many other walks and holidays that had become impossible. I had written off the possibility of visiting Machu Picchu due to my mobility issues so to actually put that back on the list, and achieve it, is a magnificent testimony to the work of Shepton Mallet hospital. Please pass on my thanks to all involved.

I attach a couple of photos to prove the point!

With huge appreciation.

Southampton Hospital

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would

We will embed the National Safety Standards for Invasive Procedures version two (NatSSIPs2) across the hospital. Monitoring of implementation will be via quarterly review and audits reported locally.

What we have achieved:

Quarterly hospital NatSSIPs2 meetings with representatives from all departments. Gap analysis undertaken. All the Team Leaders in the Operating Theatres have attended face to face Human Factors training with an emphasis on NatSSIPs2. Information available in all procedure rooms of the sequential steps. All staff training taken place. Information boards are in place in the operating theatres. Presentation to our patient forum as safety partners.

Priority 2 - Achieved

We said we would:

90% of patients who stay overnight will have To Take Out medications (TTOs) prescribed the day before discharge. Monitoring of implementation will be via auditing of prescriptions and reporting locally.

What we have achieved:

99% of all patients who stay overnight have TTO medications prescribed the day before discharge. This means there is no delay to their discharge when they are deemed medically fit for discharge home/to another care facility.

Priority 3 - Achieved

We said we would:

90% of calls to the post operative advice line will be responded to within four hours. This will mean that patients are aware of who to contact post-operatively and that they are triaged appropriately. Compliance will be monitored through the daily safety huddle and quarterly review locally.

What we have achieved:

All the previous day's calls are monitored on the daily safety huddle. 95% of all calls received are answered within the four-hour time frame and then responded to.

Local outcomes

Southampton	#	%	Comments
NJR submission	1008	97%	NJR Quality Data Provider Awards 2024 - Silver level for commitment to patient safety through the registry
VTE risk assessment	11689	98.3%	
VTE incidents	3	0.02%	
Transfers to NHS trusts	10	0.06%	Average 0.8 transfers a month, all reviewed with a SWARM Huddle
Readmissions	18	0.1%	Average 1.5 a month
Return to theatre	25	0.17%	Average 2 a month.
Surgical Site Infections (SSIs)	4	0.02%	Practice Plus Group Hospital Southampton participates in the UKHSA surveillance of arthroplasty patients.
Endophthalmitis	0	0	
Delay in diagnostic/treatment path-way	1	N/A	PSII undertaken
Incidents relating to patient harm	96	15%	15% of the incidents reported had patient harm. PPGHS are working to increase the number of near miss incidents reports. 60 were low harm 36 were moderate harm.
Patient Safety Incident Investigations (PSIIs)	3	N/A	
Complaints received	45	0.06%	
Complaints upheld/partially upheld	38	0.05%	5 not upheld, 15 upheld, 23 partially upheld, 2 still being investigated.

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

3 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- Staff receiving training on a new IT system too long before the introduction of the new system without follow-up training being provided.
- Champions needed for any new IT systems introduced within the hospital.
- Support and training of staff on how to complete PSIIs.

The patient safety improvements made in response to the reviews included:

- Additional regular departmental training on systems within the hospital.
- New role at Southampton of systems support lead has been introduced. To support the teams.

10 Emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- The key learning is that out of the total number of procedures performed only 0.06% are transferred to another provider.
- There is timely escalation of any concerns.
- All transfers are anaesthetic consultant led.
- Advice is always sought and obtained from the accepting provider.
- Every transfer is reviewed by the ward and anaesthetic team.

The patient safety improvements made in response to the reviews include:

- Practice Plus Group Hospital Southampton accepts transfers back from the transferring provider.
- This improves patient pathway care and our relationship with other providers.

18 Unplanned readmission reviews

The key learning from these reviews include:

- Any patient with a suspected surgical site infection (SSI) is always assessed by a member of the clinical team in outpatients.
- After assessment, if necessary, they are readmitted for further observation or treatment.

The patient safety improvements made in response to the reviews included:

- All pre-assessment nurses are undertaking accredited pre-assessment courses.
- Key performance indicator for post-op advice line calls has been introduced.
- Post-op advice line calls reviewed on each daily huddle.

25 unplanned return to theatre reviews

The key learning from these reviews included:

- We are reviewing any patient who has a potential infection and if necessary, they are returning to theatre for a washout and specimens taking.

3 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- The importance of recording on our local incident reporting system any possible VTE.
- The correct VTE prophylaxis and advice was given to the patients.

4 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- The importance of recording, reviewing and assessing patients who contact the post operative advice line with any potential SSI.
- The importance of continuing to participate in the UK health security agency's surgical site infection surveillance, as this allows us to track our local infection rate and compare nationally with both NHS and independent providers.

The patient safety improvements made in response to the reviews included:

- Practice Plus Group Hospital Southampton (PPGHS) has promoted Aseptic Non-Touch Technique (ANTT), with each department having an ANTT assessor.
- PPGHS were awarded the silver ANTT accreditation award in March 2025.
- A key performance indicator has been set for all advice line calls to be answered within four hours.

Learning from local patient safety priorities

An inpatient fall will prompt a SWARM huddle, followed by review at the next hospital falls meeting. All falls are also discussed at the bi-monthly quality assurance and governance meetings.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- We want incident reporting to increase by 10% across the hospital.

What will success look like?

- An increase in all incident reporting by 10%.

How will we monitor progress?

- Monthly and quarterly incident reporting.

Priority 2

What are we trying to improve?

- Upskilling our workforce to support increased acuity and activity.

What will success look like?

- 90% of nursing staff attending the Acute Life-threatening Events Recognition and Treatment (ALERT) training.
- Nurse apprenticeship programme on the inpatient ward.
- 90% of healthcare assistants attending the Bedside Emergency Assessment Course for Healthcare (BEACH) staff.

How will we monitor progress?

- Monthly training reports.

Priority 3

What are we trying to improve?

- Medicine reconciliation completed by pharmacy team - 90%.

What will success look like?

- All prescribed, OTC (over the counter), and herbal medications are verified and documented correctly by a pharmacist in >90% of admitted patients.
- TTA (to take away) prescriptions are compliant with Practice Plus Group policy and patients are appropriately counselled about them.

How will we monitor progress?

- Monthly recording of interventions by the pharmacy team. Review of any medication incidents to capture learning and improve processes.

Patient stories

Patient was referred with a history of recurrent otitis externa and a background of large right subtotal perforation in December 2019. She also had reduced hearing in the right ear and was wearing a hearing aid. She was frustrated with her symptoms which were impacting her daily life, job and mental health.

She had been seen previously at another provider who recommended surgical intervention. However, the patient decided to seek a second opinion before proceeding with any surgery. At the time of referral, she was suffering from otitis media of the right ear and was on a course of oral antibiotics.

The patient was seen for initial assessment by the surgeon on 3rd June 2024. At that time, she reported recurrent ear discharge and on odd occasions dizziness. Her hearing was also bad and although she was using a hearing aid it was not making a major difference. Upon examination her right ear showed subtotal perforation with no long process of incus, while on the left-hand side the ear drum was grossly retracted with glue ear. The hearing test carried out that day showed significant hearing loss on the right side and mild hearing loss on the left side.

The patient was listed for cortical mastoidectomy and right tympanoplasty, which was performed on 7th August 2024 and the following feedback was received from the patient via our website on 13th November 2024.

