Practice Plus Group

Quality Account

2025-2026

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, Ross Dowsett.

In Part 2 we have included details of the priorities that we intend to deliver during 2026/27.

There are also several statements of assurance from the board specific aspects of service provision in section 2.2.

Part 3 describes how we performed against the quality priorities we set for ourselves during 2025/26, together with performance against key national priorities for organisations delivering NHS care.

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

Part 1: Statement on quality from the Chief Executive

This year has been one of continued growth and evolution for Practice Plus Group hospitals and surgical centres, as we build on our role as a trusted partner to the NHS while continuing to improve access, quality and outcomes for our patients.

Additionally, this year Practice Plus Group Hospitals became part of Narayana Health following a change in ownership, announced in November 2025. This brings together Narayana Health's global expertise in delivering high-quality, high-volume healthcare with our established UK services, supporting further investment in quality, innovation and patient care.

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:

- Our 12 hospitals and surgical centres in the UK;
- Urgent treatment and walk in centres;
- Ophthalmology services, including community mobile units;
- Multi location musculoskeletal and diagnostic services.

We remain predominantly an NHS provider, with the majority of our treatment and surgery delivered to NHS patients. At a time of sustained pressure on NHS waiting lists, we are proud to support the wider system by increasing capacity and improving access to timely, life changing treatment. At the same time, we continue to expand patient choice and access, growing our private medical insurance (PMI) pathways through a network of leading insurers, alongside the continued development of our self pay offering, enabling more patients to access faster to a wide range of diagnostics and surgeries when they need it.

In the year from April 2025 to March 2026 we carried out:

- Over 130,000 day case and inpatient procedures;
- Over 280,000 outpatient consultations, including telephone consultations.

These volumes reflect both the scale of our services and the confidence that patients and commissioners place in us.

We have continued to expand and strengthen our services during the year, including further development of our Birmingham hospital and the expansion of clinical pathways across sites. This has enabled us to safely treat more complex patients and improve access to healthcare in areas particularly affected by long NHS waiting times.

We are incredibly proud of our markers of quality this year:

- Zero cases of C. difficile infection reported across our services;
- Venous thromboembolism (VTE) risk assessment compliance of 97%, exceeding the national target;
- Strong Friends and Family Test results, consistently above the national average;
- 94% of our workforce would recommend us as a healthcare provider, demonstrating confidence in the quality of our services.

All of our hospitals and surgical centres remain rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC), with no enforcement action during the reporting period.

We are also proud of the recognition our services have received. All Practice Plus Group hospitals have achieved National Joint Registry (NJR) Quality Data Provider status, recognising excellence in supporting patient safety, high-quality data submission, and strong clinical outcomes.

Alongside these outcomes, we have continued to invest in our services and infrastructure to improve quality and patient experience. This includes the further development of digital systems, strengthening of diagnostic imaging services in preparation for Quality Standard for Imaging (QSI) accreditation, and improvements to clinical pathways to enhance efficiency and reduce waiting times.

We have made good progress against the priorities we set for this year, strengthening clinical pathways, governance and patient safety systems across all sites.

As an organisation focused on listening and learning, patient safety remains at the heart of everything we do. We have continued to embed the Patient Safety Incident Response Framework (PSIRF), strengthening our approach to incident management and ensuring that learning leads to meaningful improvement. We have also continued to strengthen our culture of openness and speaking up, ensuring colleagues feel supported to raise concerns and contribute to continuous improvement.

I am as ever grateful to the skilled and dedicated people who deliver our high-quality services every day and ensure our patients receive the healthcare they need. We remain committed to supporting our workforce through continued investment in training, wellbeing and workforce stability, and to ensuring Practice Plus Group Hospitals remains an attractive place to work.

We have set seven priority areas for 2026/27, reflecting the wider programme of improvement across our services:

Strengthen patient involvement in safety learning
Embedding patient and family involvement in safety investigations to improve transparency and ensure that learning leads to meaningful and visible change.

Strengthen quality governance and patient representation
Enhancing quality governance through greater patient representation, ensuring patient voices help shape quality improvement and strengthen organisational oversight.

Achieve Quality Standard for Imaging (QSI) accreditation
Providing independent external assurance of quality and safety in imaging services, improving governance, consistency and patient experience across all sites.

Enhance the perioperative pathway
Improving patient preparation, reducing cancellations and strengthening clinical pathways through digital innovation, including the introduction of electronic pre-operative assessment.

Strengthen infection prevention and risk management
Embedding surgical site infection risk assessment tools and improving consistency in infection prevention practices across all sites to further enhance patient safety and outcomes.

Strengthen medical device governance
Strengthening governance, assurance and maintenance processes for medical devices to ensure equipment remains safe, effective and fit for purpose across all sites.

Introduction of penthrox in both endoscopy and urgent treatment centres
We will offer patients Penthrox as a lower-carbon alternative to nitrous oxide for pain relief, aiming to reduce nitrous oxide use by at least 50% across both services.

I am confident that we will continue to go from strength to strength and deliver against these priorities, striving for excellence for our patients, staff and the wider healthcare system.

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

Ross Dowsett,
Chief Executive Officer,
Practice Plus Group Hospitals

Part 2:

Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement 2026/27

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

Why have we chosen this priority?

This improvement priority has been carried forward from 2025/26 as it was partially implemented.

We originally chose 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 maintained at 100%.

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: Recruit additional Patient Safety Partners

Why have we chosen this priority?

Patient Safety Partners (PSPs) play a critical role in strengthening patient-centred care by providing lived experience insight into safety, quality, and service design.

How will we improve?

We have recruited two PSPs since the transition to the Patient Safety Incident Response Framework, but one has since left. Increasing the number, diversity, and active participation of PSPs across the organisation will support patient perspectives being consistently embedded in safety decision-making.

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

We will aim to have at least two PSPs in post who actively participate in the quarterly Quality and Governance Assurance Committee by the end of March 2027. There will be evidence of PSP influence on safety improvements.

How will we report and monitor our progress?

Progress with recruitment will be reported to the Quality and Governance Assurance Committee. Once in post, feedback will be sought from PSPs regarding their satisfaction with the recruitment, onboarding and participation in patient safety activities.

Priority 3: Quality Standard for Imaging (QSI) accreditation.

Why have we chosen this priority?

Achieving accreditation against the Quality Standard for Imaging (QSI) has been identified as a strategic priority due to its role as the recognised national benchmark for safe, effective, and high-quality diagnostic imaging services across the UK. QSI provides a comprehensive and evidence-based framework covering leadership, governance, workforce competence, clinical processes, patient experience, safety, and facilities.

The standard is specifically designed to enable imaging services to evaluate current performance, identify areas for development, and embed a culture of continuous quality improvement. Given the critical role of diagnostic imaging in clinical decision-making and patient pathways, achieving QSI accreditation will:

- Provide independent external assurance of quality and safety;
- Strengthen regulatory readiness (including assurance with CQC expectations);
- Ensure consistency across imaging services and sites;
- Demonstrate organisational commitment to best practice standards.

This quality and safety priority was identified in last year's report and the preparation against the standards were completed. The process for arranging the accreditation visits could not be arranged within this previous annual cycle and during the tenure of the head of diagnostic imaging. This will therefore be this year's priority for the newly appointed head of diagnostic imaging.

How will we improve?

Embedding QSI standards within imaging services will drive improvement across multiple domains, these include:

- Clinical Quality and Patient Safety by the standardisation of clinical protocols and imaging pathways, strengthened quality assurance processes for equipment and imaging outputs and improved incident reporting, investigation, and learning culture;
- Governance and Leadership through clear accountability structures and quality oversight frameworks, strengthened internal audit and assurance mechanisms;
- Improved documentation, policy alignment, and regulatory compliance;
- Workforce and Capability by the assurance of staff competence, training, and CPD compliance and Enhanced workforce planning and role clarity;
- Patient Experience by increasing the focus on patient-centred care, communication, and feedback and the systematic use of patient experience data to inform service improvements.

QSI is explicitly designed as a developmental standard driving continuous improvement rather than one-off compliance. It supports a structured, measurable approach to closing identified gaps. Overall, this will ensure imaging services are safe, consistent, efficient, and responsive to patient and regulatory expectations.

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

Improvement will be measured through a combination of QSI-aligned Key Performance Indicators (KPIs), audit outcomes, and assurance metrics, recognising that performance measurement is essential to objectively assess quality and drive improvement. Key measures will include:

- Quality and Safety Metrics will be demonstrated through the self-assessment and gap closure progress to evidence the compliance with QSI standards. Monitoring the number and severity of imaging-related incidents and audit compliance (clinical protocols, radiation safety, equipment QA);
- Operational Performance will be monitored through report turnaround times, Imaging capacity utilisation and waiting times for diagnostic imaging;
- Workforce Metrics will look at training compliance (mandatory and competency-based training), appraisal and supervision completion rates;
- Patient Experience through patient satisfaction scores (FFT or equivalent), complaints, concerns, and themes;
- Governance and assurance will be monitored through the completion of internal audits including quality visits, action plans, evidence of policy compliance and document control measures KPIs will be designed to be specific, measurable, and aligned to organisational objectives.

How will we report and monitor our progress?

Our Target is to achieve formal QSI accreditation (Quality Mark) within this year therefore demonstrating full compliance (or clear trajectory to compliance) against all relevant QSI domains. The QSI Quality Mark involves a formal peer-reviewed assessment and ongoing review cycle, reinforcing sustained compliance and continuous improvement.

Progress will be monitored through a structured governance framework. Operationally this will include monthly imaging quality and performance dashboards, departmental audit and action plan reviews, QSI gap analysis tracker and improvement plans. Within the central team this will include additions to the site's monthly quality business review slides for reporting and also into the 4 box Quality and Safety report to the QGA meeting and onto board as required. This will ensure the appropriate escalation of risks relating to non-compliance.

Priority 4: Electronic Pre-Operative Assessment (e-POA)

Why have we chosen this priority?

This priority has been chosen to ensure that all patients undergoing surgery across our sites benefit from a standardised, evidence-based digital perioperative assessment pathway. The pathway will help streamline the patient journey, reduce variation between sites, and support earlier identification of patients who may not yet be optimised for surgery.

By improving the quality and consistency of pre-operative assessment, we aim to support better patient outcomes, reduce delays, and ensure that patients who require further optimisation are identified and managed earlier in their pathway.

How will we improve?

We will implement a digital perioperative assessment pathway across all relevant patient pathways and sites. This will provide a consistent approach to pre-operative assessment, support clinical decision-making, and enable a more efficient process for patients, nursing teams and consultant anaesthetists.

The pathway will use technology and automation to reduce administrative burden, improve the flow of information, and allow clinical teams to focus more time on patients who require additional optimisation before surgery. It will also support increased pathway capacity by enabling more patients to move through the assessment process in a timely and consistent way.

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

We will measure improvement by monitoring the time taken from referral to the day of surgery, the number of patients completing the digital perioperative assessment pathway, and the number of patients identified as not yet ready for surgery who are then supported through an optimisation pathway.

We will also monitor the impact on administrative workload for nursing and consultant anaesthetic teams, alongside pathway efficiency, patient flow and the ability to identify bottlenecks in the patient journey.

Our targets will be to reduce delays from referral to surgery, increase the number of patients managed through the standardised pathway, improve early identification of patients requiring optimisation, and support safer, more efficient progression to surgery.

How will we report and monitor our progress?

Progress will be monitored through regular reporting on implementation, pathway uptake, referral-to-surgery timelines, patient optimisation outcomes and operational efficiency. We will develop data analytics dashboards to help identify delays, variation and bottlenecks across the pathway.

The data will be reviewed through the relevant governance and operational meetings, with sites asked to monitor implementation locally and escalate any barriers to delivery. This will allow us to track progress, share learning between sites and make further improvements to the pathway as it becomes embedded.

Priority 5: Surgical Site Infection risk assessment tool

Why have we chosen this priority?

This has been rolled over from the year 2025/2026 to ensure that implementation is completed in full, including training and addition to the electronic patient administration system.

How will we improve?

We will ensure that all staff groups will have training and that every patient undergoing hip and knee arthroplasty will have a Surgical Site Infection risk assessment completed on the electronic patient system at preassessment and on admission.

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

Our improvement will be measured by a lowering of surgical site infections and that every patient undergoing hip and knee arthroplasty procedures will have a completed surgical site risk assessment at preadmission and on admission.

How will we report and monitor our progress?

We will report and monitor by undertaking an audit and review of the clinical records to ensure that patients have had the surgical site risk assessment undertaken at preadmission and on admission and on how many surgical site infections are reported at each site.

Priority 6: Medical Device Governance

Why have we chosen this priority?

We have chosen this as a priority to increase the profile for Medical Devices within Secondary Care. All sites have an array of Medical Devices from small simple devices to large complex pieces of kit used within Theatres. Medical Devices are essential for patient pathways. The Operational aspects of Medical Devices have been successfully established and we are continuing to strengthen local and central governance mechanisms to ensure consistency and efficiency. Governance of Medical Devices is a priority to ensure that all devices are safe and fit for purpose for patient use.

How will we improve?

We have established a National Medical Devices Committee in which a Senior Manager from each site (Operations Manager) attends the meeting. The meeting is also attended by our Managed Equipment Services (MES) provider. All items are currently on an Asset Register indicating Planned Preventative Maintenance dates and schedules. The MES provider works with the Medical Devices Safety Officer (MDSO) to ensure all sites have the adequate cover they need to provide assurance of safety.

Monthly meetings are held with the sites and MES provider.

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

A monthly report is generated by the MES provider which provides information to sites as to which items have been maintained/serviced and which items are due for maintenance/servicing. Sites are able to locate the devices and update the asset register as required. Any outliers are discussed in the monthly meeting.

On-site visits by the MDSO are also taking place to provide in-person support to each site.

How will we report and monitor our progress?

The monthly report is shared with all sites, and feedback is provided to the Medical Devices Safety Officer for assurance. The MDSO is able to escalate centrally via several channels of any non-compliance. The MDSO is also able to provide support along with the MES Provider to each site.

Priority 7: Introduction of Penthrox as an alternative to Nitrous Oxide in both Endoscopy and Urgent Treatment Centres

Why have we chosen this priority?

Penthrox is a more sustainable and environmentally friendly alternative to Nitrous Oxide for pain relief whilst having a procedure, both in endoscopy and urgent treatment centres.

How will we improve?

We will ensure that every patient is given the option to have a lower carbon footprint medicine as an alternative to using Nitrous Oxide for their endoscopy or urgent treatment centre procedure.

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

A reduction in the usage of Nitrous Oxide by at least 50% in both endoscopy and urgent treatment centres.

How will we report and monitor our progress?

Audit of patient receiving records to ascertain which method of pain relief has been used.

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 2025/26 Practice Plus Group Secondary Care provided and/or subcontracted two 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 2025/26 represents 100% of the total income generated from the provision of relevant health services by Practice Plus Group for 2025/26.

2.2.2 Clinical audit

During 2025/26 two 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 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits that Practice Plus Group was eligible to participate in during 2025/26 are identified in table 1.

The national clinical audits that Practice Plus Group participated in, and for which data collection was completed during 2025/26 are listed in table 2 alongside the number of cases submitted.

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

National Clinical Audit	Eligible to participate	Participated	Comments
Child Health Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
CVDPREVENT (National Audit of Cardiovascular Disease Prevention in Primary Care)	No	-	Practice Plus Group does not provide these services
Epilepsy12 (National Clinical Audit of Seizures and Epilepsies for Children and Young People)	No	-	Practice Plus Group does not provide these services
Falls and Fragility Fracture Audit (FFFAP)	No	-	NHS Trusts only at present
Maternal, Newborn and Infant Clinical Outcome Review (MBRRACE-UK)	No	-	Practice Plus Group does not provide these services
Medical and Surgical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Mental Health Clinical Outcome Review (NCISH)	No	-	Practice Plus Group does not provide these services
National Audit of Dementia (NAD)	No	-	Practice Plus Group does not provide these services
National Audit of Eating Disorders (NAED)	No	-	Practice Plus Group does not provide these services
National Audit of Metastatic Breast Cancer (NAoMe)	No	-	Practice Plus Group does not provide these services
National Audit of Primary Breast Cancer (NAoPri)	No	-	Practice Plus Group does not provide these services
National Bowel Cancer Audit (NBOCA)	No	-	Practice Plus Group does not provide these services
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 Child Mortality Database (NCMD)	No	-	Practice Plus Group does not provide these services
National Clinical Audit of Perioperative Care (NCAPC)	No	-	Currently NHS providers only
National Clinical Audit of Psychosis (NCAP)	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)	No	-	See Part 4: Local quality updates for local site participation details
National Kidney Cancer Audit (NKCA)	No	-	Practice Plus Group does not provide these services
National Lung Cancer Audit (NLCA)	No	-	Practice Plus Group does not provide these services
National Maternity and Perinatal Audit (NMPA)	No	-	Practice Plus Group does not provide these services
National Neonatal Audit Programme (NNAP)	No	-	Practice Plus Group does not provide these services
National Non-Hodgkin Lymphoma Audit (NNHLA)	No	-	Practice Plus Group does not provide these services
National Obesity Audit (NOA)	No	-	Practice Plus Group does not provide these services
National Oesophago-Gastric Cancer Audit (NOGCA)	No	-	Practice Plus Group does not provide these services
National Ovarian Cancer Audit (NOCA)	No	-	Practice Plus Group does not provide these services
National Paediatric Diabetes Audit (NPDA)	No	-	Practice Plus Group does not provide these services
National Pancreatic Cancer Audit (NPaCA)	No	-	Practice Plus Group does not provide these services

National Clinical Audit	Eligible to participate	Participated	Comments
National Prostate Cancer Audit (NPCA)	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 (NVR)	No	-	Practice Plus Group does not provide these services
National Ophthalmology Database (NOD) Audit Age-related Macular Degeneration Audit Cataract Audit	Yes	✓	See table 2 for overview
Paediatric Intensive Care Audit Network (PICANet)	No	-	Practice Plus Group does not provide these services
Sentinel Stroke National Audit Programme (SSNAP)	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
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
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
UK Cystic Fibrosis Registry	No	-	Practice Plus Group does not provide these services
UK Renal Registry Chronic Kidney Disease Audit	No	-	Practice Plus Group does not provide these services
UK Renal Registry National Acute Kidney Injury Audit	No	-	Practice Plus Group does not provide these services

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 2025/26 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 Ophthalmology Database (NOD) Audit	10 PPG sites report into the NOD database and there are 44 surgeons aligned to PPG centres. The latest published data available covers the period of 01/04/2023-31/03/2024. All 10 sites are within normal limits for visual loss and posterior capsular rupture.

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 2025/26 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

Local clinical audit report	Findings / actions
IPC audits	Due to findings on review IPC audit content and frequency have been reviewed to remove any duplication and ensure a consistent and thorough approach across all sites. This gives time for actions to be completed and monitored by sites - ANTT audit – Quarterly and to align with ANTT® accreditation requirements IPC Board Assurance Tool – To be completed biannually by site and used a self-assessment to ensure compliance with regulations. Also completed annually by the Head of IPC or an IPC Lead from a different site for an independent review IPC Environmental and practice tool – Tailored for specific areas and now quarterly to ensure ample time to complete / update actions. Hand Hygiene audit – Twice yearly but with ad hoc completion by visiting clinical staff This new structure has seen better compliance with the schedule and clearer progress monitoring of the actions.
WHO audits	WHO audits are being reviewed due to updated WHO checklist which now aligns with the NatSIPPs2. This is currently in the trial phase and will be completed by theatre staff, Heads of Clinical Services and senior clinical teams when visiting sites to ensure a safe and consistent process.