I had surgery in August. I would like to share my huge gratitude for the brilliant work and care. I had a lot of issues with my ear for over 20 years and now everything is actually normal, which I had no idea was even possible. Not only I don't have infections anymore, but my hearing improved significantly, and I no longer need to wear hearing aid, and the hearing on the operated ear is even better than my other one. I just wanted to say a huge thank you for the amazing work the surgeon did, all the care, advice and professionalism. Thank you!

Patient is an 81 year old fit and well gentleman who played a lot of golf. However, due to hip pain he could no longer walk any distance. He found himself limping and his right hip was quite stiff. He was referred to our service on 3rd July 2024 and was seen in clinic nine days later, on 12th July 2024, during which he was listed for total right hip replacement. The surgery was duly performed on 12th October 2024.

When the patient attended his post operative follow up on 15th January 2025, he reported being very pleased with the outcome of his surgery and having returned to full function.

The patient also sent a letter to the team reading as follows:

"I am absolutely delighted with the outcome of my right hip replacement. I recovered quickly and now after eight weeks have full mobility. I cannot praise highly enough the surgeon and all of the staff at Practice Plus Group. The care and attention I received could not have been bettered. Having spent 40 years in pathology at NHS hospitals, I take great pleasure in experiencing first hand that the NHS is still doing a wonderful service."

"I was given an appointment within your urology department. After having an initial consultation with him, I had numerous other appointments for CT scans, blood and urine tests culminating in a flexible cystoscopy being carried out. I must say the treatment and care I received was exemplary, professional and efficient, they are a credit to him. I have never felt in such safe hands. I was listened to and kept informed the whole time. I did joke that after preparing myself for what I assumed would be an uncomfortable/painful procedure, it was in fact less uncomfortable than some massages I have had."

Southampton Urgent Treatment Centre

Local outcomes

Southampton UTC	#	%	Comments
Unplanned reattendance within 7 days for same condition	415	0.65%	
Incidents relating to patient harm	11	0.01%	0.01% of all patients seen in the UTC. 5 were low harm 6 were moderate harm
Patient Safety Incident Investigations (PSIIs)	0	0%	
Complaints received	23	0.03%	
Complaints upheld/partially upheld	16	0.02%	4 upheld, 7 partially upheld, 9 not upheld, 2 still under investigation

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period there was no need to undertake a patient safety priority learning response in line with the Practice Plus Group Secondary Care patient safety incident response plan.

Learning from local patient safety priorities

It was decided that a thematic review would be undertaken if the monthly unplanned re-attendance rate within seven days for the same condition exceeds five percent of attendances. During 2024-25 the reattendance was under 0.65% significantly under five percent.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- We are trying to improve the electronic prescribing system used by the UTC.

What will success look like?

- The number of prescription forms (FP10s) written in the UTC will reduce, and the use of the electronic prescribing system will allow us to trend prescribing data.

How will we monitor progress?

- Through regular audits.

Priority 2

What are we trying to improve?

- We are working to improve collaborative working through having appropriate appointments bookable in the department through the 111 service.

What will success look like?

- Currently we have 31 a day, we are looking to increase this number and spread them throughout the day.

How will we monitor progress?

- Feedback through the ICB calls.

Priority 3

What are we trying to improve?

- We would like to improve the knowledge of the public regarding the use of the UTC.

What will success look like?

- Fewer complaints where expectations are not met.

How will we monitor progress?

- By analysing the complaint themes in 25-26 compared to previous years.

Patient stories

I wanted to share my heartfelt thanks at the wonderful service we received at the RSH for my son yesterday. He is autistic and medically complex and managed to fall and slice his face. When I explained to the receptionist his difficulties, she kindly escorted us to a quieter area to wait and we were triaged pretty much immediately and seen five minutes after that. All in all, in and out in 30 minutes. My son was very distressed and awkward about the whole thing, but your team were so kind, professional and efficient and made it as easy as possible. It's easy to moan but I also think it's hugely important to praise and say thank you when it's warranted. So, thank you to everyone... brilliant service in what was obviously a very overstretched service.

I wanted to say thank you to the nurse who saw me in March, she recognised how poorly I was, she sent me to Southampton A&E department via ambulance, I was diagnosed with a blood clot which turned into sepsis, I feel had I not been seen on the day by such a knowledgeable staff member my outcome could have been very different. I am now well on the way to making a full recovery.

St. Mary's Portsmouth Surgical Centre

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would:

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 we have achieved:

A total of 15 complaints raised for 2024 (1st April 2024 to 31st March 2025) the themes included procedure cancellations, staff behaviour, two joint complaints with local trust regarding appointments delays, and one complaint relating to care provision during ophthalmology procedure. The Key Performance Indicators (KPIs) have been achieved and met within the required timeframe for acknowledgment of complaints, including the provision of holding letters if required, for extension due to obtaining patients notes. All compliments are recorded on the datix system and the friends and family feedback (FFT) is consistently above 90% for St. Mary's, Portsmouth Surgical Centre.

Priority 2 - Achieved

We said we would:

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 we have achieved:

Quality Improvement Initiative (QIP) embedded for pre-operative calls, the re-implementation of pre-operative phone calls to support DNAs and cancellations. Endoscopy have started pre op calls and seen an improvement in no on the day cancellations. The implementation of pre-operative calls for general surgery lists commenced in 2025. A post-operative calls Standard Operating Procedure (SOP) is to be ratified.

All patients are giving a phone number when their appointment is booked so that they can contact for any changes. After their appointment they are provided with various phone numbers for the alternative departments that they may require. When an appointment is booked for a patient, they are provided with contact details of the outpatient department that they can contact if they have any questions/queries.

Patients are sent a health questionnaire to fill in prior to their appointment which enables them to have time to consider any additional questions that they can bring with them on the day of surgery. At the pre-assessment additional needs and requirements are discussed so that they can assist patients. On all patient communication there is a phone number that patients can use to contact the appropriate team.

Priority 3 - Partially achieved

We said we would:

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

What we have achieved:

Quality Improvement Initiative (QIP) embedded for pre-operative calls, the re-implementation of pre-operative phone calls to support DNAs and cancellations. Endoscopy have started pre op calls and seen an improvement in no on the day cancellations. The implementation of pre-operative calls for General surgery lists commenced in 2025. A post-operative calls Standard Operating Procedure (SOP) is to be ratified.

All patients are given a phone number when their appointment is booked so that they can contact for any changes. After their appointment they are provided with various phone numbers for the alternative departments that they may require. When an appointment is booked for a patient, they are provided with contact details of the outpatient department that they can contact if they have any questions/queries.

Patients are sent a health questionnaire to fill in prior to their appointment which enables them to have time to consider any additional questions that they can bring with them on the day of surgery. At the pre-assessment additional needs and requirements are discussed so that they can assist patients. On all patient communication there is a phone number that patients can use to contact the appropriate team.

Weekly cancellation meeting chaired by clinical governance manager and attended by heads of department, bookings team and head of clinical services. A cancellation form and spreadsheet has been created with full details of the rational for a cancellation. All avoidable cancellations are recorded on datix since 2025 and investigated.

Local outcomes

St. Mary's, Portsmouth	#	%	Comments
Transfers to NHS trusts	5		1st April 2024 (SWARM) 1st May 2024 1st June 2024 1st August 2024, 1st September 2024 (PSII investigation) and 1st October 2024 (SWARM).
Readmissions and/or return to theatre	1		Unplanned readmission 1st October 2024 (PSII investigation in progress).
Surgical Site Infections (SSIs)	3		1st April 2024 superficial (Post Infection Review (PIR) 1st August 2024 Deep (Post Infection Review (PIR) and 1st February 2025.
Endophthalmitis	0		
Delay in diagnostic/treatment pathway	18		7 delays in treatment, 5 imaging delays, 2 imaging not preformed, 1 Imagining report, delay to act on, and 3 imagining delay to receive.
Incidents relating to patient harm	46		40 low (Minimal Harm) 6 Moderate 184 no harm Total 221
Patient Safety Incident Investigations (PSIIs)	2		1st September 2024 (PSII investigation in progress) 1st July 2024 relating to historic incident 2022 (PSII investigation completed).
Complaints received	15		15 stage 1 local resolution by manager.
Complaints upheld/partially upheld	8		4 upheld 4 Partially Upheld 5 Not Upheld

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

2 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- Implementation of the National Safety Standards for Invasive Procedures (Natssips2), in theatre department.
- Scanning of patient notes to be checked to ensure the scanning of documents to Medisoft is completed for every patient undergoing cataract surgery.
- Training with staff surrounding "what is a never event?" and awareness of recording never events.
- Reviewed the post operative instructions to ensure they are clear and aligned between all departments.
- All registered clinicians in process of completing ALERT course, which focuses on early escalation of a deteriorating patient.
- Staff to complete triaging training to assist with managing post procedure enquiries.

The patient safety improvements made in response to the reviews included:

- Post operative service quality improvement project initiated. Implemented a post procedure mobile phone for post operative enquiries.
- The Transfer Standard Operating Procedure (SOP) has been reviewed in partnership with local Trust.
- Teaching sessions to be conducted on surgical complications and post operative response to patient's queries.

5 emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- To ensure appropriate staff remain on site until patient is safely transferred out: no anaesthetic practitioner was present on site.
- Nil further actions required. Patient was kept safe and protocols followed for patient transfer.
- Decision on ambulance required to be taken as early as possible. This would take into account the timeline of ambulance category response. Correct process followed for the transfer of patients to local trust. Escalated early which ensured no late finish / waiting behind for an ambulance.
- Patient transferred for observation.
- To ensure staff are aware of SWARM huddle post incident and that it is documented appropriately. Correct pathway transfer of patients was adhered to and that patient is kept informed.

The patient safety improvements made in response to the reviews included:

- Local transfer SOP to be updated.
- Laminated SWARM template to be available.
- To ensure staff are aware of SWARM huddle post incident and that it is documented appropriately. Correct pathway transfer of patients was adhered to and that patient is kept informed.

0 Unplanned readmission reviews

1 unplanned return to theatre review

The key learning from this review included:

- Reviewed the post operative instructions to ensure they are clear and aligned between all departments.
- All registered clinicians in process of completing ALERT course, which focuses on early escalation of a deteriorating patient.
- Staff to complete triaging training to assist with managing post procedure enquiries.

The patient safety improvements made in response to the reviews included:

- Post operative service quality improvement project initiated. Implemented a post procedure mobile phone for post operative enquiries.
- The Transfer Standard Operating Procedure (SOP) has been reviewed in partnership with local trust.
- Teaching sessions to be conducted on surgical complications and post operative response to patient's queries.

1 Venous Thromboembolism (VTE) review

The key learning from this review included:

- Poor VTE documentation undertaken on the ward pre-operatively and post-operatively.
- Patient non-compliance with DOAC treatment upon first admission to local trust.
- Patient could not make contact post-operatively via post-operative phoneline.
- Fast administration of intravenous drugs (upon induction of anaesthesia).

The patient safety improvements made in response to the reviews included:

- Improved VTE documentation; to be completed in a concise and consistent manner.
- Review of local post-operative follow-up process.

2 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- All practice in-line with NICE and local standards. Investigation findings unremarkable.
- It has been concluded that all clinical practice was in-line with local and national guidance and recommendation. It has been queried whether an ongoing and chronic eye infection (requiring a weaning-dose of prednisolone) contributed to a post-operative infection and has since been recommended whether such chronic infections should be queried pre-operatively and considered when deciding to proceed surgically and at site-level.
- Low IPC Assurance audit scores were identified; however, it is to be noted that no outstanding actions were related to general cleaning.

The patient safety improvements made in response to the reviews included:

- Share learning from investigation with relevant people through the organisation.
- Share learning from investigation with relevant people through the organisation.
- The audit tool has since been amended to reflect up-to-date practice and audit scores have since improved (as demonstrated in July 2024).

0 Superficial SSI thematic reviews

0 Endophthalmitis-Specific PIRs (E-PIRs)

Learning from local patient safety priorities

No local patient safety priorities were identified for the surgical centre during 2024/25.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- Increase staff mandatory training completion and compliance rate.

What will success look like?

- All staff compliance rate above 90%.

How will we monitor progress?

- All staff mandatory training monitored via line manager and LMS recording.

Priority 2

What are we trying to improve?

- Increase audit completion and compliance rate.

What will success look like?

- All audit compliance rate above 90%.

How will we monitor progress?

- All audits will be monitored via the assure hub / drugs audit dashboard.

Priority 3

What are we trying to improve?

- Patient pathways and documentation.

What will success look like?

- Improved patient experience.

How will we monitor progress?

- Patient-Reported Outcome Measures (PROMS) and friends and family feedback.

Patient stories

From thank you card:

'I would like to say thank you to everyone concerned in changing my life.'

From the nurses, consultants, surgeons and receptionists my life is now back on track - thank you to each and every one of you.'

From patient call

He said "that he would like to thank everyone for his treatment in the orthopaedic department and said that we made the patients feel like they are the most important people in the world" and that he would like to thank the surgical consultant.

From friends and family

Welcoming from the reception through to testing and finally consultation. Very personable staff, very clean and tidy.

Staff were welcoming. Waiting time was minimal. I was satisfied with the options offered me.

Everyone I had contact with were very welcoming and friendly, the lady on reception, the nurse who did my scan and the consultant I saw. They gave me the information I needed and the consultant checked the other eye I had done. In fact, every time I have visited regarding my cataract surgery the service from everyone has been exemplary.

Friendly, professional staff. Clean bright waiting area. Good signage and communication. Professional and knowledgeable consultant. Clear and precise information provided.

Very impressed as soon as I entered. Lovely helpful receptionist. Didn't have to wait too long. Waiting area was clean and comfortable. The consultant was caring and understanding, informative and supportive. The nurse I saw for checks was friendly, kind and helpful. Overall, it was a pleasant and reassuring experience.

St. Mary's Portsmouth Urgent Treatment Centre

Local outcomes

St. Mary's, Portsmouth UTC	#	%	Comments
Unplanned reattendance within 7 days for same condition	0		
Incidents relating to patient harm	30		2 Deaths 20 low Minimum Harm 8 Moderate 29 No Harm 59 in total
Patient Safety Incident Investigations (PSIIs)	3		1st January 2024 (PSII completed) and 2 July 2024 (PSII completed).
Complaints received	11		3rd April 2024, 1st August 2024, 4th September 2024, 2nd November 2024, and 1st January 2025.
Complaints upheld/partially upheld	8		4 upheld 4 Partially upheld 3 not upheld Stage 1 local resolution by manager

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

3 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- Feedback to clinicians regarding documentation of reviews on behalf of other patients.
- Training sessions with reporting radiographer and practitioners to look at some pelvis imaging with osteoarthritis to support learning and development.
- Implementing change to our process for management of suspected hip fractures.
- Need for regular observations to be documented for all patients from time of arrival to discharge time especially due to regular ambulance delays resulting in patients being in the UTC for extended periods.