2.2.3 Research

The number of patients receiving relevant health services provided or subcontracted by Practice Plus Group in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee was zero.

2.2.4 CQUIN framework

Practice Plus Group's income in 2025/26 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, Emersons 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 2025/26.

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 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- Not applicable for accident and emergency care,

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

- 87.86% for admitted patient care;
- 60.15% for outpatient care; and
- Not applicable for accident and emergency care.

2.2.7 Information Governance

Practice Plus Groups 2025/26 annual Data Security and Protection (DSP) Toolkit submission achieves standards exceeded certification.

We also obtained Cyber Essentials plus certification recertification in July 2025, demonstrating our high standards in Cyber Security posture.

Practice Plus Group completed the re-certification of ISO 27001:2022 standards in August 2025.

During the period, Practice Plus Group has processed over 8,000 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 2025/26 by the Audit Commission.

2.2.9 Data quality

Practice Plus Group will be taking the following actions to improve data quality:

Practice Plus Group has updated and re-published the following policies:

- Social Media Policy;
- Information and Data Exchange Protocol;
- Information Sharing Agreement Templates;
- Information Security Risk Assessment and Management Procedure.

Practice Plus Group has also enhanced the Cyber Security Incident response plan after review and re-publication in December 2025.

Practice Plus Group continue to enforce the requirement for all Practice Plus Based systems to have Multi Factor Authentication (MFA) in place, when accessing Practice Plus Group systems externally, outside of office locations and VPN in compliance with the Cyber Essentials plus standards.

Additionally, Practice Plus Group continue to monitor and improve networks controls to only allow UK based access to our systems, as general rule access is locked but can be deployed and updated via the international access request process for rare occasions when international access is required.

Practice Plus Group have also signed an agreement with UK-based cybersecurity specialist that provides comprehensive security services and provides a managed detection and response service which detect threats, with experts focusing on identifying indicators of compromise in real-time for Practice Plus Group.

2.2.10 Learning from deaths

During 2025/26 six of Practice Plus Group patients died within 30 days of treatment. This comprised the following number of deaths which occurred in each quarter of that reporting period:

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

By 08 April 2026[date], six [number] case record reviews and [number] investigations have been carried out in relation to 100% [number] of the deaths included above.

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

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

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

One, representing 17%, [percentage] 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:

- 1, representing 17%, for the first quarter;
- 0, representing 0%, for the second quarter;
- 0, representing 0%, for the third quarter;
- 0, 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.

A second review was undertaken in respect of four of the deaths during the reporting period. This was performed by a panel of three clinicians from Practice Plus Group sites other than those where the patients received treatment, comprising a site Medical Director, Group Associate Medical Director and the Clinical Director for Anaesthetics. The review was to focus on the pre-operative assessment of the patients, including whether frailty scores had been calculated and whether the patients had all been suitable for surgery at a Practice Plus Group site. The review also sought validation of the Patient Death Review tool adopted on the Datix risk management system used across Practice Plus Group Secondary Care services. This is the investigation tool used as first line review and is derived from the NHS Structured Judgement Review Tool.

The case record reviews and investigations conducted in relation to the deaths identified:

- Appropriate thromboprophylaxis prescribed following surgery;
- Prompt and correct management of suspected DVT;
- Compliance with GIRFT advice on prescribing laxatives on discharge;
- Pre-operative assessment documentation could be improved in some cases.

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:

- Consider that all patient death reviews go through a second review by clinicians independent of the case ahead of presentation at Mortality and Morbidity;
- Consideration of a second scan when patient remains symptomatic with a high suspicion of VTE;
- Consider review of bowel complications of elective arthroplasty to ensure that care is optimised to reduce the likelihood of complication;
- Consider implementing frailty scoring as part of Pre-Operative Assessment;
- Consider electronic Pre-Operative Assessment to improve documentation of process;
- Continue emphasis on recognition of deteriorating patient.

One case record review and investigation were completed after April 2025 which related to a death which took place before the start of the reporting period. This was judged not to have been due to problems in the care provided to the patient.

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.

2024/25 data

Health gains

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

	Oxford hip score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	96.7%	69.1%	89.5%
England	97.1%	71.8%	89.3%

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

	Oxford knee score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	94.1%	61.6%	82.6%
England	93.8%	63.3%	81.5%

Data source: NHS Digital, Patient Reported Outcome Measures - Data Quality Dashboard

2025/26 data

Health gains

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

	Oxford hip score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	97.4%	66.9%	88.6%
England	Not yet published	Not yet published	Not yet published

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

	Oxford knee score improved	EQ VAS improved	EQ-5D index improved
Practice Plus Group	93.7%	60.0%	81.7%
England	Not yet published	Not yet published	Not yet published

Data source: Path Point - Open Medical

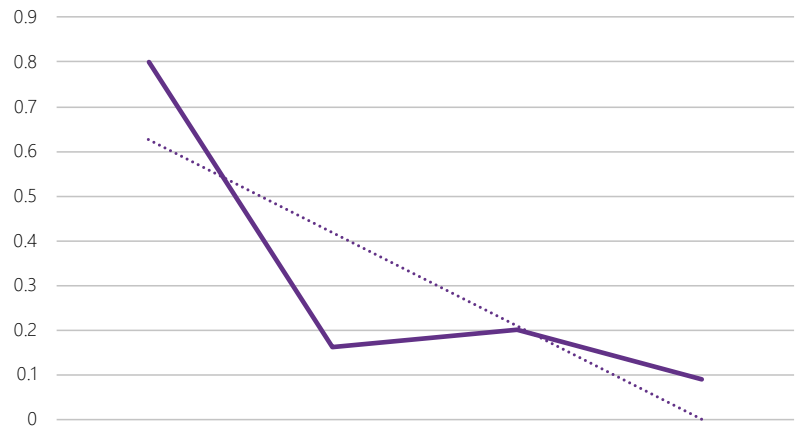
Practice Plus Group considers that this data is as described for the following reasons:

- There is a significant sample size. The response rate for full completion (pre and post op) for the PROMS data remains at 76% of eligible patients;
- We can triangulate the data against other patient safety collected metrics such as revision rates, surgical site infections, returns to theatre and National Joint Registry data.

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

- Continuous monitoring and analysis of the data to identify particularly well-performing sites and sharing best practice across all sites;
- Working to improve participation and completion rates of PROMS data where outliers are identified.

2.3.2 Emergency readmissions



	2022/23	2023/24	2024/25	2025/26
Practice Plus Group (local data)	0.80%	0.16%	0.20%	0.09%

Data source: Numerator Datix incidents Denominator Harvest activity data.

National comparative data are not available.

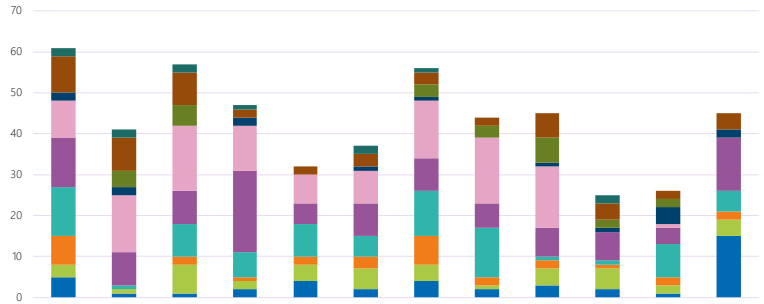
Practice Plus Group considers that this data is as described for the following reasons:

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 unplanned readmissions to Practice Plus Group sites and the NHS as a percentage of the total number of procedures performed during the reporting period.

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.

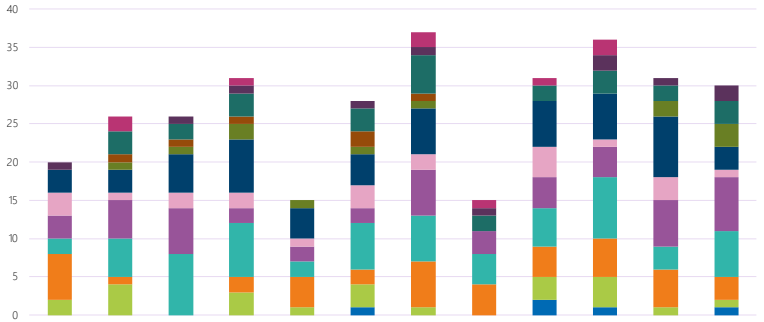
2.3.3 Responsiveness to the personal needs of patients

Number of compliments received by each site



	2025									2026		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Birmingham Hospital	5	1	1	2	4	2	4	2	3	2	1	15
Emersons Green Hospital	3	1	7	2	4	5	4	1	4	5	2	4
Ilford Hospital	7		2	1	2	3	7	2	2	1	2	2
Plymouth Hospital	12	1	8	6	8	5	11	12	1	1	8	5
Shepton Mallet Hospital	12	8	8	20	5	8	8	6	7	7	4	13
Southampton Hospital	9	14	16	11	7	8	14	16	15		1	
Devizes Surgical Centre	2	2		2		1	1		1	1	4	2
Gillingham Surgical Centre		4	5				3	3	6	2	2	
St Mary's Surgical Centre	9	8	8	2	2	3	3	2	6	4	2	4
St Mary's Portsmouth UTC	2	2	2	1		2	1			2		

Complaints received by each site



	2025									2026		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Birmingham Hospital						1			2	1		1
Barlborough Hospital	2	4		3	1	3	1		3	4	1	1
Emersons Green Hospital	6	1		2	4	2	6	4	4	5	5	3
Ilford Hospital	2	5	8	7	2	6	6	4	5	8	3	6
Plymouth Hospital	3	5	6	2	2	2	6	3	4	4	6	7
Shepton Mallet Hospital	3	1	2	2	1	3	2		4	1	3	1
Southampton Hospital	3	3	5	7	4	4	6		6	6	8	3
Devizes Surgical Centre		1	1	2	1	1	1				2	3
Gillingham Surgical Centre		1	1	1		2	1					
St Mary's Portsmouth UTC		3	2	3		3	5	2	2	3	2	3
Southampton UTC	1		1	1		1	1	1		2	1	2
St Mary's Portsmouth UTC		2		1			2	1	1	2		

Responsiveness to the personal needs of patients

A total of 310 complaints were received during the reporting period, 296 (95%) of which provided the complainant with a satisfactory resolution from the initial investigation and response at stage one. 14 complaints (i.e., 4.5% 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. Three of the complaints received during the reporting period were escalated to the Parliamentary and Health Service Ombudsman (PHSO) as stage three complaints. Two of these were closed by the PHSO after initial enquiries, while the third was partially upheld.

85% of complaints (278/325) were acknowledged within three working days, while 53% (171/321) of complainants received a response with the outcome of the investigation within 20 working days.

25% of complaints received during the reporting period were not upheld, 47% were partially upheld and 28% 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:

- 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	2025/26
Practice Plus Group	44*	95%	91%	94%

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

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

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.

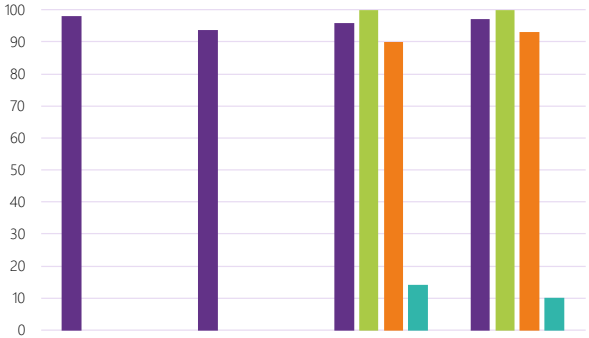
Practice Plus Group intends to take the following actions to improve this indicator, and so the quality of its services, by:

- Publicising improvements made in response to previous surveys to encourage participation;
- Balancing complaints and concerns with the number of compliments received and publishing widely.

2.3.5 Venous thromboembolism risk assessment

Venous thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. This data collection quantifies the numbers of acute hospital patient admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE within 14 hours of decision to admit, to identify those who should be given appropriate prophylaxis based on guidance NG89 from the National Institute for Health and Care Excellence (NICE). These measures have the potential to save many lives each year.

The VTE risk assessment is a national quality requirement in the NHS Standard Contract and sets an operational standard of 95% compliance.



	2022/23	2023/24	2024/25	2025/26
Practice Plus Group (local data)	97.9%	93.8%	95.9%	97%
Best performance nationally	*	*	100%	100%
National average	*	*	90%	93%
Worst performance nationally	*	*	14%	10%

Data source: NHSE at: Statistics » VTE risk assessment 2025/26

*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 restarted in April 2024.

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

It is taken directly from the national VTE data collection published by NHS England.

Our VTE risk assessment compliance stands at 97% for 2025/26, exceeding both the ≥95% target and the national average (93%). While performance is strong overall, variation across sites requires targeted intervention to ensure consistency.

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

- Deliver targeted VTE prevention training to all sites (including recorded sessions), prioritising support for lower-performing locations;
- Reinforce mandatory completion of risk assessments at admission;
- Strengthen audit feedback and governance to reduce variation and sustain performance above national benchmarks.

2.3.6 C.Difficile infection

	2022/23	2023/24	2024/25	2025/26
Practice Plus Group (local data)	0	0	0	0%
Best performance nationally	0	0	0	*
National average	115.8	135	52.4	*
Worst performance nationally	416	545	418	*

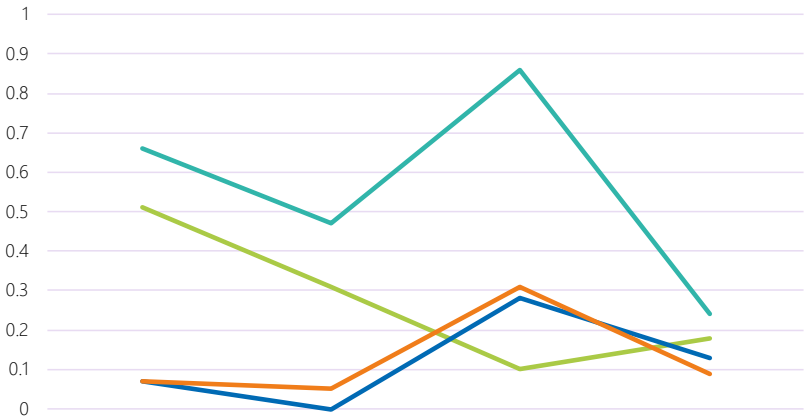
Data source: www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure

*The national data have not been published for 2025/26 at the time of reporting.

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

There have been no reported cases of C.Difficile infection within Practice Plus Group during the period 2025/2026.

2.3.7 Patient safety incidents



Patient safety incidents that...	2022/23		2023/24		2024/25		2025/26	
...resulted in severe harm	7	0.51%	6	0.31%	3	0.10%	8	0.18%
...resulted in death	1	0.07%	0	-	8	0.28%	6	0.13%
...were classified as never events	1	0.07%	1	0.05%	9	0.31%	4	0.09%
...were classified as serious incidents requiring external reporting	9	0.66%	9	0.47%	25*	0.86%*	11*	0.24%
Total number of incidents reported	1,370		1,923		2,904		4,525	

*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.

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

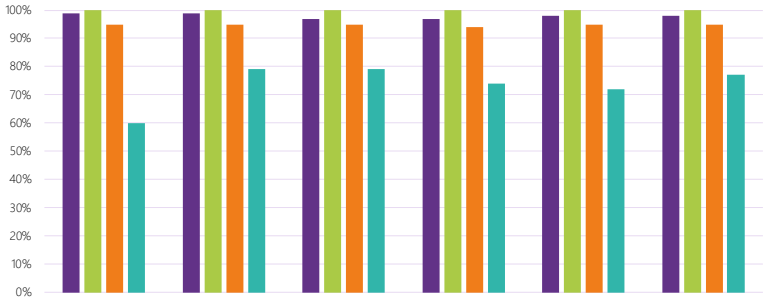
- Data are taken directly from the incident module of the datix electronic incident management system;
- Incidents are reviewed by a senior member of staff on each site within three days of reporting to ensure that all aspects of the incident, including the severity of harm and categorisation, are recorded 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 has taken the following actions to improve this indicator, and so the quality of its services, by:

- Completing a review of post-operative deaths;
- Undertaking a thematic review of all incidents relating to laparoscopic cholecystectomy.

2.3.8 Friends and family test

Percentage of positive responses by year in comparison with national performance



	Jan-21	Jan-22	Jan-23	Jan-24	Jan-25	Jan-25
Practice Plus Group	**99%**	**99%**	**97%**	**97%**	**98%**	**98%**
Best performance nationally	100%	100%	100%	100%	100%	100%
National average	95%	95%	95%	94%	95%	95%
Worst performance nationally	60%	79%	79%	74%	72%	77%

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

There has been a slight increase over the last two years in the percentage of positive responses received to the standard question “Overall, how was your experience of our service?” Practice Plus Group Hospitals has consistently performed above the national average, and just below the best performance nationally.

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

- The data are sourced from NHS England reports;
- Inpatient data are used 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 Friends and Family Test 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 have a fully embedded Freedom to Speak Up (FTSU) structure since March 2024. Practice Plus Group Hospitals have 3 FTSU Guardians and 3 central FTSU champions. Each Practice Plus Group clinical site has at least one FTSU Champion.

The FTSU champions are trained in the required FTSU modules and then have a dedicated confidential reporting platform. The FTSU Guardians are recorded on the National Guardians Office (NGO) register and have completed the FTSU Guardian training.

Practice Plus Group Hospitals have an up-to-date policy and flow chart for colleagues to refer to and we currently record trends and themes via the NGO data portal on a quarterly basis.

Our trends and themes are published to the executive board each quarter.

Our trends and themes for the year of 2025 were combined with the other divisions of the business (Health in Justice and Primary care). Moving forward FTSU themes and trends will only be captured for Practice Plus Group Hospitals as it is now a different business under Narayana Health since May 2026.

The overall numbers of FTSU concerns raised in 2025 for all divisions in the Practice Plus Group were:

- 57 FTSU concerns received January to December 2025;
- The number of the concerns raised anonymously were 22;
- The most common theme was worker safety or wellbeing.

From the above trends and themes there were many Human Resources signposting.

FTSU champions are supported in quarterly meetings where mock scenarios are discussed to aid the learning and support for the FTSU champions, we adapt the scenarios to fit the themes that are emerging from the data and to ensure that our FTSU champions are continuously learning.

Part 3:
Other information

3.1 Performance against the priorities set for 2025/26

3.1 Performance against the priorities set for 2025/26

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

We said we would:

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.

What we have achieved:

The Learning Response Review and Improvement tool developed by the HSSIB is applied at local site level when Patient Safety Incident Investigations are underway and to the final draft of the report, prior to submission to the central governance team for review and approval. The final version of the report is assessed against the same criteria as part of the central governance team approval process.

One of the criteria included in the tool is assessment of whether “People affected by incidents are compassionately engaged and meaningfully involved” [in the investigation]. All patients or families (i.e., 100%) are invited to give their perspective of the incident, contribute to the terms of reference and asked how they would like to receive the findings of the investigation at the outset. If there is no evidence of this in the final draft of the report when it is received by the central governance team, this is fed back to the site to be addressed. Generally, the response has been that the patient or family have not had anything further to add, and the sites are advised to document this in the report.