The patient safety improvements made in response to the reviews included:

- Documentation quality improvement project.
- Secondary clinicians to document in patient notes following supporting consultation.
- Audit of x-ray reports - peer review. Documentation audit. X-ray teaching sessions.
- Implementation of observation chart and NEWS2 score chart in resus and frailty assessment tool in all clinical assessment rooms.
- Staff training on x-ray image reviews and management of patient pathways.
- Alert training.

Learning from local patient safety priorities

No local patient safety priorities were identified for the UTC during 2024/25.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- Increase staff training compliance with wound care teaching sessions.

What will success look like?

- All staff wound care training compliance completed.

How will we monitor progress?

- All staff wound care training compliance monitored via line manager.

Priority 2

What are we trying to improve?

- Improve substantive staff recruitment and reduce bank and agency spend.

What will success look like?

- Increased staffing establishment within all working areas.

How will we monitor progress?

- Full recruitment into advertised positions.

Priority 3

What are we trying to improve?

- Increase staff mandatory training completion and compliance rate.

What will success look like?

- All staff compliance rate above 90%.

How will we monitor progress?

- All staff mandatory training monitored via line manager and LMS recording.

Patient stories

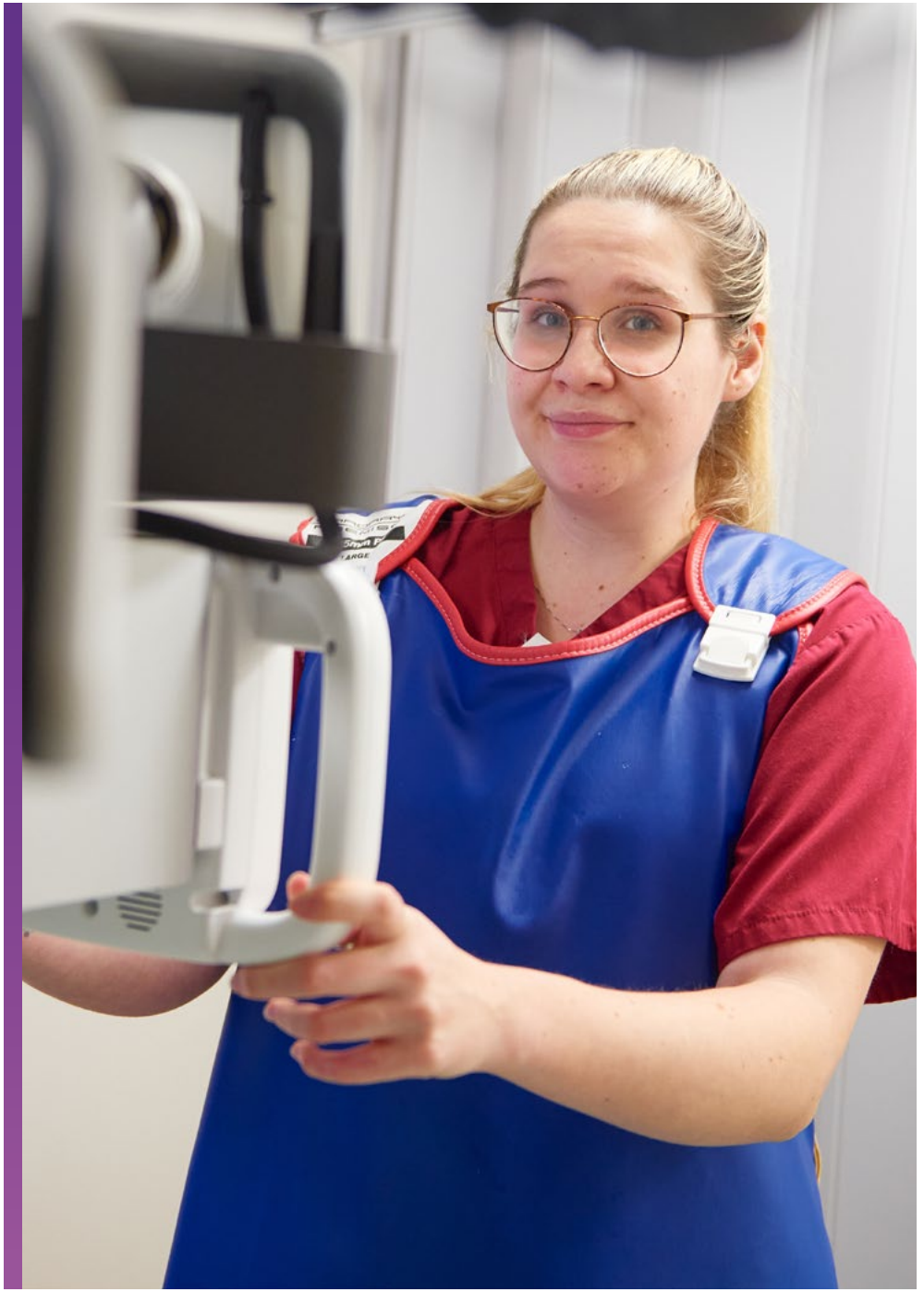
I wanted to provide feedback from my visit. I was given the best possible care from triage and the nurse practitioner. After my x-ray I was seen again and I was given advice as to what to do at home. Your staff provide an unbelievable service and I very much appreciated being seen and the advice I was given. The nurse who saw me was caring, understanding and was just an all-round wonderful human being.

I want to express my heartfelt thanks to the team at St. Mary's, in a world of constant criticism and fault finding, the team were nothing short of outstanding, from the first person I saw though to treatment, outstanding.

I want to praise the wonderful, kind, and professional staff at Portsmouth walk-in centre, on both visits the admin staff and the medical professional were first class, your staff are an absolute credit.

I had to use the walk-in centre twice in the last eight days. I saw a paramedic who described exactly what it was. He gave really good advice. His knowledge was brilliant. Yes, I waited a while but the experience and the kind way I was dealt with was great. Thank you. Today I went. Two ladies were amazing. Very courteous and professional and I was out of there in 30 minutes. This is just my opinion, but the experience has given me back the confidence in this walk-in centre. To me it has improved the patient experience from when I last went in 2024. Keep it up professionals you're all doing a great job!!

Thank you



Gillingham Surgical Centre

Performance against the priorities set for 2024/25

Priority 1 - Achieved

We said we would:

Improve our datix reporting timescales for incidents reported within 24 hours, reviewed within three days and fully investigated within 20 days to 90%+. Progress will be monitored via monthly datix meetings.

What we have achieved:

We have achieved 96% of overall compliance for the three areas of incident reporting. This is broken down into: - 98% reported within 24 hours / 96% reviewed within three days / 93% fully investigated within 20 days. There is a robust structure for reporting and reviewing of incidents which includes, daily discussion of all incident at the communication meeting and a weekly incident review meeting where all incidents are reviewed and actions agreed. Lessons learnt are shared at key hospital meetings and shared with all staff at the bi-monthly Quality Governance Assurances (QGA) day.

Priority 2 - Achieved

We said we would:

Reduce our waiting lists for general surgery patients below 45 weeks. This will be monitored through weekly utilisation and planning meeting to manage capacity and optimisation of patients on pathway.

What we have achieved:

We have achieved for the year an average waiting time of around two weeks for referral to treatment. This has been achieved by effective processes, enhanced communication with patients and teamwork by the administrative team and clinicians at the centre.

Priority 3 - Achieved

We said we would:

Provide our patients and colleagues with a clean and safe environment. Our housekeeping team will complete regular meetings and cleaning charters with heads of departments, ensuring audits are in place to drive improvements following patient survey and colleague feedback.