It is acknowledged that the patient/family is more likely to engage with a Patient Safety Partner if they are approached by them at the outset of the investigation. For this reason, our Patient Safety Partner is in the process of developing criteria against which to assess patient/family involvement from their perspective, as opposed to purely being from the sites’ perspective. This will be presented at the next Quality Governance and Assurance Committee meeting, due to be held on 9th July 2026. The remaining components of this improvement priority will be carried over to 2026/27 for completion.

Priority 2: Achieve quality standards for imaging (QSI) - partially achieved

We said we would:

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.

What we have achieved:

All sites have been prepared and feel ready for assessment, and have access to a Teams channel where all of the supporting data are accessible. The assessment fee has been submitted and dates are to be arranged once a new Head of Diagnostic Imaging is in post and has had the opportunity to review the information.

Priority 3: Enhance the perioperative pathway - partially achieved

We said we would:

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.

What we have achieved:

Our teams have completed health guidance training to ensure we are enhancing the support offered to our patients in becoming fit for surgery.

Updated acceptance criteria are now in place for Practice Plus Group Hospitals and clinical sites. Multidiciplinary team meetings are now well-embedded across the sites in order to make decisions for accepting patients into our service that are fit for surgery. The evidence for MDT meetings is captured in our electronic patient record system and has been audited for the effectiveness and to ensure the acuity for our ward-based care sites is appropriate.

Our pre assessment process will transition in the next year to a bespoke ePOA platform which will future enhance from our electronic patient record version that is currently in place.

A Pre-Operative Blood Testing Matrix has been established nationally that encompasses ASA and NICE guidelines for blood testing.

Cancellations reporting is now displayed in a clinical governance dashboard which is utilised by sites to review trends and themes.

Sip to send protocols are now in place and embedded across our hospitals and surgical centres.

Priority 4: Surgical site infection risk assessment - partially achieved

We said we would:

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 preadmission and on the day of surgery and implement the necessary actions to prevent surgical site infections in those identified as at risk.

What we have achieved:

We have revised the internal surgical site risk assessment tool in full and adding it to our electronic patient record system (Maxims). We need to do further training with individual staff groups to ensure that it is completed correctly and the actions to undertake if a patient having hip or knee arthroplasty has a high-risk score. This will therefore be rolled over to the year 2026/2027 as a priority.

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

We said we would:

- 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.

What we have achieved:

We successfully hosted a cohort of five trainees in 2025/26 and achieved a 100% fill rate for trainee roles for 2026/27.

All trainees have progressed through their training milestones, with sign-off completed by their designated supervisors and designated prescribing practitioners, enabling them to sit the summer registration assessment.

The programme has strengthened service resilience, with trainees supporting staffing across two sites during vacancy periods and reducing reliance on agency staff. Trainee survey feedback was positive, particularly in relation to clinical skills development, protected study time, manageable workload, cross-sector placements, inclusion, and contribution to the team.

The feedback also highlighted opportunities to widen supervisor capacity and improve access to external teaching courses. These improvements will be incorporated into the 2026/27 cohort.

Priority 6: Utilisation of Point of Care Testing (POCT) - partially achieved

We said we would:

- 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.

What we have achieved:

Successfully established regular National POCT Committee meetings throughout the year, initially monthly then moved to bi-monthly once embedded.

Local site level committee meetings are currently being established and are being supported to hold regular meetings by the National POCT Lead.

Sites are working towards completing audits to review the POCT service they provide and are being supported by the National POCT Lead.

Routine on-site inspections are well-established with any areas of improved and learning shared with sites, following completion of self-assessments that form the basis of the on-site inspection.

Quality control is well established at all sites for all devices and quality assurance is in place where this is required by the local ICB. Sites are supported by the National POCT Lead for any advice regarding QC/QA.

There will be a continued effort to ensure that the above is delivered, established and maintained.

3.2 National Joint Registry (NJR) quality data provider awards

All Practice Plus Group hospitals were awarded NJR Quality Data Provider status for 2025 after successfully completing a national programme of local data audits.

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 2025. 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);
- Birmingham Hospital (gold award);
- Emersons Green Hospital (silver award);
- Ilford Hospital (gold award);
- Plymouth Hospital (gold award);
- Shepton Mallet Hospital (gold award);
- Southampton Hospital (bronze award).

NJR quality data provider scheme

Snapshot of award levels

Eligibility Criteria	Bronze	Silver	Gold
Uploading a clean set of audit data by 31/08/2026 for primary and revision procedures for hips, knees, shoulders, elbows and ankles (where relevant procedures are undertaken) for the NJR audit period **2025/26** with initial baseline compliance rate of:	95.00% to 96.99%	97.00% to 98.99%	99.00% to 100%
Resulting in a final audit compliance by 30/09/2026 of:	98%	99%	100%
Review of audit report and classifications of missing cases as appropriate. Percentage of cases with no status, which is to be no higher than the percentage stated here for each category	2%	1%	0%
Missing cases identified by the audit to be fully submitted to the NJR. Percentage of cases failed to submit, which is to be no higher than the percentage stated here for each category.	2%	1%	0%

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 2025/26

Priority 1 - Achieved

We said we would:

- Increase referrals / conversion rates from more complex patients;
- Achieve better theatre utilisation.

What we have achieved:

- Increase in theatre 1 utilisation from the previous year which continues to grow;
- Increase in weekend sessions across all theatres;
- Increase in referrals – the 2024/25 monthly average of 444 referrals has increased to 468 monthly average during 2025/26;
- Inclusion criteria have been expanded to include more complex patients.

Priority 2 - Partially achieved

We said we would:

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

What we have achieved:

- Noticeable increase in incident reporting – 375 incidents reports in 2024/25 compared with 703 incidents reported in 2025/26, accompanied by more thorough and effective investigation processes;
- Clinical Governance meetings are well-attended with meaningful discussion and shared learning;
- There has been some improvement but there is still work to be done with consultant involvement in investigations. This will be our focus for the coming year with the appointment of the new Medical Director.

Priority 3 - Achieved

We said we would:

- 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.

What we have achieved:

- Reduction in patient transfers from previous year;
- Increase in staff retention – 91.8% compared to 89.4% in 2024/25;
- ALERT training for all clinical staff giving them more confidence to recognise and manage more complex patients;
- Expansion of inclusion criteria in line with Practice Plus Group.

Local outcomes

Barlborough	#	%	Comments
NJR submission	2687	100%	NJR Quality Data Provider Awards 2025 - Practice Plus Group Hospital – Barlborough - Gold Level
VTE risk assessment	2979	100%	Checked each month to ensure compliance
VTE incidents	20	0.67%	
Transfers to NHS trusts	10	0.18%	
Readmissions and/or return to theatre	55	1%	18 readmissions, 2 returns to theatre (RTT), 35 both readmission and RTT. Includes readmission and RTT at other providers, some of which may be due to reasons not related to index surgery
Surgical Site Infections (SSIs)	45	0.97%	24 Superficial, 21 Joint Space
Endophthalmitis	0	0%	No incidents in 2025/26
Delay in diagnostic/treatment pathway	0	0%	No incidents in 2025/26
Incidents relating to patient harm	349		300 low harm, 45 moderate harm, 4 Deaths within 31 days of surgery
Patient Safety Incident Investigations (PSIIs)	1		Emergency Transfer resulting in patient death
Complaints received	20	0.36%	
Complaints upheld/partially upheld	12	60%	

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 Investigations (PSIIs)

The key learning from these reviews included:

- Patients with suspected vascular injury need to be transferred to the appropriate provider with adequate onsite expertise – in this case Derby Hospital would be the preferred hospital. SOP has been updated to include specialist areas including vascular, ophthalmology and bariatrics.
- Documentation needs to be written in real time and should be clear and comprehensive.
- Pedal Pulse charting should be done for all patients with who have undergone lower limb surgery.

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

- As below.

11 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- SBAR format should be used to ensure a comprehensive handover with quick and clear information sharing to all teams;
- Escalation of deteriorating patients were highlighted promptly with all members of the team able to raise concerns.

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

- Updated emergency transfer SOP to include speciality transfers e.g. vascular complications;
- ALERT training for all clinical staff to manage patients with more complex post op needs;
- SWARM huddles to include all team members within 48 hours and be recorded on Datix.

53 Unplanned readmission reviews

The key learning from these reviews included:

- Reviews showed that patients were discharged appropriately and only when they were clinically fit, with no evidence of premature discharge or missed clinical concerns. This provided assurance that readmissions were not linked to the initial discharge decision but were instead related to factors arising after discharge;
- Readmissions may be linked to difficulty accessing GP appointments;
- Patients were not always contacting the hospital directly with concerns, particularly where they do not live locally, meaning the patient had already been readmitted to another trust or their condition had worsened and requiring readmission.

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

- Ensuring patients are aware of red flags to know when to seek assistance;
- Dedicated post operative helpline is in place to ensure patients can access support and advice post discharge with clear signposting to other services if necessary;
- Develop links with other trusts to ensure information is received regarding external readmissions.

37 Unplanned returns to theatre

The key learning from these reviews included:

- The decision to take patients back to theatre should be made by the MDT and not just the operating surgeon. This should be clinically reasoned and, if for infection, there should clear evidence of infection e.g. swab results;
- Datix should be completed and investigated promptly to identify trends;
- All returns to theatre should be recorded as ‘moderate harm’ and Duty of Candour completed.

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

- All patients must be reviewed by the MDT before return to theatre except in the case of emergencies e.g. post op dislocation;
- Datix investigations need to be competed within the specified timescales and any learning, themes or trends shared with the wider team;
- Duty of Candour to be completed for all returns to theatre and documented on Datix

20 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- All venous thromboembolism (VTE) investigations conducted during the reporting period were thoroughly reviewed and completed in line with established clinical protocols and governance standards. Each case was assessed for adherence to risk assessment, prophylaxis, diagnosis, and management pathways. The outcomes demonstrated full compliance with expected practice, and no concerns, deviations, or lapses in care were identified. Furthermore, there were no recurring themes or trends that suggested the need for additional training or system changes. As a result, no specific learning points were highlighted, and current practices are considered effective and appropriate.

21 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- Limited documented evidence was found that enhanced interventions were not implemented for patients scoring 6 or above on the SSI risk assessment tool, highlighting missed opportunities for risk-based prevention;
- Microbiological cultures revealed a broad range of organisms, reflecting a multifactorial pattern rather than a single source;
- Variability in environmental cleanliness standards within theatre settings, including gaps in routine assurance processes and reduced housekeeping capacity during periods of staff absence;

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

- Surgical site risk assessment tool used to inform decision making in terms of appropriate dressing application immediately following surgery;
- Introduction of weekly cleaning audits in theatre with clear documentation and governance oversight;
- Increased IPC Lead spot-check surveillance to provide independent assurance of cleaning standards;
- Formal escalation of audit findings and required actions to Heads of Departments, with accountability for timely completion;
- Staffing increased within the housekeeping team to ensure consistent service provision and compliance with National Healthcare Cleanliness standards.

24 Superficial SSI thematic reviews

The key learning from these reviews included:

- Inconsistent wound-cleansing practices and dressing selection during post-operative clinic reviews;
- Variations in wound swab testing and antibiotic prescribing post-operatively.

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

- Development of a formal postoperative wound-management policy, and implementation of an SSI management policy, creating structured, evidence-based, and consistent care pathways for post-op care;
- Clinical teams to adhere to strict ANTT® procedures during dressing changes post-operatively;
- Monthly audits of antibiotic prescription practices are conducted to ensure adherence to the National Institute for Health and Care Excellence (NICE) antimicrobial prescribing guidelines, thereby promoting effective antimicrobial stewardship.

No cases of Endophthalmitis

Learning from local Patient Safety Priorities

Five adverse clinical outcomes (e.g., hip dislocations, leg length discrepancies) associated with the same surgeon in a 6-month period will prompt a thematic review. This threshold was not reached during the reporting period.

Priorities for 2026/27

Priority 1

What are we trying to improve?

- Strengthen the Medical Leadership team with the appointment of the new Medical Director, embedding a culture of accountability, collaboration and continuous improvement to drive high quality patient care and high performance.

What will success look like?

- Clear, unified Clinical Leadership;
- Improved engagement in clinical teams;
- How will we monitor progress?
- Compliance with clinical quality indicators;
- Timeliness and quality of clinical decision making.

Priority 2

What are we trying to improve?

Introduction of new specialties and new procedures available for patients.

What will success look like?

Introduction of new specialties to include, but not limited to,

- Cervical spines;
- Weight loss surgery;
- Thumb/finger joint replacements;
- Injections such as hyaluronic acid;
- Oculoplastics.

How will we monitor progress?

- Referrals received for new specialties;
- Number of patients seen/treated;
- Clinic/Theatre utilisation;
- Clinical outcomes.

Priority 3

What are we trying to improve?

- Improve the reporting, management and prevention of surgical site infection using evidence based practice.

What will success look like?

- Better integration with the local NHS MDT Revision Service;
- Reduction in the number of unnecessary wound swabs;
- Reduction in antibiotics given when not indicated.
- How will we monitor progress?
- Reduction in SSIs;
- Quality of incident reporting;
- Increase in investigations completed within the timeframe;
- Infection Prevention and Control Lead will continue to monitor rates of SSIs and work closely with Deputy Director of Infection Prevention and Control to review findings.

Priority 4

What are we trying to improve?

- Implementing “Paper Light” patient files.

What will success look like?

- Patient Administration System to be used for all post-operative appointments.
- All staff accessing the Patient Administration System (Maxims) for information on patients rather than patient files.
- Further identification of other documents that could be removed from files and input direct to the Patient Administration System.

How will we monitor progress?

- Reduced number of documents in a patient file
- Increased direct input into the Patient Administration System
- Check all patient files are scanned on the day after discharge

Patient stories

To all the staff at Barlborough,

I am writing to express my sincere gratitude for the outstanding care I received during my recent stay with you for my hip replacement surgery.

From the moment I arrived, I was met with kindness, professionalism, and genuine compassion. Every member of staff, from the nurses and doctors to the support and administrative teams, made me feel comfortable, reassured, and well looked after throughout my entire experience.

The level of care I received was truly exceptional. The staff took the time to explain each step of the process, answered all my questions with patience, and ensured I felt confident and at ease before and after my surgery. Their dedication and attention to detail did not go unnoticed.

I am especially delighted with the outcome of my new hip. The improvement in my mobility and comfort has already made such a positive difference in my daily life, and I feel incredibly grateful for the expertise and skill of the surgical team.

Thank you all for your hard work, kindness, and commitment to patient care. It made a significant difference to my recovery and overall experience.

With heartfelt thanks and appreciation.

Dear Barlborough Team,

I came in creaky, hobbling slow,
My hip said firmly, “No more golf, no go!”
Each step a wobble, each swing a myth,
I’d nearly retired… thanks to my hip.

But then you stepped in, calm and kind,
With magic hands and brilliant minds.
From nurses cheering me on each day,
To surgeons who swung the ultimate play.

You fixed me up with skill and care,
A brand-new hip beyond compare!
You patched me, oiled me, made me whole,
And now I’m dreaming of the 18th hole.

No more limping down the fairway grass,
No more letting my playing partners pass.
I’ll grip my club, take a mighty swing—
(And blame the wind for everything!)

Thanks to you all, I’m back in the game,
Though my scorecard may still look the same…
But I’ll walk the course with a happy grin,
With a hip that’s ready to go for the win!

So thank you all, you wonderful crew,
For all that you did—you truly came through.
If there were trophies for care so great,
You’d win them all… no need to debate!

With heartfelt thanks (and a golfer’s cheer!),
I’ll think of you on every round this year.

Yours gratefully.

Birmingham Hospital

Performance against the priorities set for 2025/26

Priority 1 - Not achieved

We said we would:

Achieve 100% compliance with VTE risk assessment.

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.

What we have achieved:

91.5% (snapshot audit results)

The key issues identified include incomplete discharge VTE assessments, where the clinician's signature is present, but the discharging nurse's signature is frequently missing. In addition, the acknowledgement box confirming whether VTE leaflets were provided at the pre-operative stage is sometimes left unticked. There are also instances where some of the 3–4 VTE assessments completed during a patient's inpatient stay are not fully completed.

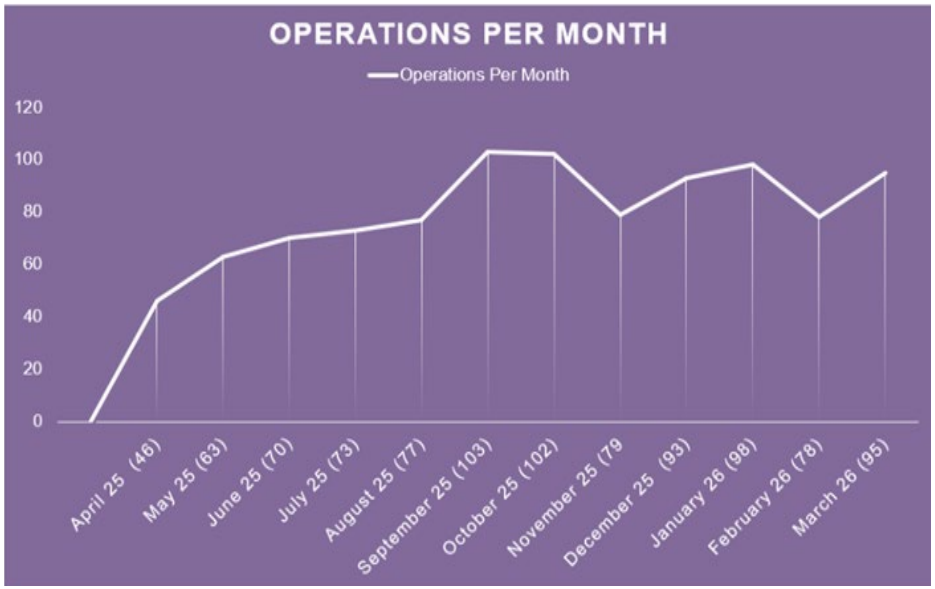
These findings have been highlighted as learning points in Quality Governance and Medicines Management Meetings, as well as communicated directly to relevant staff via email. Ward-level training on completing VTE assessments has also been delivered. However, as compliance remains below the required standard, the organisation's VTE lead will provide further training at the next Governance Day in May, which will also cover the updated Practice Plus Group VTE Policy.

Priority 2 - Partially achieved

We said we would:

Improve our theatre utilisation and increasing our productivity whilst monitoring opportunities for efficiencies.

Theatre cases per month



What we have achieved:

The average theatre utilisation over the 12-month period is 65.1%. The mean theatre turnaround time between cases across the same period is 10.5 minutes. Theatre administrative booking efficiency over 12 months stands at 72%.

Priority 3 - Not achieved

We said we would:

Our private healthcare manager and coordinator are working hard to convert outpatient appointments into admissions. Our current conversion rate is 66% and our target conversion is 70%.

What we have achieved:

Private self pay (30%) and Private medical insurance: (38%): 68%

NHS: 32%

Local Outcomes

Birmingham	#	%	Comments
NJR submission	298	98%	
VTE risk assessment	1055 / 1062	99%	This has been taken from Harvest
VTE incidents	2/728	0.2%	
Transfers to NHS trusts	2	0.19%	
Readmissions and/or return to theatre	1	0.10%	
Surgical Site Infections (SSIs), excl. superficial SSIs	2	0.19%	
Endophthalmitis	0	0	
Delay in diagnostic/treatment pathway	0	0	
Incidents relating to patient harm	17	15.5%	
Patient Safety Incident Investigations (PSIIs)	0	0	
Complaints received	5	0.7%	
Complaints upheld/partially upheld	0	0	

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:

- 0 Patient Safety Incident Investigations (PSIIs).
- 0 Emergency Transfer SWARM huddles, supported by SEIPS analysis.
- 0 Unplanned readmission reviews.