What we have achieved:

We have achieved and proudly display our five star cleanliness rating through the year for all our cleaning audits. The audits which are based on the national standards of healthcare cleanliness have been completed as per the centres local audit schedule. The housekeeping lead is a member of the IPC committee and meets regularly with the centre's IPC lead to review progress. All results and actions are shared with the housekeeping team, relevant departments and shared widely at the QGA days.

Local outcomes

Gillingham	#	%	Comments
Transfers to NHS trusts	1/7,567	0.01%	22nd January 2025 (SWARM).
Readmissions and/or return to theatre	4/7,567	0.05%	13th September 2024 - returned to theatre / 21st November 2025 return to theatre / 17th December - return to theatre / 10th January - unplanned readmission.
Surgical Site Infections (SSIs)	4/7222	0.05%	1 eye superficial infection - August 2024 3 Orthopaedic patients all superficial infections - March 2025.
Endophthalmitis	0/345	0%	
Delay in diagnostic/treatment pathway	11/7,567	0.15%	1 delay in treatment 1 imaging not performed 3 reporting failures - pathology 5 delay to receive - pathology 1 pathology test not performed
Incidents relating to patient harm	10	3.28%	277 No harm 17 Low harm 10 Moderate harm Total = 304
Patient Safety Incident Investigations (PSIIs)	0	0%	
Complaints received	7/7,362	0.09%	7 stage 1 - local resolution.
Complaints upheld/partially upheld	0	0%	Upheld - 2 Partially upheld - 0 Not upheld - 5

Learning from Practice Plus Group Secondary Care patient safety priorities

During the reporting period the following patient safety priority learning responses were undertaken, in line with the Practice Plus Group Secondary Care patient safety incident response plan:

No Patient Safety Incident Investigations (PSIIs)

1 emergency transfer SWARM huddles, supported by SEIPS analysis

The key learning from this review included:

- To ensure that a variety of IV fluids are available within the ward environment.
- Staff to have competency training on all equipment during their induction.
- Transfer out documents to be easily accessible on the ward when required in an emergency.

The patient safety improvements made in response to the reviews included:

- All fluids now available in the treatment room on the wards and a monitoring and ordering process in place.
- New folder implemented on the ward which includes all relevant transfer out documents.
- Transfer out policy updated.
- Learning on a page completed and shared with all staff.

1 Unplanned readmission review

The key learning from this review included:

Patient was re-admitted due to wound haematoma and returned to theatre:

- All checks completed post operatively as per Practice Plus Group policy.
- Patient met the discharge criteria, no bleeding or swelling observed on discharge.

The patient safety improvements made in response to the reviews included:

- Investigation outcome showed it was a complication of surgery which was listed on the consent form.
- Correct processes followed.
- Incident discussed at key governance meetings.

3 unplanned returns to theatre reviews

The key learning from these reviews included:

- Rapid response referral completed in timely fashion after incident however communication between hospitals needs improving.
- Theatre documentation on maxims to be improved to ensure more detailed description.
- Where suitable patients to return to Gillingham Surgical Centre for follow up next day post operatively for clinical review.

The patient safety improvements made in response to the reviews included:

- Meeting held with local trust ophthalmic leads regarding improving communication between sites.
- Ophthalmic pathway review undertaken with support from central team.
- Ophthalmic governance meetings reintroduced quarterly.

No Venous Thromboembolism (VTE) reviews

No Post Infection Reviews (PIRs)

Superficial SSI thematic reviews

The key learning from these reviews included:

- Anti-Microbial Resistant (AMR) sutures not used for the orthopaedic hand procedures.
- Clear instruction not given to patients on what to do if there was a possible infection.
- If patients suffer with nylon allergies no clear guidance on what sutures to use instead.

The patient safety improvements made in response to the reviews included:

- Implementing AMR sutures for key procedures.
- Review of discharge information given to patient to ensure clear wound advice is included.
- Review local allergy standard operating procedure and include nylon. Allergies and list suitable alternatives.

0 Endophthalmitis-Specific PIRs (E-PIRs)

Learning from local patient safety priorities

The centre continued to implement the Patient Safety Incident Response Framework (PSIRF) and plan.

Priorities for 2025/26

Priority 1

What are we trying to improve?

- Use the National Safety Standards for Invasive Procedures version 2 (NatSSIPs2) to continually improve adherence to safety protocols.

What will success look like?

- Through the creation of an action plan which will capture the implementation of: - WHO safety champions, human factors training via LMS, WHO audits and the launch of a safety campaign.

How will we monitor progress?

- The WHO quarterly audits will monitor compliance, against the NatSSIPs eight and allow us to track progress and identify any trends. Reporting and regular review of relevant incidents will enable us to monitor patient safety.

Priority 2

What are we trying to improve?

- To improve the communication of pre-operative information between departments to reduce avoidable cancellations and improving patient safety.

What will success look like?

- Reduction in the percentage of avoidable cancellations on the day of surgery from April 2024 to March 2025, compared to the previous year by 5%.

How will we monitor progress?

- Monthly audit of cancellations will be undertaken to establish themes.

Priority 3

What are we trying to improve?

- Delivering objectives identified by the new appointment Leadership team to drive an implement the quality improvement plan.

What will success look like?

- Completion of SMART objectives identified on the quality improvement plan. To ensure areas of quality improvement are robustly embedded with supporting evidence.

How will we monitor progress?

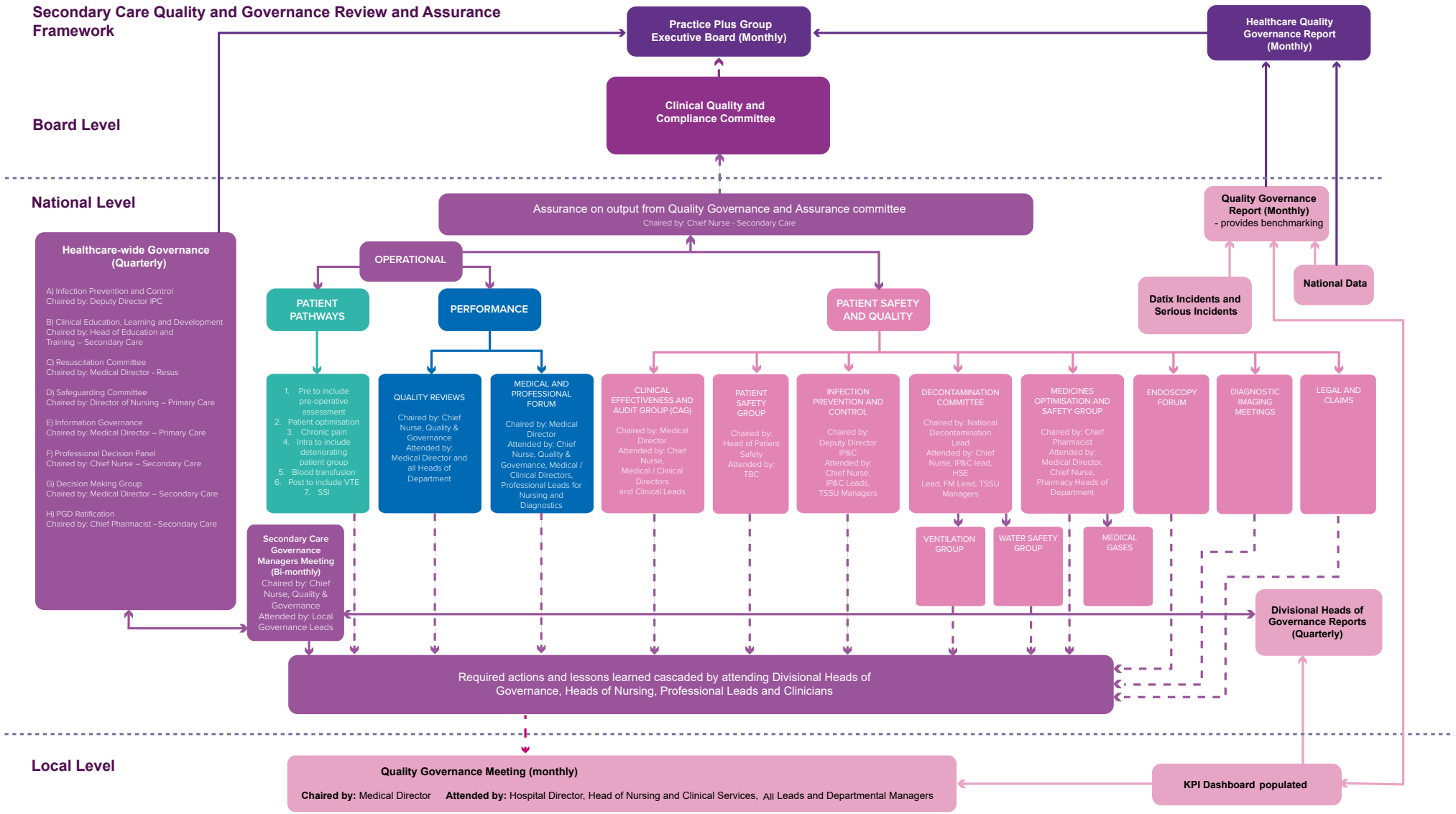
- The senior management team will hold themselves accountable to the quality improvement plan.