1 Unplanned return to theatre review

Dislocation following hip replacement.

The key learning from these reviews included:

- The patient developed increased pain post operatively and was struggling to weight-bear (unable to establish how dislocation occurred and this is a known complication). The patient was X-rayed and returned to theatre the same day for manipulation.

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

- The correct process was followed. Shared learning was escalated to the team. Staff reminded to escalate concerns when a patient has increased pain and has difficulty mobilising.

2 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- Weight and BMI should be recorded on admission and documented on patient drug chart.
- VTE risk assessment was partially completed at discharge.

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

- New VTE policy learning session was undertaken on governance day.
- SBAR style learning vignette created and shared with staff.
- Learning session recorded on teams cascaded to Drs to disseminate new VTE guidance.

1 Post Infection Review (PIRs)

Patient admitted for left total hip replacement and discharged the following day with no concerns. 6 weeks post operation Birmingham Practice Plus Group patient taken back to theatre for wash out. A PIR was conducted and no adverse findings were identified from this case.

The key learning from this review included: None

1 Superficial SSI thematic review

SSI following hernia repair.

The key learning from this review included:

- Optimisation of patient health.

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

- Encourage weight loss, smoking cessation, and strict glucose control before elective hernia repair.
- Screen for Infection: Treat any active infections (skin, urinary, respiratory) before surgery.
- Administer appropriate antibiotic within 60 minutes before incision.
- Educate patients on wound care and signs of infection (redness, swelling, pus, fever).
- Provide patients with clear instructions for dressing changes and hygiene.

0 Endophthalmitis-Specific PIRs (E-PIRs): None

Learning from local Patient Safety Priorities

No broken suture needles for the same surgeon in the last year compared with 2 recorded incidents from the previous year.

Priorities for 2026/27

Priority 1

What are we trying to improve?
VTE audit compliance sits at 91.5%.

What will success look like?
We aim to achieve 100% VTE compliance. VTE training implemented on the governance day for all staff. Implement dual sign off of VTE assessment on the ward and visual prompts to distribute leaflet at pre op appointment. Create VTE champions in all areas.

How will we monitor progress?
We will continue to audit this but this will now be a dual audit completed by the ward and pharmacy department.

Priority 2

What are we trying to improve?
SSI rates to remain low with increased clinical activity

What will success look like?
To have no upward trend of SSIs over consecutive months with increased clinical activity.

How will we monitor progress?
SSIs will be recorded on Datix and a thematic review completed within 40-60 days.

Priority 3

What are we trying to improve?
Antimicrobial Stewardship is audited quarterly. The pre surgery antibiotics are given correctly but the doses vary and are not always in line with Practice Plus Group policy.

What will success look like?
Alignment for all staff with the Practice Plus Group policy.

How will we monitor progress?
Continue audit quarterly and identify any actions from this

Patient stories

To the wonderful team,

When my mum came in for her hip replacement last week, we expected good care. What we experienced is something beyond that. From friendly voices on the phone when we first called, to the warm welcome every time we walked through the door, we felt looked after from the beginning. The Consultants were impeccable, professional, reassuring and clear. The nurses after the operation were kind, positive and attentive. The physio ensured mum went into surgery feeling informed and confident. Then there were thoughtful touches, the catering team opened early twice, the spotless wards, the cheerful cleaning team, and the delicious free coffee. Every single person played a part in making this a truly exceptional experience. Quite simple 11 out of 10.

To all the wonderful staff at Practice Plus Group Birmingham,

A million thanks for all your love, care and support, helping me to get through my surgery.

You're all so amazing!!

I cannot thank the team at Practice Plus Group Hospital Birmingham enough for the incredible care I have received.

As a veteran, I had been waiting over 6 months on another hospital's list with no surgery date in sight and was living in constant, agonising pain.

I saw a post on Facebook, and I discovered that Practice Plus not only welcomes veterans but also has serving and ex-serving military staff on their team, which gave me great confidence that I'd be understood and well looked after.

From the moment my GP referral was made, the difference was life changing. Within just 7 days I travelled to Birmingham and had a consultation, X-rays and the necessary tests. To my amazement, I was called in for surgery only 3 weeks later. On the day of my operation, I was greeted by name, shown straight to my room and fully prepared for surgery. Later that day, the Consultant and his surgical team performed my hip replacement with outstanding professionalism and care.

From start to finish, every single member of staff – catering, admin, nurses, and the surgical team – was friendly, supportive and made me feel completely at ease.

A special thank your business development manager who kept me fully informed throughout and ensured everything went smoothly. She is amazing!

As a veteran, I cannot recommend Practice Plus Group Hospital Birmingham enough. Their understanding, efficiency and compassion – supported by a team that includes fellow servicemen and women – is second to none.

They have given me a new lease of life, and I would encourage any veteran in need of treatment to reach out and experience the same outstanding care, all done within 2 visits, which means there wasn't a huge amount of painful traveling.

Warmest regards.

Devizes Surgical Centre

Performance against the priorities set for 2025/26

Priority 1 - Achieved

We said we would:

Improve incident reporting and management

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

What we have achieved:

We have on average achieved over 95% of all incidents reported, reviewed and investigated within the required time frames. We have also increased reporting within the last year, from approximately 6/10 incidents reported per month, to an average of 15/20 incidents reported. We have also seen an improvement in the accuracy and quality of the information reported within the incidents, by using the SBAR template. This has led to improved quality of investigations and reports.

Priority 2 - Not achieved

We said we would:

Improve ANTT® compliance and training

- 95% or higher in ANTT® training compliance.
- 100% of all relevant staff trained in ANTT®.

What we have achieved:

We have not achieved ANTT® compliance within the last year due to staffing restrictions; however this is a priority for 2026-27. We will be training ANTT® accredited trainers to support in training all necessary staff, as well as support from Emersons Green Hospital, which has been awarded Silver accreditation.

Priority 3 - Partially achieved

We said we would:

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

What we have achieved:

We have reviewed our target of 30% response rate and have established this was an ambitious target. We have seen an increase in responses, from an average of 6% in 2024-2025, to an average of 12% in 2025-2026. We will continue to aim for an average response rate of 10%.

Local outcomes

Devizes	#	%	Comments
Transfers to NHS trusts	3	0.04%	
Readmissions and/or return to theatre	5	0.07%	
Surgical Site Infections (SSIs)	0	0	
Endophthalmitis	1		One Endophthalmitis. EPIR was completed and no concerns found
Delay in diagnostic/treatment pathway	10	0.14%	These were delayed IPTs. Gap was identified and training provided.
Incidents relating to patient harm	149	2.1%	107 no harm, 23 low harm and 11 moderate harm.
Patient Safety Incident Investigations (PSIIs)	0		0 PSII for NHS patients
Complaints received	19		
Complaints upheld/partially upheld	11	58%	

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 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Improved communication and use of SBAR

1 Unplanned readmission reviews

The key learning from these reviews included:

- Ensuring appropriate fit for discharge;
- Good practice returning patient to theatre to support wound healing.

4 Unplanned returns to theatre reviews

The key learning from these reviews included:

- Patient did not fully understand what was normal and when/how to contact the centre with their post-operative complications

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

- We have shared the post-operative instruction leaflet used at Emersons Green with Devizes

1 Endophthalmitis-Specific PIRs (E-PIRs)

The key learning from these reviews included:

- Quick response from the team to assess the risk to patients and put in the appropriate steps required;
- Agency staff involved followed a different process than that followed locally.

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

- High Level deep clean of the theatre;
- Ensure agency staff have a full induction including referencing local policy and procedures;
- Review of staff competencies.

Learning from local Patient Safety Priorities

It was identified several patients were delayed onward referrals due to a gap in our Consultant training programme. Although none of these delays resulted in moderate or severe harm to the patients, it did identify a need for training and an onward referral guide.

We added this concern to our risk register, as well as creating an audit tool and a change to process to reduce the risk of reoccurrence. We have since seen a reduction in delayed referrals.

We continue to report any missed or delayed referrals and will continue to monitor and audit this through 2026/27.

Priorities for 2025/26

Priority 1

What are we trying to improve?

Standardisation of quality process and procedures across both Devizes Surgical Centre and Emersons Green Hospital

What will success look like?

Effective standardisation and reporting mechanisms, removing duplication and process gaps.

How will we monitor progress?

We will monitor progress through Governance Days and effective departmental reporting.

Priority 2

What are we trying to improve?

ANTT accreditation

What will success look like?

Obtaining accreditation

How will we monitor progress?

Training records, reporting and Devizes leadership reporting

Priority 3

What are we trying to improve?

Transfer of patients who require overnight monitoring or experience complications during surgery

What will success look like?

Improved patient care and safety. Improved patient experiences. Effective SOPs and processes in place.

How will we monitor progress?

Datix and patient safety incidents

Patient stories

Patient Story 1:

I'm emailing on behalf of my husband who was triaged then seen by the exact person who spotted the signs of a very rare illness. Therefore, meaning his treatment was speedy and his prognosis for recovery will likely be easier. On the 31st March he went to the Devizes treatment centre and was seen by a physio, I'm sorry I don't remember his name but for his knowledge and the triage being spot on he's been incredibly lucky. He's now in GWH after being admitted immediately after seeing your physio and is receiving treatment for Guillain Barre syndrome. I want these incredible people thanked please as they may have saved my husband an even longer time recovering

Patient Story 2

Dear Consultant,

I am writing to you to thank you so much for the Cataract removal you did on my left eye on the 15th May 2025 at Devizes. I can see so much better and it is healing very well. I am using the eye drops, and I have followed all the dos and don'ts.

Also, the nurses were wonderful, all the care they gave me was so reassuring. I was very frightened, but I won't be when my right eye Cataract is removed because I know what happens and the good care us patients have from all the team and wonderful skills you and the team possess.

Thank you very much, I really am grateful to you all.

Emersons Green Hospital

Performance against the priorities set for 2025/26

Priority 1 - Partially achieved

We said we would:

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

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

What we have achieved:

All reported infections within 2025/2026 have had a short investigation completed which have been uploaded to Datix. Any infection identified as requiring a PIR has been completed within the 20 days and are now approved by the Central IPC team as per process. These PIRs are now also sent to patients with Duty of Candour.

Priority 2 - Partially achieved

We said we would:

Improve ANTT® compliance and training.

- 95% or higher in ANTT® training compliance.
- 100% of all relevant staff trained in ANTT®.

What we have achieved:

Emersons Green have been awarded Silver accreditation. Our IPC lead is now working towards achieving Gold accreditation for 2026/27.

Priority 3 - Partially achieved

We said we would:

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

What we have achieved

We have reviewed our target of 30% response rate and have established this was an ambitious target. We have seen an increase in responses, from an average of 9% in 2024-2025, to an average of 20% in 2025-2026. We will continue to aim for an average response rate of 10%.

Local outcomes

Emersons Green	#	%	Comments
NJR submission			
VTE risk assessment	7578	92%	
VTE incidents	4	0.05%	
Transfers to NHS trusts	11	0.07%	
Readmissions and/or return to theatre	19	0.12%	
Surgical Site Infections (SSIs)	15	0.1%	13 Superficial 1 Deep 1 Joint Space
Endophthalmitis	0		
Delay in diagnostic/treatment path-way	9	0.06%	
Incidents relating to patient harm	277	1.8%	161 no harm 81 low harm 35 moderate harm
Patient Safety Incident Investigations (PSIIs)	3	0.02%	
Complaints received	40		
Complaints upheld/partially upheld	37	92.5%	

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:

3 Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

From our first PSII the following was identified:

- Appropriate and timely escalation of a procedural complication did not occur
- Senior Management were not notified of the complication or the recovery plan until a compliant was received by the patient
- Timely documentation was poor

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

- Escalation process put in place for any cancellation or complications to be escalated to Senior Management at the time of the incident
- Staff empowered to raise concerns internally with CUSS training planned for early 2026
- Shared learning with all consultants and clinical staff at our Clinical Governance Day to highlight the need for timely and accurate reporting.

From our second PSII the following was identified:

- Trial equipment was in the building being used, however Senior Management were not aware and no process or discussion had been had as to the appropriateness of when to use it
- No evidenced training on the trial equipment before use
- MIA processes were not followed and as the Rep was known to staff, their attendance was not challenged
- Lack of evidenced debrief of complications that happened within surgery
- The patient safety improvements made in response to the reviews included:
- The use of trial equipment was immediately halted whilst we await a company wide policy to be created with very clear processes in place
- Staff retrained on the importance of MIA processes
- A shared learning exercise at the Clinical Governance Day on the importance of debrief and documentation. A review is also in place to look into incorporating debrief documentation into the WHO checklist audit

From our Third PSII the following was identified:

- Never Event – incorrect implant
- NJR processes were not followed
- Theatre check processes were not followed

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

- The incident was immediately shared with all theatre staff to be aware of the incident and the identified areas of concern
- All staff reminded to follow correct NJR processes including scanning implants to identify correct implant has been selected
- All staff reminded to follow theatre check processes, including scrub nurse and consultant checks of the correct sided implants.

12 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Good use of SBAR
- Improved documentation
- Efficient and timely attendance from our resus team

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

- Daily Resus huddles
- Daily Emergency Call Bell testing
- Regular Resus scenarios with our Resus Leads

13 Unplanned readmission reviews (including 3 returns to theatre)

The key learning from these reviews included:

- Patients were attending A&E before contacting the helpline with concerns
- Discharge criteria reviewed, all patients were fit for discharge and complications developed later, such as dental infections.
- Reporting of readmissions have significantly improved, including documentation in SBAR format

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

- Discharge information reviewed. Staff ensuring patients are fully aware of any concerns to look out for and the details our of 24-hour helpline
- Readmissions are shared at Clinical Governance Days for shared learning

9 Unplanned returns to theatre reviews (including 3 readmissions)

The key learning from these reviews included:

- Patients encouraged to return to Emersons Green hospital instead of A&E
- All return to theatre were due to known complications
- The patient safety improvements made in response to the reviews included:
- Nurses and Resident Doctor continue to bring patients with concerns on the 24-hour helpline back to Emersons Green hospital instead of directing to A&E
- Creating flexibility in our consultant rota to allow patients to return to theatre who require it, also in turn supporting primary care
- Practice Plus Group Review into Bile Duct injuries

4 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- Good practice in using dopplers on patients with suspected DVTs
- The patient safety improvements made in response to the reviews included:
- Shared learning companywide about the use and access of dopplers on patients with suspected DVT

Learning from local Patient Safety Priorities

Following a recent Quality Review, it was identified that there were concerns in our compliance in good medicines management and safer surgery criteria such as the WHO checklist.

All transfers, readmissions and return to theatre incidents are now required to review the patient WHO checklist and upload to the patient Datix. Any incident or concern raised against safe surgery or compliance is escalated to the Senior Management team and will trigger an investigation. Any failed theatre audit is now escalated to the Senior Management team for review with an action plan.

All medicine incidents are now reviewed by the Clinical Governance Manager and Head of Pharmacy for trends and themes which will trigger a review. Any failed Pharmacy audit is now escalated to the Senior Management team for review with an action plan.

Priorities for 2026/27

Priority 1

What are we trying to improve?

Following a recent Quality Review, it was identified that there were concerns in our compliance in good medicines management. We will therefore be commencing a project to improve what medicine management looks like at Emersons Green.

What will success look like?

Successful medicine management would involve high scoring regular audits and reduced incidents requiring reporting, which would be evidenced by embedded effective training and staff ownership and accountability.

How will we monitor progress?

We will be monitoring progress through multiple monthly audits, as well as ensuring staff competencies and training are completed to the required standard. We will report any incidents relating to medicines management, which will be reviewed and monitored by the Governance Manager and Head of Pharmacy. Any trends, themes or concerns identified will be escalated to the senior management team.

Priority 2

What are we trying to improve?

Following a recent Quality Review, it was identified that there were concerns in our Surgical Safety, specifically around our WHO compliance.

What will success look like?

Improved safer staffing would involve high scoring regular audits and reduced incidents requiring reporting, which would be evidenced by embedded effective training and staff ownership and accountability.

How will we monitor progress?

We will be monitoring progress initially through weekly audits, which will reduce to monthly audits once compliance is assured. We will be ensuring staff competencies and training are completed to the required standard. We will report any incidents relating to safer staffing our WHO checklist compliance, which will be reviewed and monitored by the Governance Manager and Head of Nursing. Any trends, themes or concerns identified will be escalated to the senior management team including the Hospital and Medical Director. We will also be discussing and sharing learning at our Bi monthly Clinical Governance Days, as well as reviewing any concerns raised with our clinical teams.

Priority 3

What are we trying to improve?

ANTT accreditation by aiming to achieve Gold accreditation by the end of 2026.

What will success look like?

Achieving Gold Accreditation.

How will we monitor progress?

We will monitor progress through our staff training and track progress through our IPC Committee meetings, which are hosted by our IPC Lead.

Patient stories

Patient story 1

I'm writing to express my heartfelt thanks for the outstanding care I received during my recent hysterectomy on 6th March 2025, carried out at your hospital. From start to finish, the experience was marked by professionalism, kindness and a high level of care. My initial consultation with My Consultant set the tone. His reassuring manner, clear communication, and can-do, enabling approach gave me the confidence I needed to proceed with the surgery. I felt fully informed and supported throughout. The preoperative team carried out their assessments with thoroughness, and every staff member maintained a cheerful and positive demeanour. On the day of the surgery, the nursing care was exceptional. Nurse 1 initially, and then Nurse 2, were both attentive and calm, qualities which made a real difference at a vulnerable time. Post-operatively, I continued to feel well looked after. When I had some concerns during recovery, the nurse once again was most helpful. I was also very grateful that your anaesthetist who took the time to call me personally to provide clarity. Likewise, the nurses I spoke to on the aftercare helpline were patient and knowledgeable. Please also pass on my sincere thanks to My Consultant.

Patient story 2

I was referred here by my NHS GP in December 2024. After my referral, I was seen by the lovely Consultant at the hospital in January 2025 for a consultation and then had my prolapse surgery in July.

I was delighted to have a private room with a TV, and my own shower/toilet facilities. And the kitchen staff ensured I was offered lots of hot drinks and plenty to eat. The menu is lovely and varied (so much choice). The food is very nice, well presented and nothing was any trouble for the clinical/non-clinical staff. Everyone was delightful.

The staff at the hospital are all fantastic, I stayed overnight for my procedure and every nurse took such great care in looking after me, I felt genuinely cared for and nothing was too much. All of my nursing staff were great and ensuring I was comfortable/free from pain.

The surgical/theatre team were also fantastic, my surgeon explained the procedure and all the theatre staff explained their roles in the operating theatre. This helped me to remain calm as I was very nervous. I had a spinal anaesthetic with sedation. I was so relaxed by this I ended up sleeping through the majority of the procedure.

The surgeons caring, empathetic and calming nature really helped settle my nerves and I felt at ease and also well looked after. My Anaesthetist and anaesthetic practitioner were both excellent too. Their humour helped me relax and made me feel at ease in theatre - in particular we shared a laugh when the cold spray on my back was applied making me jump slightly before the spinal was applied.

My surgeon saw me on the ward later the same day after the procedure to check how I was feeling. He explained the steps taken in theatre and the additional surgery he completed as part of my repair when assessing the severity of my condition under anaesthetic. The aftercare was well explained and he carefully stated what I should/should not do during my recovery.

I was given a contact number for the enquiries phone which is with the clinical staff 24hrs a day so they can answer any query day or night which is highly reassuring. I would thoroughly recommend this hospital for anyone having any procedure. Brilliant nursing staff, excellent surgeons, wonderful receptionists and catering staff, phenomenal care from this hospital from everyone involved. I cannot recommend them enough.

Ilford Hospital

Performance against the priorities set for 2025/26

Priority 1 - Partially achieved

We said we would:

We will increase our flu vaccination uptake with two thirds of our staff vaccinated.

What we have achieved:

We have dedicated staff members providing flu vaccinations and have circulated communications outlining how staff can access these and the associated benefits. Our flu vaccination uptake has improved compared with last year; however, we have not vaccinated two thirds of our staff. This shortfall is partly due to some staff receiving their vaccinations externally, while others have chosen not to be vaccinated.

Priority 2 - Partially achieved

We said we would:

Improve PROMS data collection, with 95% of PROMS completed.

What we have achieved:

There has been an increase in our PROMs data collection compared with last year; however, we have not yet been able to reach the 95% threshold. We plan to continue focusing on this area and will carry this priority forward into next year to ensure further improvement.

Priority 3 - Achieved

We said we would:

Patients will have a smoother pathway, a better patient experience and the wait time for nurse-led appointments will decrease with the introduction of one-stop clinics.

What we have achieved:

We have undertaken an improvement project based on Capacity challenges to achieve this priority. At the start of the project in November 2025, our benchmark data (April to September) showed that only 49% of patients were being cleared at a one-stop clinic, and approximately 628 patients were waiting to return for a second nurse-led clinic appointment. This created delays in the pathway, a fragmented experience for patients, and limited our ability to book effectively.

By early March 2026, the number of patients waiting to return for a nurse-led clinic appointment had reduced to 161. Clearance rates have also improved significantly, with 76% of orthopaedic patients and 80% of general surgery patients now being cleared at their one-stop clinic.

Local outcomes

Ilford	#	%	Comments
NJR submission	665/665	100%	Ilford Hospital awarded Gold Award
VTE risk assessment	7434 / 7945	94%	
VTE incidents	4/8676	0.04%	4
Transfers to NHS trusts	8 / 8676	0.09%	8 Transfers to NHS Trusts
Readmissions and/or return to theatre	23/8676	0.26%	22 Unplanned Readmissions 1 Unplanned return to theatre 5 Unplanned Readmissions resulting in return to theatre
Surgical Site Infections (SSIs)	39/8676	0.44%	38 Superficial 0 Deep 1 Joint (Post op 5 months)
Endophthalmitis	0	N/A	
Delay in diagnostic/treatment path-way	2 / 8676	0.02%	2 Delays resulted from NHS trust system changes
Incidents relating to patient harm	81 / 469	17.2%	Total of 469 Incidents 66 were associated with Low Minimal Harm 15 were associated with Moderate Harm 388 were associated with No Harm 0 Deaths
Patient Safety Incident Investigations (PSIIs)	1 / 81	1.2%	We undertook 1 patient safety investigation
Complaints received	57 / 8676	0.65%	57 Complaints Received 55 Stage 1 Complaints 2 Stage 2 Complaints 0 Stage 3 Complaints
Complaints upheld/partially upheld	37 / 57	64.9%	24 Complaints Upheld 13 Complaints Partially Upheld 20 Complaints Not Upheld 100% (57/57) of complaints acknowledged within 3 working days. 96.4 % (55/57) received a response 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:

- Manual systems for tracking Patient Group Direction (PGD) expiry and training compliance created gaps, leading to missed oversight and inconsistent assurance;
- Audit processes varied significantly across departments, with some lacking the depth, consistency, and challenge required to identify risks;
- Cultural factors such as blind conformity, unclear escalation pathways, and limited challenge within the team reduced the likelihood of concerns being raised or acted upon.

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

- Strengthening governance processes by standardising audit expectations, improving PGD oversight, and ensuring clearer accountability for training verification;
- Enhancing staff support through pharmacy led education, improved Learning Management System utilisation, and clearer escalation routes to promote psychological safety and critical thinking;
- Introducing more consistent, cross-departmental forums and review mechanisms to ensure learning is shared, concerns are escalated, and deviations are identified earlier.

8 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Escalation pathways and communication practices are being strengthened, with clearer guidance on when to activate crash calls, improved expectations around contacting on call managers, and more structured coordination with external trusts;
- External operational pressures within the NHS affected the timeliness of transfers, including extended delays due to bed pressures and competing clinical demands at the receiving hospital;
- Teams are managing operational pressures effectively, even in challenging circumstances such as transfer delays, NHS bed pressures, equipment limitations, and competing clinical demands, demonstrating resilience and commitment to maintaining patient flow and safety.

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

- Reinforcing escalation pathways and communication expectations, including when to activate crash calls, ensuring on call managers are contacted, and improving coordination with external trusts;
- Strengthening governance, audit consistency, and documentation standards, ensuring all MDT members can document on Maxims, improving audit depth, and addressing gaps in equipment checks and alarm protocols;
- Enhancing staff awareness, training, and equipment reliability, including education on ABG handling, addressing latent equipment risks, and reinforcing transfer processes to reduce delays.

22 Unplanned readmission reviews

The key learning from these reviews included:

- Patients were not contacting the service directly with concerns, meaning the team often only became aware of deterioration once the patient had already been readmitted to another trust or informed us following their readmission;
- Reporting on readmissions has improved significantly, giving us much better oversight of emerging patterns and trends;
- The reviews showed that patients were discharged appropriately and only when they were clinically fit, with no evidence of premature discharge or missed clinical concerns. This provided assurance that readmissions were not linked to the initial discharge decision but were instead related to factors arising after discharge.

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

- Patients now receive clear information about the 24 hour helpline at discharge, with all contact fully documented to support continuity of care;
- Investigators are informed of required learning-response timescales, clearly recording any delays; this is monitored through weekly incident meetings;
- Major surgery patients are contacted post-operatively to pick up potential problems early, and comprehensive readmission reviews are carried out to evaluate care and inform learning.

6 Unplanned return to theatre reviews

The key learning from these reviews included:

- The reviews demonstrated strong clinical oversight, with timely assessments and appropriate escalation to theatre when complications were identified;
- Duty of candour was undertaken for all patients who required a return to theatre, ensuring open communication, transparency, and appropriate support throughout their care;

- Intervention was applied at the appropriate time, ensuring the patient received timely and effective care;

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

- Continuing to refine follow-up pathways to ensure early review of patients at higher risk of complications, supporting timely intervention and reducing the likelihood of deterioration;
- Ensuring all clinical documentation meets a high standard, strengthening continuity, accuracy, and learning;
- All relevant risk factors continue to be assessed and incorporated into mobilisation decisions to promote patient safety and optimal outcomes.

4 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- The importance of completing VTE risk assessments at every required stage of the surgical pathway (pre-assessment, admission, post-op, 24 hours, and discharge) to ensure accurate risk stratification and timely prophylaxis;
- Recognition of how timely MDT involvement and clear escalation pathways support safer and more efficient management when patients re present with symptoms of VTE or post operative complications;
- The value of accurate documentation, including age-related risk factors, BMI, vital observations, and escalation decisions, to support safe continuity of care and reduce avoidable variation in practice.

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

- Strengthening of pre assessment and ward processes to ensure vital observations, BMI, and risk factors are consistently recorded in Maxims;
- Clear guidance issued to Resident Doctors to ensure prompt clinical review and MDT planning for patients returning with suspected DVT/PE, reducing unnecessary delays in diagnostics;
- Continued emphasis on open communication, duty of candour, and patient reassurance, supporting patient confidence, medication adherence, and early recognition of complications

1 Post Infection Review (PIR)

The key learning from this review included:

- Ensuring early escalation of potential infections to the IPC lead to support timely and appropriate intervention;
- Patients who are readmitted to other providers with wound concerns are often not swabbed, resulting in treatment being started without confirmation of an infection, which limits diagnostic accuracy and affects antimicrobial stewardship

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

- Processes have been strengthened to promote more consistent wound swabbing and improve communication;
- Earlier escalation of potential infections to the IPC lead has been reinforced across the team, ensuring timely review and stronger oversight of infection-prevention concerns.

39 Superficial SSI thematic reviews

The key learning from these reviews included:

- The importance of taking wound swabs before prescribing antibiotics, ensuring that antimicrobial treatment is targeted, evidence based, and aligned with good antimicrobial stewardship;
- The need for more accurate and consistent incident reporting, enabling clearer identification of themes, trends, and areas requiring improvement across the service;
- Recognition that early escalation of potential infections to the IPC lead is essential to support timely intervention, reduce risk of deterioration, and strengthen overall infection-prevention oversight.

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

- Increased use of wound swabs before prescribing antibiotics, alongside improved adherence to ANTT® to strengthen infection prevention practice;
- Greater encouragement for patients to use the helpline has helped them access timely advice, reducing delays in care and enabling earlier identification of potential complications;
- The introduction of a wound walk-in clinic has created a more responsive pathway for assessment and treatment, helping to prevent deterioration and ensuring patients receive prompt, appropriate support.

0 Endophthalmitis-Specific PIRs (E-PIRs)

We have not had any endophthalmitis-specific PIRs.

Learning from local Patient Safety Priorities

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

We were experiencing a number of avoidable cancellations caused by incomplete pre-operative investigations and by essential kit or consumables not being available on the day of surgery.

Following monthly reviews of avoidable cancellations, a new Standard Operating Procedure (SOP) has been developed for the General Surgery department. The document is designed to support consultants in scheduling the correct procedures, ordering the appropriate pre-operative investigations. By implementing this policy, the department aims to reduce unnecessary cancellations and enhance the overall quality of patient care through a more consistent and reliable surgical pathway.

We have also restructured the Theatre User Group to ensure that on-the-day cancellations related to kit or consumable constraints are avoided. This change supports better planning, clearer communication, and improved resource availability across the surgical pathway.

Delayed MDT input will prompt a SWARM huddle

We have not had any delayed MDT input that has resulted in a SWARM being triggered. All patients requiring MDT discussion have an outcome recorded on Maxims, and this is routinely monitored by the lead anaesthetist to ensure timely and appropriate decision-making.

Priorities for 2026/27

Priority 1

What are we trying to improve?

We aim to increase our response rate for the Friends and Family Test in order to achieve a larger and more representative sample size. Strengthening participation will provide more reliable feedback and support meaningful improvements in patient experience.

What will success look like?

Success will be reflected in a sustained increase in the number of completed surveys each month, with a broader cross section of patients contributing feedback.

How will we monitor progress?

Progress will be monitored through monthly reports, trend analysis, and comparison with previous quarters.

Priority 2

What are we trying to improve?

We aim to improve the completion and accuracy of Falls Risk Assessments to ensure that all patients are appropriately assessed on admission and that any identified risks are acted upon promptly. Strengthening this process will support safer care and reduce the likelihood of avoidable falls.

What will success look like?

Success will be demonstrated by a higher proportion of patients having a fully completed Falls Risk Assessment within the required timeframe, with clear documentation of risk factors and corresponding interventions. We would also expect to see a reduction in fall-related incidents as assessments become more consistent and reliable.

How will we monitor progress?

Progress will be monitored through regular audits of Falls Risk Assessment completion rates, review of incident reports, and trend analysis over time. Feedback from ward teams and safety huddles will also help identify barriers and highlight areas where further support or training may be needed.

Priority 3

What are we trying to improve?

We are trying to improve the collection of PROMs data to ensure we capture a more complete and accurate picture of patient reported outcomes across our services.

What will success look like?

Success will be demonstrated by a sustained increase in PROMs completion rates, moving closer to the 95% threshold. We would expect to see more consistent engagement from patients, fewer missing data sets and a more reliable dataset.

How will we monitor progress?

Progress will be monitored through regular reviews of PROMs completion rates and comparison with previous months and years.

Patient stories

Patient 1 feedback

“I wanted to thank you for the outstanding care I received. From my first visit for pre-surgery to the day of arrival, from the ladies that made me coffee and food, to the who surgical team - the lovely nursing staff who were on duty during my stay - they deserve a special mention. You all have changed my life and I wanted to thank you from the bottom of my heart.”

Patient 2 feedback

“From the very beginning my assigned nurse was the most warmest and caring, she displayed immediate warmth and compassion, calming presence and professionalism. During procedure the nurse that took me to the surgery room was also very kind and caring and helped put me at ease. After the surgery all staff were very caring and showed empathy and their friendly nature, helped me feel at ease and placed me in a comfortable state, allowing my stay to be smooth and easy. I would like to show my complete gratitude to all the staff. My heartfelt thanks to each of the team for their kindness and professionalism.”

Patient 3 feedback

“I consider my stay at your hospital to be one of the most pleasurable hospital stays I have ever had (and believe me there have been quite a few). My treatment and support provided in all respects was exemplary and EVERY member of staff that I came into contact with could not have treated me any better than if I had been a member of the Royal Family. Thank you.”

Plymouth Hospital

Performance against the priorities set for 2025/26

Priority 1 - Achieved

We said we would:

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 (POA).
2. Surgery date.
3. Post-operative appointment.
4. Physio.

What we have achieved:

Patients receive a first appointment letter explaining that they may need to remain in the hospital for up to three hours to complete their initial consultation with the surgeon. This includes consent, x-rays, and a review by the nursing team to complete their pre-operative assessment (POA). Most patients who are suitable for surgery at Practice Plus Group Hospital Plymouth have both the consultation and POA completed on the same day. The occasions when this cannot be facilitated are typically when a patient is seen by the surgeon towards the end of the clinic, or when a patient chooses to return on a separate date for their POA if they prefer not to wait.

The majority of patients require only one post-operative review with a member of the surgical team, and wherever possible this appointment is carried out by their operating surgeon. Patients are advised of the expected timeframe for this review at the point of discharge, so they know when to anticipate their follow-up appointment.

Practice Plus Group Hospital Plymouth offers all major arthroplasty patients- those undergoing knee or hip replacement surgery- the opportunity to attend our Joint School. This session allows patients to meet the physiotherapy team and learn what to expect from their surgery and recovery. Attendance is optional, and we provide both face-to-face and virtual sessions to accommodate individual preferences and needs.

All major arthroplasty patients are reviewed by the physiotherapy team prior to discharge. Most patients undergoing hip replacement surgery are discharged with a home exercise plan and do not usually require further physiotherapy unless they experience complications. Patients who have had a knee replacement are routinely referred to their local NHS outpatient physiotherapy service for ongoing rehabilitation and support.

Priority 2 - Partially achieved

We said we would:

Implement Getting It Right First Time (GIRFT), with evidence that we have fully implemented the GRIFT recommendations and received the GRIFT accreditation.

What we have achieved:

GIRFT is part of business as usual throughout our whole hospital and changes to guidelines are reviewed regularly and any changes to practice are communicated and implemented through policy and procedures.

Although GIRFT accreditation has not yet been achieved, we are committed to strengthening the quality and consistency of our service. A structured plan will be implemented for 2026/2027, outlining the specific actions, timelines, and governance processes required to work towards accreditation. This plan will focus on evidencing enhanced clinical pathways, improved data quality and benchmarking, and ensuring that our practices continue to align with national best-practice standards. Our aim is to continue to use the GIRFT framework as a driver for continuous improvement, ultimately supporting safer, more efficient, and more patient-centred care.

Priority 3 - Achieved

We said we would:

Continuous reviewing of all current patient information 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 (POA).

What we have achieved:

The Patient Forum Group meets quarterly and has reviewed each stage of the patient pathway, from referral to post-operative support. This has allowed patients to feedback on existing documentation including packs given to patients during their pre-operative assessment appointments and patient discharge advice packs from the ward. Locally, document owners regularly review their literature, ensuring that it is accurate to the current processes and advice that patients are given and is in line with Company and National policies and guidelines.

The administrative team contact all patients who have been deemed fit for surgery (FFS) within 14 days of their POA to either book their surgery date or to inform them they are FFS or that they will be contacted when a date becomes available. This is monitored via a worklist on the patient database. Any patients who are not yet fit for surgery are contacted by the Referral to Admissions (R2A) team within 14 days of their POA to inform them of their next steps.

Local outcomes

Plymouth	#	%	Comments
NJR submission	2664	100%	
VTE risk assessment	6602	97%	
VTE incidents	9	0.35%	4 pulmonary embolisms. 5 deep vein thrombosis.
Transfers to NHS trusts	13	0.21%	
Readmissions and/or return to theatre	44	0.71%	33 unplanned re-admissions. 4 unplanned returns to theatre. 7 unplanned re-admission resulting in a return to theatre
Surgical Site Infections (SSIs)	53	0.94%	48 superficial infections. 2 joint space infections. 3 deep infections
Endophthalmitis	0	0%	
Delay in diagnostic/treatment path-way	30		
Incidents relating to patient harm	195	38.1%	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)	2	1%	
Complaints received	46	0.74%	3 complaints escalated to stage 2 for review by the Managing Director of Healthcare
Complaints upheld/partially upheld	26	63%	

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:

- Reinforcing the absolute requirement to follow the “Stop before you block” process;
- Staff didn’t always feel comfortable to speak up about their concerns.
- The patient safety improvements made in response to the reviews included:
- Surgical safety checklists are now submitted real-time digitally on the patient’s electronic record;
- Human factors training has been held to build upon multi-disciplinary communication in theatre;
- Training has been provided to empower team members to speak up when they have concerns about patient safety.

25 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Deteriorating patients were highlighted early and escalated to appropriate members of the clinical team;
- All members of the team felt comfortable to raise concerns about a patient’s deterioration;
- There was sometimes difficulty in translating the clinical needs of the patient to the local ambulance service.

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

- A local SOP has been implemented outlining information which needs to be passed on to the 999 call handlers to get an appropriate and timely response;
- All emergency transfers are communicated with the clinical teams to share learning;
- Extra training days and clinical scenarios are held to further build staff confidence and competence when dealing with deteriorating patients.

40 Unplanned readmission reviews

The key learning from these reviews included:

- Patients were given appropriate clinical advice to reattend Practice Plus Group Hospital Plymouth or to present to another care facility where they had concerns requiring a clinical review;
- There was often a delay in finding out that a patient had attended another healthcare setting other than Practice Plus Group Hospital Plymouth (such as their GP, local Minor Injuries Unit or Emergency Department);
- There is a strong reliance on patients to inform the clinical team if they have had any changes to their health post-surgery or if they were experiencing any complications.

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

- Strong Clinical Governance links have now been made with all 3 local NHS trusts to allow notification if a Practice Plus Group patient has attended their facilities;
- A dedicated post-operative helpline number has been implemented to allow patients a direct line to clinical support post-discharge;
- Any recurring themes relating to readmissions are reviewed by the Clinical Governance team.

9 Unplanned return to theatre reviews

The key learning from these reviews included:

- Any return to theatres which were due to a deep infection had a full Post Infection Review undertaken;
- Where the complications were noticed at Practice Plus Group Hospital Plymouth, prompt escalation and decision making was exercised to arrange a theatre space with the appropriate clinical team;
- There was clear communication with the patients throughout including the Duty of Candour process and informing patients of the result of their investigations.