Patient stories

I came in for a colonoscopy at Practice Plus Group, Gillingham and all the staff helped put my mind at rest, they were all caring and amazing.

I had both my cataract procedures undertaken and from the moment I arrived at Practice Plus Group, Gillingham I was greeted with a warm “hello” and can I help you at reception. Once escorted to the ward, all the nursing staff introduced themselves and put me at ease. The consultant was a credit to their profession, overall an amazing experience, thank you.

Appendix 1: Practice Plus Group Assurance Framework



Appendix 2: 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 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 health and safety 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 Hampshire and Isle of Wight Integrated Care Board (ICB)

NHS Hampshire and Isle of Wight Integrated Care Board would like to thank Practice Plus Group for the opportunity to comment on their Quality Account for 2024/25. 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, over the last year, to seek assurances that the services delivered meet the required standards for safe, effective, and person-centred care, acting for improvement where necessary.

We supported the local improvement priorities for 2024/25 and are pleased to note the significant progress made against these. Specifically, Southampton hospital achieved all three of their improvement priorities, which included embedding the National Safety Standards for Invasive Procedures 2 (NatSSIPs2) across the hospital, which aligned with one of the Hampshire and Isle of Wight system quality priorities. Whilst not fully achieving one of their priorities, Portsmouth surgical centre successfully implemented a quality initiative to improve post-operative queries/advice and embedded a consistent and positive perioperative patient journey.

We recognise the quality and patient safety improvement work undertaken by the urgent treatment centres. This has included a documentation project and implementation of observation and national early warning score two charts in Portsmouth and the continued work in Southampton focused on decreasing the number of patients reattending within seven days for the same condition.

It is recommended that these improvements are embedded and that their impact on patient outcomes continues to be monitored during 2025/26.

We recognise that there are many other achievements noted in the Quality Account, including, but not limited to:

- Southampton hospital achieving the National Joint Registry silver award.
- Portsmouth surgical centre obtaining a ‘good’ Care Quality Commission (CQC) rating across all domains following an inspection in August 2024.

We would like to thank Practice Plus Group for facilitating our participation in their internal quality governance meetings and their annual quality visits to support our own assurance processes. Thank you for supporting local and system quality improvement by being a valued member of the patient safety specialist network.

We welcome the Practice Plus Group 2025/26 priorities for improvement outlined in the Quality Account and look forward to the sharing of improvements and examples of best practice and innovation.

NHS Hampshire and Isle of Wight are pleased to endorse the Quality Account for 2024/25 and look forward to continuing to work closely with Practice Plus Group during 2025/26 as they progress their local priorities to further improve the quality of care delivered to our population.

Yours sincerely,
Nicky Lucey
Chief Nursing Officer

NHS Somerset Integrated Care Board (ICB)

NHS Somerset integrated care board is the lead commissioner of health services from the hospital based at Shepton Mallet, which forms part of the Practice Plus Group (PPG). In line with the NHS (Quality Accounts) regulations 2011 and the amended regulations 2017, the information contained within the Practice Plus Group Quality Account has been shared with key members of staff across the ICB, it has been reviewed and checked against data sources, where this is available, and we confirm this to be accurate and fairly interpreted to the best of our knowledge.

NHS Somerset integrated care board statement for inclusion in the Practice Plus Group hospital Quality Account.

We welcome the opportunity to provide this statement and comment on your Quality Account 2024/25.

Firstly, we would like to acknowledge that the Quality Account provides good evidence of the commitment to quality improvement, the review of the 2024/25 priorities provides evidence of the achievements in the year including the implementation of the Patient Safety Incident Response Framework (PSIRF), achieving quality standards for imaging, enhancing the perioperative pathway for patients and the evaluation of annual site quality visits.

We note the six priorities for the Practice Plus Group in 2025/26:

- Co-Production and communication of learning from harm with patients and families, we acknowledge the work already undertaken in relation to PSIRF and the opportunity to further include patients and families. We look forward to seeing how this evolves and will continue to work with you providing support on this journey.
- Achieve quality standard in imaging, we recognise the efforts demonstrated in the previous two quality accounts and look forward to updates on the progress supporting Practice Plus Group in achieving UKAS accreditation.
- Enhance the perioperative pathway, we eagerly anticipate the progress achieved in this priority. I understand that the quality lead for acute services has engaged our Shepton Mallet colleagues in the acute hospital peri-operative meeting to foster a system-wide approach.
- Surgical site infection risk assessment, it is reassuring to see the ongoing efforts to reduce surgical site infections in hip and knee arthroplasty patients. We are eager to gain insight into the progress being made on this priority.
- Participation in the national NHS foundation pharmacist training programme, we recognise the importance of training vacancies and are encouraged to see that Practice Plus Group are taking part in this national training programme.
- Utilisation of Point Of Care Testing (POCT), it's good to see the work undertaken in developing point of care testing and are looking forward to seeing this in practice to further monitor the safety culture of the organisation.

It is encouraging to see the organisation's ongoing commitment to enhancing patient safety through established initiatives, including participation in national clinical audits, local audit reporting, learning from deaths, and addressing patient safety incidents and complaints. We recognise the continued work being undertaken in relation to VTE risk assessment including the actions being undertaken to improve outcomes and quality of services. Somerset ICB note the increase in the completion of VTE risk assessments on the previous year.

The collective data for Practice Plus Group in the friends and family test remains consistently high at 98%, reflecting an increase from the previous year. Similarly, the number of patient complaints during the same period has remained low, showing a further reduction compared to the previous year.

We acknowledge the rise in the total number of reported incidents compared to previous years, demonstrating a clear and robust process for timely incident review, including those requiring a learning response. Notably, since Practice Plus Group's transition to PSIRF, incident reporting has continued to improve, indicating a positive reporting culture.