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

- Stronger communication links with the 3 nearby NHS trusts to allow clear passage of information;
- Clear and detailed documentation is required to ensure that care has been thorough post-operatively.

9 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- The VTE policy was adhered to and any variations were clearly documented with a clinical rationale;
- Compliance with reporting VTE risk assessments was good, but often missed at the sign-out stage of theatre;
- A VTE thematic review showed that there was no correlation between surgery type and patients who developed a VTE.

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

- New WHO checklist implemented prompts a full VTE risk assessment at the sign-out stage of surgery for all patients;
- Clinical teams taking a post-operative helpline call are to have a high suspicion of VTE until all red flag symptoms are clearly ruled out.

5 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- There was no common organism throughout any of the completed PIRs;
- There were no other trends between the infections such as surgeon, surgical team or operation site;
- One of the most common findings from the PIRs was that there is a requirement to strengthen documentation provided to patients via the post-operative helpline including having a protocol for escalation triggers and advice.

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

- Clinical advice is only to be passed on directly by a clinical member of staff on the post-operative helpline number;
- Where possible, patients are invited to re-attend the hospital for an early review and to take wound swabs to ensure appropriate antimicrobial prescribing;
- Each department has an Infection Control Link who attends regular training and meetings with the Infection Prevention and Control Lead.

39 Superficial SSI thematic reviews

The key learning from these reviews included:

- It is difficult to always gain an accurate understanding of SSI trends due to patients being seen in other clinical settings such as GP or Minor Injuries Units;
- Most patients feel well educated about when to raise concerns regarding the appearance of their wounds;
- Staff members undertaking dressing changes are trained to a high standard in Aseptic Non-Touch Technique and audits undertaken across the site reflect this.

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

- All patients who attend Joint School are provided with information from the Infection Prevention and Control Lead surrounding wound healing, caring for a post-operative wound and when to get in touch if concerned about a wound post-discharge;
- All patients who have had major joint surgery are provided with an SSI questionnaire to complete after discharge; there is now a thorough process in place for reviewing responses;
- Consultants discuss return to theatre cases as part of their bi-monthly clinical supervision sessions and any trends are reviewed to see if there are common risk factors which could be highlighted pre-surgery.

Learning from local Patient Safety Priorities

More than two incidents related to patient skin integrity during admission in one month will prompt a Patient Safety Learning Team approach.

A Safety Learning Team review was undertaken in response to three reported incidents of skin damage occurring during surgery. The findings indicated that these incidents were likely the result of a combination of factors, including patient positioning being carried out by newer theatre staff and the increased vulnerability of patients with particularly fragile skin.

As a result of these findings, all patients identified as having vulnerable skin during their pre-operative assessment will now have an alert added to their electronic patient record. In addition, patients will undergo a skin inspection on the day of surgery upon arrival at the hospital. This ensures that any pre-existing skin damage is clearly documented and provides a further opportunity to identify patients with particularly fragile skin.

For patients identified as having particularly fragile skin, this alert will be clearly communicated between the admission and theatre teams. Additional precautions will then be taken intra-operatively to minimise the risk of skin injury and ensure that appropriate protective measures are in place throughout the procedure.

Two adverse clinical outcomes in a month related to hip dislocations, leg length discrepancies or intraoperative fractures will prompt an after-action review.

During the 2025/2026 period, there were two intra-operative fractures. Both incidents were fully investigated in line with PSIRF requirements. The findings confirmed that there were no omissions in care, and both patients have since made a successful recovery. No cases of leg-length discrepancy were identified during this period.

In the same timeframe, five patients experienced post-operative hip dislocations, two of which occurred prior to discharge. Of these patients, one was successfully treated with a manipulation under anaesthetic, while the other required transfer to the local acute NHS trust for further surgical management. Although these two cases occurred within the same month, they involved different surgeons and different theatre teams. The investigations found no shared themes or trends between the cases, and in both instances the clinical teams acted promptly and appropriately once the dislocations were recognised.

Readmissions related to wound ooze will be subject to a 6-monthly structured case notes and pathway review.

8 wound ooze readmissions in first 6 months of reporting period (6 of which were knee arthroplasties or arthroscopies, 1 soft-tissue ankle surgery and 1 hip arthroplasty).

2 wound readmissions in second 6 months (1 knee arthroplasty and 1 foot osteotomy).

These numbers show a similar incidence to the previous year (12) however, this is a rate of 0.16% of all patients treated at Practice Plus Group Hospital Plymouth readmitted due to wound ooze compared with 0.2% of patients in the year 2024/2025 and therefore a decrease in rates of readmissions related to wound ooze.

Patient-reported surgical site infections will prompt a quarterly thematic case and pathway review.

Following an increase in reported surgical site infections and the findings from a number of Patient Incident Reviews (PIRs), a comprehensive programme of actions has been implemented to strengthen the early identification, escalation, and management of surgical site infections (SSI).

Quarterly thematic case and pathway reviews were held and all cases were collated to identify themes, contributory factors, and compliance with the SSI prevention and management pathway.

Improvements introduced include enhanced helpline triage, clearer referral and escalation pathways, improved patient education and discharge wound care advice, reinforced compliance with MRSA/MSSA decolonisation, updated wound care and documentation processes, targeted staff training, and correction of the SSI risk scoring tool. Additional measures include mandatory senior clinical review for persistent post-operative wound concerns, along with a review of theatre ventilation compliance against HTM 03-01 standards, and system improvements to support consistent infection risk assessment and strengthened governance oversight.

All findings from quarterly thematic reviews are discussed within appropriate governance forums and used to inform ongoing improvements to pathways, staff development, and quality initiatives, supported by continued surveillance to maintain assurance.

Priorities for 2026/27

Priority 1

What are we trying to improve?

Increase the number of patients who can be safely and successfully treated as day-case major arthroplasty procedures at Practice Plus Group Hospital Plymouth.

What will success look like?

By optimising pre-operative assessment, enhancing peri-operative pathways, and strengthening post-operative support, we aim to improve patient experience, reduce length of stay, and ensure that more individuals can benefit from the efficiency and comfort of same-day discharge.

How will we monitor progress?

A quarterly review will be conducted to assess how many patients booked for major arthroplasties had been listed as day-case patients and this will be compared with how many of these cases successfully were discharged on the day of surgery. This will be assessed in combination with reviewing patient outcomes following discharge.

Priority 2

What are we trying to improve?

Strengthen the rigour and consistency of how we report and record surgical site infections (SSIs). As part of this work, we will also focus on enhancing the quality of our wound-care practices, with the aim of achieving formal wound care accreditation.

What will success look like?

1. Achieve Silver ANTT® accreditation
2. Support selected staff members to undertake postgraduate training in tissue viability, ensuring that our clinical teams are equipped with the specialist knowledge required to deliver more bespoke, evidence-based wound management
3. Early notification of patients who have suspected SSIs
4. An improved rate of wound swabs taken before antibiotic treatment is commenced

How will we monitor progress?

The Infection Control Lead and Clinical Governance team for Practice Plus Group Hospital Plymouth will continue to monitor rates of SSIs monthly and escalate trends to the Deputy Director of Infection Prevention and Control.

Priority 3

What are we trying to improve?

Increase our rates of medicines reconciliation and optimisation across all stages of the patient pathway at Practice Plus Group Hospital Plymouth.

What will success look like?

We will strengthen the accuracy and timeliness of medication reviews at admission and discharge, ensuring that patients receive safe, appropriate, and fully optimised medication plans. Excellence for our site would be for all patients to have medicines reconciliation undertaken at the same stage as their pre-operative assessment.

How will we monitor progress?

Rates of medicines reconciliation and optimisation are already reported on monthly. The Pharmacy Department Manager will review trends quarterly and implement a quality improvement plan to achieve optimal rates.

Patient stories

Patient 1:

A young woman presented for a pre-operative assessment at Practice Plus Group Hospital Plymouth, ahead of a planned ankle surgery. She has a complex medical history, a combination of learning disabilities and mental health conditions. She also had significantly reduced mobility, requiring the use of crutches and a leg brace. Despite these challenges, she was enthusiastic but understandably apprehensive about the upcoming surgery.

Given her complex needs, a Multi-Disciplinary Team review was conducted to determine the suitability of proceeding with surgery at Practice Plus Group Hospital Plymouth. The patient required significant emotional support throughout her journey and the site Safeguarding Lead played a pivotal role in supporting her from pre-assessment through to discharge, ensuring continuity of care and emotional reassurance, and attending as a chaperone to each of the patient's appointments to allow for a continuous familiar face.

The surgery was successfully completed, and the patient was discharged on the same day, with her family providing post-operative support at home

Patient 2:

Excerpt from Plymouth Live (local Plymouth News provider): A Plymouth mum has 'defied expectations' by representing Great Britain at the World Veteran Judo Championship - just two years after having a hip replacement.

[Patient name], from [Plymouth area], has earned a place on the Great Britain Veterans Judo Squad and is preparing to represent her country at the Veteran World Championships in Paris this November. [Patient name] was told about NHS Patient Choice, [Patient name] was quickly referred to Practice Plus Group Hospital, Plymouth, where she was assessed and booked for surgery within just three months - dramatically reducing her wait and setting her on the path to recovery.

Her surgery, performed just before Christmas 2023, went smoothly. She said: "I went into theatre at 9am, was back on the ward by 11am, and discharged the next morning. The hospital was brilliant and I was so pleased with the outcome. I can't thank them enough for treating me so quickly and give me the chance to get back to the judo I love again."

Patient 3:

A patient had a Left Total Hip Replacement after their original date was delayed due to them being extremely anxious about surgery and being unable to leave their house. The patient was so anxious they could not even answer a phone call from the hospital, and this was the first major surgery the patient had, so had never experience anxiety like this in their life.

To try to help overcome this anxiety, the Practice Plus Group Hospital Plymouth physiotherapy team invited the patient to Joint school which is held in the hospital which discusses all stages to expect throughout the surgical pathway with the patients; the patient found this very beneficial. Whilst at Joint School, physiotherapy staff arranged for the patient to be admitted the night before their operation to settle some nerves, this was greatly appreciated. The patient had his surgery the next day and it very successful. They were able to complete physiotherapy, along with being made medically fit for discharge the day after surgery.

The patient mentioned whist with the physiotherapy team after surgery that they do not know what they were so nervous about as it all went so well; they were extremely happy with the result.

Shepton Mallet Hospital

Performance against the priorities set for 2025/26

Priority 1 - Partially achieved

We said we would

Streamline admission of inpatients, with single admission for patient and reduced duplication of tasks, whilst maintaining patient safety prior to surgery. This should be reflected in an improvement in the friends and family score.

What we have achieved:

Review of pre-operative patients. This is being carried forward to 2026-27 with the introduction of the traffic light system. Friends and family scores are 99-100% rated on their experience.

Priority 2 - Partially achieved

We said we would:

Review the 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.

- Reliable surveillance database from the electronic patient record (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 Joint Advisory Group (JAG) accreditation.

What we have achieved:

- Maintained JAG accreditation;
- EPR worklists are used to make effective booking;
- Referral to Treatment (RTT) times have been reduced;
- Effective onward referral

Priority 3 - Achieved

We said we would:

LEAN project to improve the environment for patients and staff.

- 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.

What we have achieved:

- Storage redesigned and improved to promote efficient locating of surgical prostheses;
- Redesign of layouts and function of workspaces;
- Enhancement and alteration to staff rest areas;
- Improved and newly designed signage to navigate the building;
- PLACE score increased for appearance, ward food, disability and dementia

Local outcomes

Shepton Mallet	#	%	Comments
NJR submission	1926	100%	Achieving gold status.
VTE risk assessment	9334	98%	All patients are assessed at pre assessment, pre operatively and on admission and then finally prior to discharge
VTE incidents	4	0.1%	VTE events which occurred within the 90 day post operative period. No non compliances found within the investigations
Transfers to NHS trusts	11	0.1%	1 patient was an outpatient referred by their GP for an x ray which revealed a fracture hence transfer out
Readmissions and/or return to theatre	36	0.1%	All readmissions have a review of their index procedure pathway
Surgical Site Infections (SSIs)	21	0.1%	1x deep hand infection, 4x joint space infections, 16 Superficial Infections
Endophthalmitis	0	0	2166 cataract procedures undertaken over the year
Delay in diagnostic/treatment path-way	9	0.1%	No harm occurred in any the 9 cases reported
Incidents relating to patient harm	122	0.14%	367 incidents reported in total. Of these, 245 incurred no harm, 64 incurred low harm, 56 incurred moderate harm, 2 incurred severe harm. The 2 severe harm incidents were associated with known complications of surgery
Patient Safety Incident Investigations (PSIIs)	0	0	Escalation calls were made where incidents indicated a potential to have a detailed investigation however no PSII's were required
Complaints received	22	0.1%	All complaints were resolved at stage 1
Complaints upheld/partially upheld	23	0.1%	All complaints resolved at stage 1 and learning taken to the learning from patient experiences group

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:

0 Patient Safety Incident Investigations (PSIIs)

No PSII's were required to be undertaken over this period. However a Learning from Patient Safety Events meeting has been set up and occurs monthly to review all actions outstanding and to review compliance with completed actions and share learning from other incidents both from the Shepton Hospital and other Practice Plus Group sites.

The key learning from these reviews included:

- Check and double check post operative pulse and sensation in limbs. If no pulse then act fast
- Listening to patients and relatives descriptions of their symptoms is paramount to making a judgement about whether to see a patient face to face. If in doubt request they come to the hospital.
- Accurate listening and recording skills are required for taking helpline calls.

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

- Following a known local post operative complication affecting the arterial supply in a leg. Local knowledge of hospitals who perform CT angiography has been checked and is held in relevant departments for future reference.
- Guidance on helpline calls to check for hip dislocation as one of the top priority post operative complications.
- Coaching on telephone assessment of a helpline call provided to all teams both clinical and non-clinical.

11 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Use SBAR to communicate effectively with internal and external teams.
- Ensure secondary emergency equipment is kept on charge eg aids to lift patients from floors
- All patients who had been transferred out were done so appropriately in an appropriate timeframe

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

- Volume on defibrillator increased to full volume
- Reiteration of 2222 emergency call and involve scenario training
- Remove unnecessary equipment from anaesthetic area

30 Unplanned readmission reviews

The key learning from these reviews included:

- Overall the reviews undertaken to assess the quality of the pre operative, post operative care and discharge at the index procedure were assessed as being either 'good care' or 'excellent care'
- Post operative documentation is invaluable to assessing the background for readmission
- Readmissions were not due to omissions during the index procedure

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

- Ensuring patients are aware of red flags to know when to seek assistance
- Ensure staff are aware of the red flags and will respond effectively understanding when urgent attention is required Alert course has been undertaken by all RN's and HCA's.
- Staff reminded of how and when to escalate to clinical staff.

18 Unplanned return to theatre reviews

The key learning from these reviews included:

- Listening and responding to patient helpline calls
- Bring patients back to the hospital to review face to face if more information is required to make a decision
- Do not delay when patients have concerns relating to their surgery

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

- Helpline calls triage sheet developed
- Coaching on telephone answering and responding to patients
- Assess and document appropriately who should handle to patient concern. Any clinical concern must be handled by a suitably qualified clinician

4 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- All VTE events occurred in patients who had the correct VTE prophylaxis
- VTE audit and monthly reporting of VTE assessment rates verifies compliance with the VTE assessment

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

- Ensure a robust process to provide assurance that patient reported red flag symptoms consistently reach a clinically trained staff member and that the documentation of contacts is thorough and contemporaneous

5 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- Any deviations from the standard perioperative protocols must be accompanied by a clearly documented rationale; lack of documentation affects antimicrobial stewardship and may delay the understanding of treatment decisions during post operative reviews.
- Open lesions in proximity to the surgical field should be swabbed and confirmed as healed prior to proceeding with surgery
- Adherence to MSSA decolonisation timing protocols needs to be ensured.
- Remind the anaesthetic staff the importance of intraoperative temperature recording every 30 minutes in line with NICE guidance.

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

- IPC lead to continue work of post operative infection pathways and SOP to ensure that patients are offered a same day review when raising red flag symptoms
- Clear guidance and advice on avoiding prolonged soaking or icing of post operative wounds.
- Patient information card including red Flags and contact details for external professionals when infection is suspected.

17 Superficial SSI thematic reviews

The key learning from these reviews included:

- Continue with hand hygiene training
- Increase audit frequency of hand hygiene compliance

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

- New infection alert patient information card developed to provide patients the red flag symptoms and when and how to contact Shepton Mallet.
- Education provided to all teams on when to escalate a call from a patient and the appropriate personnel to take the call.
- Group email for infection prevention and control introduced to improve visibility of patients with a suspected infection.

Zero Endophthalmitis-Specific PIRs (E-PIRs)

Learning from local Patient Safety Priorities

Five or more patient falls will prompt a SWARM huddle and thematic review

Eight inpatient falls were recorded. Patients falls were due to individuals exerting their independence and over balancing. No serious injuries were sustained for inpatient falls.

Five or more medication administration errors will prompt a thematic review.

Ten medication errors were reported and reviewed.

Any errors that occurred were reviewed and there were no common themes one to one coaching was provided for staff individuals where identified.

Five or more MUA/CPN in three months will prompt a multidisciplinary review.

Six MUAs were undertaken over the 12 months undertaken when patients had stiffness, pain and swelling or were unstable with extension lag.

Priorities for 2026/27

Priority 1

What are we trying to improve?

Efficient effective use of investigations, systems and resources to improve sustainability

What will success look like?

- Undertake pre operative investigations that are necessary
- Theatre lists will be used effectively and efficiently
- Anaesthesia which are sustainable total intravenous anaesthesia (TIVA)
- Use only the ventilation system only when required
- Reduce length of stay
- Use of laminar flow outside of operating hours
- Only appropriate blood sampling will be used on pre operative patients where required
- Patients go home on day of surgery.

How will we monitor progress?

- Increased use of TIVA
- Increase in number of day zero discharges
- Reduced cancellations

Priority 2

What are we trying to improve?

- A standardised pre operative pathway

What will success look like?

- Standardised pre operative assessment format
- Aligning pre assessment process with national best practice as per GIRFT
- Improvement of patient health optimisation by utilising pre existing services already available in NHS local area
- Implement early pre operative screening using RAG system
- Implementing comprehensive geriatric assessment performed by a peri operative doctor for the higher acuity patients with higher risk with the aim to increase ambulatory cases.

How will we monitor progress?

- More patients knowing what tests they may require at their first appointment.
- Fewer patients having long waits for tests ending in cancellation

Priority 3

What are we trying to improve?

To embed a consistent, organisation-wide Quality Improvement (QI) approach that supports continuous enhancement of patient safety, experience and clinical outcomes within our hospital services.

What will success look like?

We will implement a structured QI programme to ensure improvement activity is visible, supported and sustained across all departments.

This will include:

- Monthly QI meetings to oversee progress, share learning and align improvement activity with organisational priorities
- Integration of QI into Heads of Department 1:1s, ensuring routine focus, accountability and early identification of risks or opportunities
- Capturing of small scale improvements enabling both small-scale changes and larger projects to be recognised, evaluated and shared across the hospital
- Digital Safety Reporting

This will take the form of priority QI project will focus on the digitalisation of safety briefs and monitored bed reporting.

This will:

- Enable real-time electronic data capture at ward and departmental level
- Improve accuracy, timeliness and accessibility of safety information
- Support proactive management of patient safety risks
- Data will be integrated into a daily Power BI dashboard, providing clear oversight of safety metrics and supporting timely, informed decision-making by clinical and operational teams.

How will we monitor progress?

- Improved completeness and timeliness of safety data reporting
- Evidence of shared learning and sustained improvements
- Positive impact on key safety and quality indicators.

Patient stories

Patient 1: To all the staff at Shepton Mallet

I am writing to express my deepest gratitude for the outstanding care I received during my recent partial knee replacement surgery on the 20th January 2025. From the moment I arrived until my discharge, every member of your team went above and beyond to ensure I felt safe, comfortable, and well cared for.

A special thank you to Mr A Klink. My exceptional Surgeon Mr A. Rozycki and his surgical team for their skill and expertise. Your professionalism and reassurance made a significant difference in my experience, and I am truly grateful for the successful outcome of my surgery.

I also want to recognise the incredible nursing staff, physical therapists, and support team who showed such kindness and dedication throughout my stay. Your patience, encouragement, and compassion made my recovery process smoother and more manageable.

Thanks to your exceptional care, I am now on the path to a better quality of life, and I couldn't be more appreciative. Please extend my sincere thanks to everyone involved in my treatment.

I now look forward to my upcoming left knee surgery at Shepton Mallet, in the very near future.

With heartfelt appreciation.

Patient 2

I would like to extend my most grateful thanks indeed for your surgery on my umbilical hernia last week, and for the consultation and attention that led up to it.

Both from you, and your team on the day - as to which the names of Dawn who checked me in, Annabella, the anaesthetist, and Genneve, who checked me out, stand out for me for their care and diligence before and after the surgery.

With the tummy button now meshed inside, rather than poking outside, I feel a renewed confidence, both specifically in that area, and generally.

Patient 3

For quite sometime life had become challenging...

Climbing stairs, driving, working. I no longer had an active life.

Thank you to the surgeon, along with the many staff on your team who have given me my life back.

Two months later I returned to work. I'm enjoying pain free moderate exercise again with plans to ski 2027

Southampton Hospital

Performance against the priorities set for 2025/26

Priority 1 - Achieved

We said we would:

Increase incident reporting by 10% across the hospital.

What we have achieved:

41% compared with April 2024 to March 2025

Priority 2 - Achieved

We said we would:

Upskill our workforce to support increased acuity and activity with:

- 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.

What we have achieved:

We have achieved this. 90% of our nursing staff have completed the ALERT course, one HCA is undertaking a four year nurse apprenticeship course on the Inpatient Ward and 100% of HCAs have attended the BEACH course.

Priority 3 - Achieved

We said we would:

- 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.

What we have achieved:

All admitted patients on the inpatient ward have their medications reviewed by a pharmacist. A ward round with a pharmacist takes place daily Monday to Friday.

TTA medications are reviewed by pharmacy and are compliant with policy. Patients are counselled on these medications by the nursing staff or pharmacy on the ward. Any issues are escalated via Datix.

Local outcomes

Southampton	#	%	Comments
NJR submission	971	98%	NJR Quality Data Provider Awards 2025 – Bronze for commitment to patient safety through the registry
VTE risk assessment	14,301	98.3%	
VTE incidents	3	0.02%	1 investigation ongoing
Transfers to NHS trusts	8	0.05%	
Readmissions and/or return to theatre	26	0.17%	16 readmissions 3 unplanned return to theatre 7 unplanned readmissions and return to theatre
Surgical Site Infections (SSIs)	11	1.18%	
Endophthalmitis	0	0.00%	
Delay in diagnostic/treatment path-way	5	0.01%	
Incidents relating to patient harm	109	12%	Low harm – 81 Moderate harm – 22 Severe harm – 1 Death - 5
Patient Safety Incident Investigations (PSIIs)	1	0.92%	Ongoing Investigation
Complaints received	51	0.08%	
Complaints upheld/partially upheld	44	86.27%	

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:

Patient Safety Incident Investigations (PSIIs)

The key learning from these reviews included:

- This investigation is ongoing.

7 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Out of the total number of procedures performed only 0.05% 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.

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

- Pre assessment questions in the Endoscopy department have been reviewed and patients seizure history has now been included. Patients with a history of seizures in the last 12 months are referred back to the local NHS trust.
- Anaesthetic drugs and muscle paralysers / reversals are to be stored in the Endoscopy department medication cabinets.

16 Unplanned readmission reviews

The key learning from these reviews included:

- All patients are given advice on discharge of the 24 hour Patient advice helpline and advised to call if any concerns,

All patients are reviewed by the Resident Doctor or a Consultant when presenting back to the hospital and readmitted for further observation or treatment if required.

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

- Post op advice line calls reviewed daily and collaborative working with Portsmouth Surgical Centre Practice Plus Group to support their out of hours service.

10 Unplanned return to theatre reviews

The key learning from these reviews included:

- All patients reviewed by a consultant and taken back to theatre if required for appropriate surgery.

3 Venous Thromboembolism (VTE) reviews

The key learning from these reviews included:

- The importance of thorough risk assessment and prophylaxis
- The audit process confirms compliance with policy

3 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- No documentation of patients being provided with Octenisan bodywash;
- Patients were not being effectively communicated with about how to use Octenisan wash;
- Discharge documentation about wound care advice to be reviewed.

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

- Quality of discharge documentation to be reviewed as part of 2026/27 quality indicators ensuring wound care advice is up to date and in line with current guidelines;
- Octenisan bodywash to be given to patients at pre assessment and documented on Maxims;
- For Patient admissions team to ask patient on their 72 hour phone call (pre surgery) if they have been given their bodywash and ensure they know how to use this in advance of their surgery.

Learning from local Patient Safety Priorities

An inpatient fall will prompt a SWARM huddle, followed by review at the Falls meeting.

This period we had 10 falls on the Inpatient Ward, compared with an average of 11 in the preceding three years. We undertook a SWARM Huddle following each fall, this was the key learning:

- Reinforcing patients to seek help mobilising, especially at night;
- Reinforce the use of the call bell inside the toilet;
- Reinforce use of walking aids whilst mobilising in the ward;
- Use of commodes / bottles at night for patients with known episodes of Vasovagal/ Low Blood Pressure.

Priorities for 2026/27

Priority 1

What are we trying to improve?

Patient safety and satisfaction by ensuring every patient feels informed, confident, and supported when leaving our care. We will focus on the key PREMS indicators related to discharge communication, medication understanding, and post-discharge support.

What will success look like?

Improvement in patient experience measures.

How will we monitor progress?

To drive measurable improvements in the discharge experience, we will adopt a baseline audit. We will begin by conducting a survey to capture current Patient-Reported Experience Measures (PREMS) and identify specific communication gaps, such as lack of medication clarity or post-discharge instructions. This will be followed by targeted improvement work centred on redesigning discharge documentation to ensure it is patient-friendly, jargon-free, and accessible. Finally, a formal re-audit will be performed to evaluate the impact of these changes, allowing us to compare post-intervention data against our baseline to ensure that patients feel significantly more informed, safe, and supported as they transition out of our care.

Priority 2

What are we trying to improve?

To enhance patient autonomy and clinical capacity by optimising the ratio of new to follow-up appointments.

What will success look like?

This will be achieved by implementing personalised follow-up schedules, expanding Patient-Initiated Follow-Up (PIFU) pathways, and ensuring that every return visit adds clear clinical value to the patient's treatment plan.

How will we monitor progress?

- Specialty-Level Ratio: Monthly reporting of the N2FU ratio by department and individual consultant to identify outliers or areas where follow-up cycles are unnecessarily long.
- New Patient Throughput: Measuring the "Waiting List Movement." If the ratio improves, there should be a corresponding increase in the number of new patients seen each month.
- PIFU (Patient-Initiated Follow-Up) Uptake: Tracking the percentage of patients moved from traditional scheduled appointments to PIFU or SOS (See on Symptom) pathways

Priority 3

What are we trying to improve?

To ensure patient safety and continuity of care by verifying that discharge summaries are transmitted to General Practitioners (GPs) within established timeframes and contain the comprehensive clinical detail necessary for seamless ongoing management.

What will success look like?

GPs receive a digital summary within 24 hours of discharge that clearly highlights medication changes and urgent pending test results.

A seamless transfer of accountability where the GP has the right information at the right time to manage the patient's recovery safely, reducing the risk of avoidable harm or hospital readmission.

How will we monitor progress?

To monitor the success of this priority, the focus will be on ensuring that discharge information is both technically reliable and clinically actionable. Progress will be tracked through quantitative metrics, such as the percentage of summaries transmitted to GPs within 24 hours, alongside qualitative audits to verify the presence of essential data like medication changes and pending results.

By establishing a continuous feedback loop with General Practitioners using surveys, the hospital can identify and resolve information gaps. Ultimately, success is defined by a seamless transition where the GP is fully equipped to manage ongoing care, thereby reducing the risk of medication errors and avoidable hospital readmissions.

Patient stories

Patient story 1

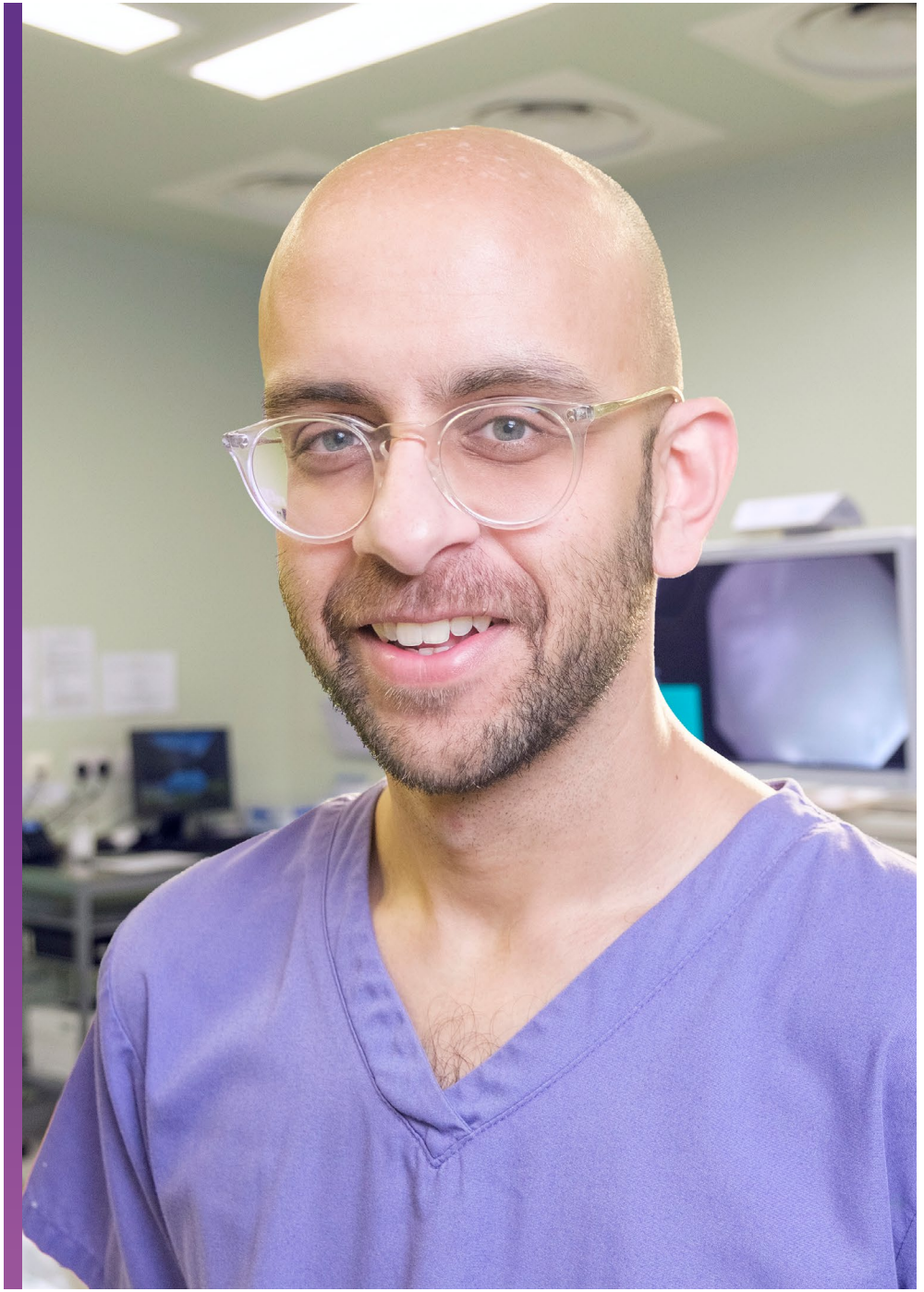
“I’ve suffered with 3 completely broken teeth for years and it was something I’d put off as the process is expensive and nerve wrecking. I can’t remember the surgeons name or the people who were in the room, but my appointment was at Southampton on 21st Jan at 4:50pm. I’d appreciate it if you could tell them how great they were, they made me feel completely comfortable, the procedure was completely painless and easy. The people in the room could clearly read my personality and were keeping it casual and humorous, which was perfect. Aftercare has been a breeze with literally no pain.”

Patient story 2

“Just a note to say thank you all for the excellent experience I had under your care for colonoscopy. Having had past pelvic surgery, I know there was risk of an uncomfortable experience, but due to your expertise I felt relaxed, cared for and comfortable. Thank you all for all you do.”

Patient story 3

“The patient states that he is 52 years old and has been scared of the dentist since he was 17 years old. However, A was brilliant. The patient also stated that he has no pain, the hole has healed up and he is able to chew. He also advised that he has full sensitivity and jaw movement. The patient went on to say that in a weird way it was actually an enjoyable experience.”



Southampton Urgent Treatment Centre

Performance against the priorities set for 2025/26

Priority 1 - Achieved

We said we would:

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.

What we have achieved:

Significantly reduced to electronic prescribing system now in use and working well.

Priority 2 - Partially achieved

We said we would:

Improve collaborative working through having appropriate appointments bookable in the department through the 111 service, with an increase from 31 a day, spread throughout the day.

What we have achieved:

We have achieved this, there are 31 appointments available for 111 to use, this has not been increased as there are still issues with how these are used by 111. The service still receives inappropriate referrals and not all appointments are being utilised.

Priority 3 - Achieved

We said we would:

Improve the knowledge of the public regarding the use of the UTC, with fewer complaints where expectations are not met.

What we have achieved:

10 complaints received in 2025/26 compared with 19 in the previous financial year. The website has provided improved information about who should come to the UTC and when.

Displaying the waiting times updated 2 hourly on the website has improved the knowledge for patients prior to attending the UTC and manages expectations.

Local Outcomes

Southampton UTC	#	%	Comments
Unplanned reattendance within 7 days for same condition	580	1%	Total patients seen 62,661
Incidents relating to patient harm	23	41%	Low harm - 16 Moderate harm - 7 Severe harm - 0
Patient Safety Incident Investigations (PSIIs)	0	0%	
Complaints received	9	0.01%	
Complaints upheld/partially upheld	8	89%	

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:

0 Patient Safety Incident Investigations (PSIIs)

Learning from local Patient Safety Priorities

A thematic review will be undertaken if the monthly unplanned re-attendance rate within 7 days for the same condition exceeds 5% of attendances.

Priorities for 2026/27

Priority 1

What are we trying to improve?

Improve knowledge of the local primary care providers about referrals into the UTC.

What will success look like?

Reduction in volume of inappropriate referrals.

How will we monitor progress?

Ongoing open discussions with 111 management team, these take place on a regular basis, provide regular feedback to them about referrals and where improvements can be made. UTC leads to monitor locally.

Priority 2

What are we trying to improve?

Improve staff training compliance in Advanced Life Support (ALS).

What will success look like?

One ALS trained staff member on every shift.

How will we monitor progress?

Training plans ongoing and monitored by training lead.

Priority 3

What are we trying to improve?

Sustained turnover rate of <10% monthly.

What will success look like?

Workforce experienced and familiar with all pathways and running of the UTC therefore providing a smooth and seamless service to patients and ensuring a happy workforce.

How will we monitor progress?

Monthly turnover rates monitored by lead and reported where required.

Patient stories

I am writing to voice how happy I was with the care I received when visiting your Urgent Treatment Centre, Fanshaw Wing, Royal South Hants Hospital, located in St Marys, Southampton.

I was particularly fortunate to be seen by Alicia Kaye, a Health Care Assistant. She assisted one evening when I visited after a fall, by gluing a wound on and above my eyebrow and again three weeks later when I visited, concerned about infection.

On both occasions she was professional, kind and reassuring. She is very knowledgeable about wound care and completely put my mind at ease.

I would also like to add previously to this, about two years ago, I passed out from histamine intolerance and split open a childhood scar under my chin. When visiting the treatment centre, I was fortunate enough to have a very kind gentlemen stitched me up and because of his care to detail the scar is not noticeable today.

Because of Alicia, a traumatic experience was easier for me to deal with. I will always be grateful to her for her patience, compassion, care and understanding. Thank you.

St. Mary's Portsmouth Surgical Centre

Performance against the priorities set for 2025/26

Priority 1 - Achieved

We said we would:

Increase staff mandatory training completion and compliance rate above 90%.

What we have achieved:

Mandatory training compliance across all clinical, non clinical and bank staff at St. Mary's Portsmouth Surgical Centre (PPGPSC) is actively monitored through robust governance arrangements led by the Clinical Practice Educator, Heads of Department and line managers. The Learning Management System (LMS) provides real time visibility of individual compliance status for all staff.

Performance against mandatory training requirements is reviewed monthly and formally reported to Practice Plus Group (PPG) via the Quarterly Business Review (QBR) using the monthly Quality Report. This report is cascaded internally through management and clinical governance forums and shared externally with the Integrated Care Board (ICB).

As at January 2026, overall mandatory training compliance at PPGPSC was 92%, with performance consistently maintained above 90% month on month.

To further strengthen assurance, in house Immediate Life Support (ILS) and Safeguarding Children Level 3 training programmes were introduced in 2026 and are being delivered to all clinical staff.

Priority 2 - Achieved

We said we would:

Increase audit completion and compliance rate above 90%.

What we have achieved:

All audits are conducted by Heads of Department/allocated departmental auditors using the Assure platform or the Safety Culture platform. Audit compliance is overseen by the Infection Prevention and Control (IPC) and Compliance Manager.

Audit performance is reported monthly to Practice Plus Group through the QBR as part of quality reporting. This report is shared internally across PPGPSC via monthly managers' meetings, quarterly Quality and Clinical Governance meetings and governance day events, it is also shared externally with the ICB.

Audit data for January 2026 demonstrates an overall average compliance score above 90% across PPGPSC, as recorded on the Assure and Safety Culture platforms.

Priority 3 - Achieved

We said we would:

Improve patient experience, evidence by Patient-Reported Outcome Measures (PROMS) and friends and family feedback.

What we have achieved:

Friends and Family Test (FFT) feedback for PPGPSC is reviewed monthly through the Patient Participation Group, which is chaired by a Healthwatch patient representative. FFT performance data and qualitative feedback are reported monthly to the corporate Practice Plus Group via the QBR report.

The QBR report is shared internally across PPGPSC through monthly managers' meetings, quarterly Quality and Clinical Governance meetings and governance day events, and shared externally with the ICB. FFT feedback is disseminated to all staff via Heads of Department and is displayed within the centre in poster format.