It is remarkable that Practice Plus Group has not recorded any clostridium difficile infections over the past five years. The infection prevention and control team at Somerset ICB maintains a strong working relationship with the Practice Plus Group hospital Shepton Mallet and will continue to offer support to colleagues throughout 2025/26 if needed.

During 2024/25, eight Practice Plus Group patients died; however, investigations determined that these deaths were not linked to the care provided by Practice Plus Group. Notably, actions were taken to enhance patient safety, including reviewing medication prescriptions for patients on codeine-based treatment and ensuring recorded observations for all urgent treatment centre patients.

Looking locally at performance for the Practice Plus Group hospital Shepton Mallet, it is recognised that the team have been making great strides with the three priorities for 2024/25.

- **Improve medication reconciliation**, Practice Plus Group has significantly improved medication reconciliation, maintaining over 98% compliance since April 2024. It is encouraging to see that patients now receive pre-admission consultations with pharmacists, ensuring medication accuracy and optimisation. These enhancements have also led to notable improvements in patient engagement and safety.
- **Streamline admission of inpatients**, Somerset ICB recognises that this priority has been partially achieved. The streamlining of the inpatient admission process has successfully reduced duplication while maintaining patient safety. The improvements in continuity of care, with extended staff interactions and a 100% friends and family score, are acknowledged. Future plans include redesigning the theatre admissions environment to further enhance the process.
- **Paper free medical records**, Somerset ICB recognises the positive impact of transitioning to paper-free medical records, which has reduced paper usage, enhanced efficiency, and minimised the risk of lost records. Key forms have been successfully digitised, and electronic booking processes have improved workflow management. Future plans involve integrating direct uploads from medical devices to further optimise record-keeping.

Shepton Mallet is commended for earning the bronze award in the national joint registry submission. Locally, a well-defined process for VTE risk assessment is recognised, with Shepton Mallet achieving 97%. Somerset ICB acknowledges the declaration of five patient safety incident investigations (PSII) for 2024/25, including three never events, which have led to learning and process improvements. The principles of PSIRF have been effectively applied through SWARM huddles, addressing key themes such as emergency transfers, unplanned readmissions, and unplanned returns to theatre.

We also note Shepton Mallet's three priorities for the coming year:

- **Priority 1; Streamline admission of inpatients:** It is reassuring to see ongoing progress in this priority and the positive impact on patient experience. We look forward to further developments in this area.
- **Priority 2; Reviewing endoscopy patient flow:** The improvements to the endoscopy patient flow are acknowledged, with the pathway being streamlined through the electronic patient record (EPR) to enhance surveillance, referrals, and diagnostics. The outcomes of this work are eagerly anticipated.
- **Priority 3; Improved environment for patients and staff:** It is reassuring to see the ongoing efforts to establish a clean, well-maintained, and efficiently organised environment for patients and staff. We look forward to the results of the audits and the continued progress in this area.

The care provided at Shepton Mallet is recognised as being of a high standard, as evidenced by the report highlighting over 100 patient compliments received throughout

2024/25. This is further supported by the patient stories featured in this year's quality account.

We extend our gratitude to the Practice Plus Group for its continued commitment to delivering safe and responsive care. This year's Quality Account reflects a strong dedication to quality, and we appreciate the organisation's positive approach. Somerset ICB acknowledges the excellent working relationship between the team at Practice Plus Group Shepton Mallet and the quality lead for acute services. We look forward to collaborating further throughout 2025/26.

Yours sincerely,
Bernice Cooke
Director of Nursing and Deputy Chief Nurse
NHS Somerset Integrated Care Board

NHS Bristol, North Somerset, and South Gloucestershire Integrated Care Board (ICB)

NHS Bristol, North Somerset, and South Gloucestershire (BNSSG) Integrated Care Board (ICB) welcome the opportunity to comment on a draft copy Practice Plus Group's Quality Account 2024/25. BNSSG ICB acknowledge that the report is in draft form and some additional information may still need to be added prior to the final publication, so please accept our observations on that basis.

Practice Plus Group's Quality Account encapsulates all sites, however BNSSG ICB will only be commenting on Devizes Surgical centre and Emerson's Green hospital.

The ICB acknowledges that Practice Plus Group elected three quality priorities for 2024/25.

These were:

1. Implementing NatSSIPs2
2. Reducing superficial wound infections
3. Improving friends and family responses/compliments

All three quality priorities have been achieved, achieving these quality priorities will lead to improved patient safety and experience of Practice Plus Group's services.

The ICB commends Practice Plus Group for the work completed in achieving these priorities. Concerning NatSIPPS2 compliance the ICB notes the continuous improvements to ensure NatSIPPS2 in implemented and complied with.

The ICB acknowledges the improvements made to reducing wound infections with the support of a dedicated IPC lead and two IPC facilitators

The ICB supports Practice Plus Group's effort to improve friends and family responses with better response rates and creating a quality initiative project in response to friends and family feedback, it is important that this engagement continues.

The ICB supports Practice Plus Group's priorities for 2025/26

Devizes:

- Improve recording and quality of patient safety incidents
- Improve ANTT compliance and training
- Continue to improve friends and family response rates.

Emerson's Green:

- Improve quality and timeliness of data and investigations round reporting of SSIs and PIRs
- Improve ANTT compliance and training
- Continue to improve friends and family response rates.

Vicki Cooper, Patient Safety Specialist
On behalf of Bristol, North Somerset, and South Gloucestershire ICB

NHS North East London Integrated Care Board (ICB)

Commissioners statement for Practice Plus Group's 2024/25 Quality Account

NHS North East London integrated commissioning board is the lead commissioner responsible for commissioning health services from Practice Plus Group on behalf of the population of North East London.

Thank you for asking us to provide a statement on Practice Plus Group's 2024/25 Quality Account and priorities for 2025/26. We welcome the six new priorities identified and we are grateful to the Practice Plus Group and its staff for their commitment and continued collaborative partnership work that supports our North East London integrated care system.

We congratulate the consistently high-quality measures that have remained during this challenging year and retained high-quality metrics in addition to a continued Care Quality Commission (CQC) rating of 'good' across all themes.

We are aware of the important work that was undertaken last year and the ICB note the priorities identified for improvement for 2025-26. It is encouraging that these include 'co-productions and communication of learning from harm with patients and families', 'achieve quality standard in imaging', and 'surgical site infection risk assessments. In March 2025 97% of Venous Thromboembolism (VTE) assessments were completed and achieved above the national target of above 95%. We acknowledge the monitoring actions that are in place to show an upward trajectory.

We confirm that we have reviewed the information contained within the account and checked this against data sources where these are available to us, and it is accurate.

Overall, we welcome the 2024/25 quality account and look forward to working in partnership with Practice Plus Group as they strive to achieve their set objectives and priorities for 2025/26.

Zina Etheridge
Chief Executive Officer
North East London Integrated Care Board

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

NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (ICB) welcome the opportunity to review and comment on the Practice Plus Group Quality Account for 2024/ 2025. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring and aligns to NHSE Quality Account requirements.

BSW ICB notes the comprehensive overview of the Practice Plus Group's achievements, challenges and future priorities for 2025/26.

It is the view of the ICB that the Quality Account reflects the ongoing commitment to providing high quality patient care and a culture of continuous learning and improvement, evidenced by examples of key achievements including:

- Sign up to Quality Standard Imaging (QSI), to upload documents and information to support the QSI standards. This will enable improved oversight of key areas, including patient safety and experience.
- Enhancing the perioperative journey. Of note, is the review undertaken of the perioperative patient pathway, which was informed by several resources including Getting It Right First Time (GIRFT). The review resulted in several changes being implemented including guidance on skin integrity and joint school, aimed at supporting patients to get fit for surgery and reducing the risk of cancellations.
- Achieving a local priority to improving medicines reconciliation, increasing to 98% against a target set of over 90% (evidencing improvement).
- A review and evaluation of PSIRF implementation, including targets for key performance indicators which have been partially achieved. Although still in contraction stage, there is a commitment to progress towards use of Power BI dashboards to support improved triangulation of quality and performance data.

The ICB also recognises the priority areas identified for further development and support the plans to address these, which includes:

- Co-production and communication of learning from harm with patients and families
- Achieving quality standard in imaging
- Enhancing the perioperative pathway
- Review of surgical site infection risk assessment
- Participation in the national NHS foundation pharmacist training programme
- Utilisation of point of care testing

NHS Bath and North East Somerset, Swindon and Wiltshire ICB are committed to sustaining strong working relationships with Practice Plus Group and together with our wider stakeholders will continue to work collaboratively to achieve our shared priorities as an integrated care system in 2025/26.

Yours sincerely,
Gill May
Chief Nurse Officer
BSW ICB

NHS Devon Integrated Care Board (ICB)

NHS Devon Integrated Care Board (ICB) would like to thank Practice Plus Group for the opportunity to comment on their Quality Account for secondary care for 2024/25. Practice Plus Group is commissioned by NHS Devon ICB to provide a range of secondary care elective services across Devon. We seek assurance that care provided is safe and of high quality, ensuring that care is effective and that the experience of care is positive.

As commissioners we have taken reasonable steps to review the accuracy of data provided and consider it contains accurate information in relation to the services provided and reflects the information shared with the commissioner over the 2024/25 period.

This Quality Account has highlighted progress against the national quality priorities chosen for 2024/25 as below and sets out the six quality priorities identified for 2025-26. National quality priorities 2024/25:

1. **Review and evaluate PSIRF implementation.**
   Each site hosts a weekly meeting to review any open incidents, ensuring the completion of required learning responses as set out in the Patient Safety Incident Response Plan (PSIRP). A dashboard has been produced to support efficient management of these meetings. Improvements are reflected in the compliance with the incident management key performance indicators:

   - Incidents reported within 24 hours of identification - 86%.
   - Incidents reviewed within three working days - 99%.
   - Incidents investigated within the timescales set out in the PSIRP - 86%.

   Work will continue in 2025-26 with a focus on co-production with patients and their families.

2. **Achieve quality standards for imaging.**
   Practice Plus Group have signed up to the Royal College of Radiologists (RCR) Quality Standard for Imaging (QSI) and are working towards bringing together all aspects of operating practices for the service. This work will remain a priority in 2025-26 with the focus on achieving the quality standard. A QSI imaging manual will co-locate all aspects of operating practices for the service, key performance indicators and metrics and operational aspects for the service delivery including staffing, equipment, environment, quality, safety, and patient experience

3. **Enhance the perioperative pathway.**
   The perioperative review programme has supported an adaptive and responsive approach to increasing demands from a growing and ageing population. A gap analysis was undertaken against the GIRFT pathway, alignment of perioperative care pathway NICE and alignment of perioperative care pathway - Centre of Perioperative Care (CPOC). Key gaps were identified and an action plan was put in place to align with the relevant guidance. Further enhancements against identified priorities will continue in 2025-26.

4. **Evaluate annual site quality visits.**
   The self-assessment tool is widely adopted, with all quality visits reports and regulatory inspections updated, monitored, and audited centrally.

The ICB also notes and welcomes the six 2025/26 national priorities outlined by Practice Plus Group in their Quality Account, and will look forward to seeing achievements related to:

1. **Co-production and communication of learning from harm with patients and families.**
   This priority will ensure patients and families are not only involved in patient safety incident investigations but are also able to see how their experiences contribute to learning and meaningful change.

2. **Achieve quality standard in imaging.**
   Achieving the QSI mark will provide independent recognition of the quality of Practice Plus Group imaging services.

3. **Enhance the perioperative pathway.**
   Building on improvement work from 2024-25 the service will review the perioperative pathway to adapt and respond to increasing demands from a growing and ageing population, and to conform to best practice protocols.

4. **Surgical site infection risk assessment.**
   This priority will ensure patients that are having hip and knee arthroplasty are risk assessed prior to surgery for the potential of developing a surgical site infection post operatively. This will ensure that all appropriate action is taken to safeguard the occurrence, which will have better outcomes for the patient.

5. **Participation in the national NHS foundation pharmacist training programme.**
   In 2025-26, Practice Plus Group secondary care pharmacy will take part in the national NHS foundation pharmacist training programme for the first time, hosting seven foundation pharmacist trainees across Practice Plus Group hospitals. This marks a milestone for both Practice Plus Group and the independent healthcare sector.

6. **Utilisation of Point of Care Testing (POCT).**
   A national Practice Plus Group Point Of Care Testing (POCT) committee with leads at all sites is established. Robust frameworks and a national policy to ensure that the required assurance of quality within the testing undertaken will support the service to work towards the ISO quality standards of 15189:2022 which incorporate POCT testing.

Additionally, and commendably Practice Plus Group identify quality priorities specific to their local sites, Plymouth hospital has demonstrated progress across the following in 2024-25:

1. **Optimise patients to decrease long waiters in the wider health community** through continuing to utilise the BMI clinic, the creation of a diabetic clinic, a reduction in clinical cancellations and decrease the number of patients on active monitoring and continuing to work in conjunction with commissioners to reduce the numbers of patients experiencing long waits.
2. **Increasing and upskilling the workforce to support increased activity and acuity** has been achieved through multiple innovations including recruiting a clinical educator to ensure clinical competence across all departments. These initiatives demonstrate commitment to staff development and continuous professional growth.
3. **Re-shaping the support infrastructure to support clinical activity, staff and patient safety** where fully established environmental, health and safety, medical devices, infection prevention and control and resuscitation committees, each supported by clear terms of reference have been established.

Plymouth hospital quality priorities for 2025-26 incude:

1. **Referral to admissions - to improve pathway efficiency.**
2. **To implement Getting It Right First Time (GIRFT).**
3. **Patient information leaflets review.**

Each of these programmes will continue to evidence and improve quality and safety for the benefit of patients, families, carers and staff building on the lessons learned from 2024/25.

Care Quality Commission (CQC) involvement

As commissioners, we have worked closely with Practice Plus Group during 2024/25 and will continue to do so in respect of any future CQC inspections undertaken, to receive the necessary assurances of continued, high-quality care. There have been no inspections to note in 2024/2025 and all Practice Plus hospitals and surgical centres remain rated either ‘good’ or ‘outstanding’ by the CQC. Practice Plus Group Plymouth hospital received an overall rating ‘good’ from a short announced comprehensive inspection published 16th February 2023. All Practice Plus Group hospitals retain National Joint Registry (NJR) quality data provider status, recognising excellence in supporting the promotion of patient safety standards through compliance with the mandatory NJR data submission quality audit process, and all endoscopy services remain JAG-accredited.

On review of this Quality Account, the commitment of Practice Plus Group to continually improving the quality of care is evident. The ICB looks forward to working alongside Practice Plus Group in the coming year, continuing to make improvements to healthcare services provided to the people of Devon.