Patient Reported Outcome Measures (PROMs) are routinely collected for Ophthalmology patients at PPGPSC.

Local outcomes

St. Mary's, Portsmouth	#	%	Comments
Transfers to NHS trusts	8	0.08%	2 April 2025 (Basic Datix Review, SWARM and SEIPS), 1 August 2025 (SWARM and SEIPS), 1 September 2025 (SWARM and SEIPS), 1 October 2025 (SWARM and SEIPS), 2 November 2025 (SWARM and SEIPS), 1 December 2025 (Basic Datix Review)
Readmissions and/or return to theatre	3	0.3%	1 September 2025 (Post Infection Review), 1 December 2025 (SEIPS), 1 March 2026 (Basic Datix Review)
Surgical Site Infections (SSIs)	9	0.09%	1 April 2025 (Superficial; SSI Thematic Review), 1 August 2025 (Superficial; Basic Datix Review), 1 September 2025 (Superficial; Post Infection Review), 1 December 2025 (Superficial; Basic Datix Review); 1 December (Deep; Post Infection Review), 1 January 2026 (Superficial; Thematic Review), 2 February 2026 (Superficial; Thematic Review), 1 March 2026 (Superficial; Basic Datix Review)
Endophthalmitis	5	0.05%	1 January 2026 (endophthalmitis Post Infection Review), 2 February 2026 (Thematic Review), 2 March (Thematic Review)
Delay in diagnostic/treatment pathway	3	0.03%	1 June 2025 (Basic Datix Review), 1 September 2025 (Patient Safety Incident Investigation), 1 March 2026 (Basic Datix Review)
Incidents relating to patient harm	57	0.55%	398 No Harm, 47 Low Harm and 10 Moderate Harm
Patient Safety Incident Investigations (PSIIs)	2	0.02%	1 September 2025 (delay actioning histology) and 1 January 2026 (incorrect medicine administered)
Complaints received	26	0.25%	3 May 2025, 2 June 2025, 3 July 2025, 2 September 2025, 5 October 2025, 2 November 2025, 2 December 2025, 2 January 2026, 1 February 2026, 4 March 2026
Complaints upheld/partially upheld	21	0.20%	21 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:

- Organisational learning required to strengthen the management of histology processes across the service;
- Local review of histology and pathology pathways, including processes for recording outcomes and escalating results to PPGPSC clinical teams and consultants across surgical specialties;
- Review of the endoscopy pathway to reduce the risk of single points of failure across the patient journey.
- The patient safety improvements made in response to the reviews included:
- Established a weekly endoscopy histology and onward referral review meeting, supported by administrative input;
- Completed an endoscopy pathway review, with interim and longer term digital solutions developed in collaboration with IT;
- Implemented improved electronic tracking and flagging of histology specimens.

6 Emergency Transfer SWARM huddles, supported by SEIPS analysis

The key learning from these reviews included:

- Effective availability of equipment and timely return to theatre where required;
- Strong multidisciplinary communication and rapid coordination of transfer to local acute trusts;
- High standards of clinical monitoring, handover and escalation, with appropriate allocation of staff to remain with patients pending transfer;
- Consistent adherence to transfer pathways and safe staffing levels;
- Identified learning regarding coordination of ward-based transfer processes and availability and use of point of care testing equipment.

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

- Establishment of a dedicated point of contact at receiving trusts to improve communication and patient tracking;
- Shared learning through governance forums and departmental meetings;
- Completion of ISTAT training on 17 December 2025 to increase resilience and staff competence.

1 Unplanned readmission review

The key learning from this review included:

- Timely recognition of complications, effective interdepartmental communication and rapid return to theatre when required.

0 Unplanned return to theatre reviews

0 Venous Thromboembolism (VTE) reviews

2 Post Infection Reviews (PIRs)

The key learning from these reviews included:

- It was identified that antibiotic prophylaxis was not administered in line with NICE guidance and local Trust policy, highlighting the need to reinforce compliance with established prescribing standards;
- Identification of the importance of contingency planning and dynamic risk assessment when surgical approaches change, particularly in relation to MRSA screening.

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

- Development of a local Surgical Site Infection (SSI) Risk Assessment for patients undergoing hernia repair to identify high risk cohorts and implement targeted mitigations.
- Review and alignment of the local MRSA screening policy with corporate standards; this is progressing through a corporate led review process.

1 Superficial SSI thematic reviews

The key learning from these reviews included:

- The need to strengthen and standardise escalation pathways for patients re presenting with deteriorating wounds;
- Identification of omitted intraoperative antibiotic therapy; local review initiated to align antibiotic regimens with local acute trust guidance.

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

- Alignment of antimicrobial prescribing with local trust policy.
- Implementation of SSI risk assessment for all patients, supported by a corporate day surgery risk assessment tool.
- Ongoing monitoring for emerging themes and trends via thematic review processes.

1 Endophthalmitis-Specific PIRs (E-PIRs)

The key learning from these reviews included:

- The incident highlighted the need to locally review the volume of pre prepared instrument sets to ensure this remains appropriate and proportionate to clinical need.

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

- To improve and standardise communication pathways between the UTC and surgical teams to ensure timely escalation, shared situational awareness and continuity of patient care;
- To review and update clinical prompts and triage protocols to support the early recognition and escalation of high risk symptoms, strengthening patient safety and reducing the risk of delayed intervention.

Learning from local Patient Safety Priorities

No local Patient Safety Priorities were identified for the Surgical Centre during 2025/26.

Priorities for 2026/27

Priority 1

What are we trying to improve?

We will strengthen and improve waste segregation compliance across all services to support both patient safety and environmental sustainability. This will include increasing staff awareness and training, standardising waste segregation practices, and implementing robust monitoring and audit processes.

Improving waste segregation will directly enhance patient safety by reducing the risk of cross-contamination and infection, ensuring hazardous and clinical waste is managed appropriately, and preventing exposure to harmful materials for both patients and staff. Clear and consistent segregation at the point of disposal will also minimise the risk of sharps injuries and accidental contact with infectious waste. By embedding safe waste management practices, we will create a safer care environment, reduce avoidable harm, and support high standards of infection prevention and control.

This work will also contribute to our commitment to sustainable healthcare by reducing environmental impact and promoting responsible resource management.

What will success look like?

- High compliance rates: consistent waste segregation compliance across all areas (e.g., ≥95% correct segregation in audits);
- Improved audit outcomes: regular audits show sustained improvement, with clear reduction in errors such as incorrect disposal of clinical, offensive, or sharps waste;
- Reduced incidents: fewer reported incidents related to waste handling, including sharps injuries, contamination risks, and inappropriate waste disposal;
- Stronger infection prevention: demonstrable contribution to lower infection risks through safe and correct waste management practices;

- Staff confidence and awareness: staff feel confident in correctly segregating waste, supported by training completion rates and positive feedback;
- Clear accountability and monitoring: robust reporting mechanisms in place, with teams actively reviewing performance and taking action where needed;
- Environmental impact: increased recycling rates and reduced clinical waste volumes, supporting sustainability targets alongside safety improvements.

How will we monitor progress?

- Regular audits: conduct routine waste segregation audits across all areas, measuring compliance rates and identifying common errors or trends;
- Key performance indicators (KPIs): track agreed metrics such as percentage compliance, audit scores, reduction in waste-related incidents, and recycling rates;
- Incident reporting and review: monitor Datix (or equivalent) reports for waste-related incidents (e.g. incorrect disposal, sharps injuries), with regular review and learning shared;
- Training compliance: deliver waste management training as part of staff induction, with completion rates monitored and measured to ensure all new starters are appropriately trained. Staff understanding will be reinforced and assessed through spot checks or competency assessments;
- Spot checks and walkarounds: carry out unannounced observational checks to assess real-time practice and provide immediate feedback;
- Governance oversight: review progress through relevant governance forums (e.g. local Infection Prevention and Control meeting, local Health and Safety meeting), ensuring oversight and escalation where required;
- Action plans and continuous improvement: use audit findings and incident trends to develop and monitor targeted improvement actions.

Priority 2

What are we trying to improve?

We will enhance our local emergency blood transfusion administration training programme to support the delivery of safe, effective, and timely advanced care in critical situations. This will include strengthening induction and refresher training, incorporating current best practice guidance, and ensuring staff are competent and confident in emergency transfusion protocols.

Enhancing this training will directly improve patient safety by reducing the risk of errors during time-critical transfusions, ensuring accurate patient identification even under pressure, and promoting strict adherence to emergency administration procedures. It will also support the early recognition and rapid management of transfusion reactions, helping to prevent avoidable harm and improve outcomes in high-risk, urgent scenarios.

Through robust training delivery, competency assessment, and ongoing monitoring, we will ensure that all relevant staff maintain high standards of practice and are prepared to respond safely and effectively to emergency transfusion needs.

What will success look like?

- High training compliance: all relevant staff will complete emergency blood transfusion training at induction and maintain up-to-date competencies through regular refreshers;
- Demonstrated competency: staff can confidently and correctly follow emergency transfusion protocols, evidenced through assessments, simulation exercises, and observational checks;
- Improved response times: staff are able to initiate and manage emergency transfusions promptly and effectively in time-critical scenarios;
- Safe practice under pressure: consistent adherence to safety checks and protocols even in high-pressure environments;
- Early recognition and management of reactions: staff reliably identify and respond to transfusion reactions, minimising harm and improving patient outcomes;
- Positive audit and assurance outcomes: internal audits and reviews demonstrate sustained compliance with national guidelines and local policy;
- Staff confidence and feedback: improved staff confidence in managing emergency transfusions, supported by positive feedback and engagement with training.

How will we monitor progress?

- Training compliance monitoring: track completion rates for emergency blood transfusion training at induction and ongoing refresher sessions, ensuring all relevant staff remain up to date;
- Competency assessments: evaluate staff competency through simulation exercises, practical assessments, and observational checks in clinical settings;
- Audit and review: conduct regular audits of emergency transfusion practice to assess adherence to protocols, documentation standards, and national guidance;
- Incident reporting and learning: monitor and review all emergency transfusion-related incidents and near misses, with learning shared and actions implemented;
- Simulation and scenario testing: use simulated emergency transfusion scenarios to test team response, identify gaps, and track improvement over time;
- Governance oversight: review progress through relevant governance groups (e.g. local Blood Transfusion forum, local Quality and Clinical Governance forum) to ensure oversight and escalation where needed;
- Staff feedback and confidence measures: gather feedback from staff on training effectiveness and confidence in managing emergency transfusions, using this to inform ongoing improvements.

Priority 3

What are we trying to improve?

The focus is on improving the service design across Outpatients, Ward, and Diagnostics departments. The aim is to review and enhance patient pathways to ensure an optimal patient experience and clinical excellence.

Each department is undertaking a Quality Improvement (QI) project, using established QI tools to assess current service delivery and identify opportunities for improvement. These projects are clinically led, with Clinical Leads driving the implementation of changes and ongoing service development.

What will success look like?

Success will be evidenced through measurable improvements across each department:

Outpatients

- Improved utilisation of clinic capacity;
- Better optimisation of patients for surgery;
- Streamlined and more efficient patient pathways;
- Improved staff morale;
- Delivery of targeted training in Outpatient and Pre-assessment skills.

Diagnostics

- Effective utilisation of the new IT system (Maxims);
- Improved oversight and management of bookings via ERS;
- Enhanced clinical management within the system;
- Reduced waiting times and consistent achievement of KPIs.

Ward

- Improved patient pathway from admission to discharge;
- Better utilisation of ward capacity (patient bays and theatres);
- Enhanced collaboration across Ward, Endoscopy, and Theatres teams;
- Optimised staffing skill mix to support safe and effective ward care.

How will we monitor progress?

Progress will be monitored through regular project meetings involving key stakeholders. These meetings will:

- Review progress against planned improvements;
- Maintain momentum of change initiatives;
- Identify challenges and enable timely adjustments;
- Ensure continuous alignment with project objectives.

Patient stories

Retrieved from Friends and Family feedback;

"The service I have received for my Hernia has been outstanding from everyone. I can't THANK The Surgeon enough for her professionalism and making me feel at ease with everything going on before and after."

"I am always dealt with in a kind and polite manner. It makes me more relaxed about seeking support."

"I was attended to before my scheduled appointment. I felt welcomed and treated courteously. I felt very comfortable with the nurse and doctor. The doctor explained the proposed procedure and answered all my questions."

"It was our first visit and we were very pleased in the way your team received us. We could not find anything that you need to change Thank you so much for your professionalism."

"Excellent receptionists, upbeat and efficient. Comfortable waiting area. The nurses were kind and explained the process and finally the Consultant put me at ease. A very good experience."

"Very professional and calm personnel! Everything is explained to the smallest detail, starting from the lady in the reception through assistants to the doctor, that makes even unpleasant test or procedure to be bearable. Unable to name individuals everyone I dealt with are superb! Thank you."

From a patient 'Thank-You' card

"Thank you very much for your speedy work, much appreciated."

St. Mary's Portsmouth Urgent Treatment Centre

Performance against the priorities set for 2025/26

Priority 1 - Partially achieved

We said we would:

Increase staff training compliance with wound care teaching sessions, with all staff completing wound care training.

What we have achieved:

During the reporting period, robust arrangements remained in place to monitor mandatory training completion for all clinical, non clinical and bank staff. Oversight is provided by the St Mary's Portsmouth Urgent Treatment Centre (PPGPUTC) Clinical Practice Educator and Clinical Manager, ensuring ongoing compliance and workforce competence.

To improve the quality and safety of wound care delivery, targeted Wound Care teaching sessions were introduced in February 2026. These sessions were and continue to be delivered by the Head of Clinical Services, supported by the Infection Prevention and Control (IPC) and Compliance Manager, and form part of a broader quality improvement programme to strengthen clinical practice across the UTC.

Further assurance is being provided through the development of a comprehensive Wound Care Competency framework. Once implemented, this will support a standardised approach to training and assessment and ensure that all relevant staff are appropriately trained, assessed and competent in the provision of wound care.

Priority 2 - Partially achieved

We said we would:

Improve substantive staff recruitment and reduce bank and agency spend, with full recruitment into advertised positions.

What we have achieved:

During the reporting period, positive progress has been made against this priority. A reduction in agency expenditure has been achieved through increased utilisation and greater consistency of the internal bank workforce, supporting improved workforce stability and continuity of care.

Recruitment has remained a key area of focus, resulting in the successful appointment of two permanent General Practitioners. These appointments have strengthened service resilience and enhanced continuity for patients. In addition, Trainee Practitioners are currently in the final stages of completing their portfolios and are expected to qualify by August 2026. Their development has been supported through dedicated educational supervision, including 50% protected non clinical time facilitated by a Development Practitioner.

While significant progress has been made, recruitment across all roles remains ongoing. As such, this priority is assessed as partially achieved, with further work planned during the next reporting period to consolidate and sustain improvements

Priority 3 - Achieved

We said we would:

Increase staff mandatory training completion and compliance rate above 90%.

What we have achieved:

During the reporting period, robust processes remained in place to monitor mandatory training compliance for all clinical, non clinical and bank staff. Oversight is provided by the PPGPUTC Clinical Practice Educator and the Clinical Manager, supported by individual staff access to real time compliance data via the Learning Management System (LMS).

Mandatory training compliance is reviewed monthly and reported to Practice Plus Group (PPG) through the Quality Business Review (QBR) as part of the standard Quality Report. This information is shared internally through PPG Portsmouth (PPGP) managers' meetings, quarterly Quality and Clinical Governance meetings and governance events, and externally with the Integrated Care Board (ICB), providing assurance on workforce preparedness and patient safety.

As of January 2026, LMS data demonstrated an overall mandatory training compliance rate of 94% for PPGPUTC, with performance consistently maintained above 90% month on month, including sustained compliance of 94% in March 2026.

To further strengthen local capability and accessibility, in house Immediate Life Support (ILS) and Safeguarding Children Level 3 training programmes were introduced within the UTC in early 2026. These initiatives have enhanced workforce competence and provide additional assurance that staff are appropriately trained to deliver safe and effective care.

Local outcomes

St. Mary's, Portsmouth UTC	#	%	Comments
Unplanned reattendance within 7 days for same condition	0	-	
Incidents relating to patient harm	29	0.04%	79 no harm, 27 low harm and 2 moderate
Patient Safety Incident Investigations (PSIIs)	0	-	
Complaints received	8	0.01%	2 May 2025, 1 July 2025, 2 October 2025, 1 December 2025, 2 January 2026, 0 February, 0 March
Complaints upheld/partially upheld	8	0.01%	8 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:

0 Patient Safety Incident Investigations (PSIIs)

Learning from local Patient Safety Priorities

No local Patient Safety Priorities were identified for the UTC during 2025/26.

Priorities for 2026/27

Priority 1

What are we trying to improve?

We aim to build on the progress made this year by further strengthening the stability and resilience of our workforce. Although we reduced agency spend and secured new substantive appointments, full recruitment into all positions was only partially achieved. Over the next year, we will continue our commitment to improving substantive recruitment, reducing reliance on temporary staffing, and enhancing development pathways to ensure a skilled, sustainable workforce.

What will success look like?

Success will mean achieving full recruitment into all vacant clinical and non clinical positions, resulting in reduced bank/agency use and improved workforce continuity. We expect to see increased staff retention and stronger team stability, supported by clear development pathways for Trainee Practitioners and existing staff. A more consistent and well established workforce will lead to improved patient experience, greater team cohesion, and enhanced service reliability.

How will we monitor progress?

Progress will be monitored through monthly workforce data, including recruitment activity, staffing levels, turnover rates, and agency/bank usage. Workforce performance will be reviewed at managers' meetings and Quality and Clinical Governance meetings to ensure trends are identified and addressed promptly. Updates will also be shared with Practice Plus Group and included in routine Quality Reporting to the ICB.

Staff development will be tracked through competency frameworks and training compliance records, ensuring clear visibility of progression against workforce objectives.

Priority 2

What are we trying to improve?

We aim to further strengthen our clinical workforce development by embedding and expanding the newly established Trainee Practitioner portfolio. Introduced this year, the programme has provided a structured pathway for developing advanced clinical skills and supporting progression toward autonomous practice. With the first cohort expected to complete their portfolios and qualify by August 2026, our focus for the coming year is to consolidate the programme, refine the competency framework, and prepare for the recruitment and onboarding of a new cohort of Trainee Practitioners.

What will success look like?

Success will involve the current cohort completing their portfolios on schedule and transitioning into fully qualified roles within the service, contributing directly to clinical capacity and reducing the need for temporary staff. A strengthened and well established programme will enable the seamless commencement of a new group of trainees later in the year. This will ensure a continuous pipeline of skilled practitioners, enhance service resilience, and support longer term workforce sustainability.

How will we monitor progress?

Progress will be overseen through regular portfolio reviews, competency sign off meetings, and supervision sessions led by the Development Practitioner and senior clinical team. Monthly updates will be provided through workforce and education dashboards, with progress discussed at managers' meetings and Quality and Clinical Governance meetings. The onboarding and early progression of the next trainee cohort will also be monitored to ensure the programme remains robust, supportive, and aligned with service needs.

Priority 3

What are we trying to improve?

We aim to review and strengthen patient pathways within the Urgent Treatment Centre to ensure patients are directed to the right service, at the right time, and in the right place. This will focus on reducing avoidable delays where patients wait in UTC before being redirected elsewhere, and improving the accuracy of early triage decisions. Key to this will be enhancing senior clinical support within triage, ensuring the shift lead is visible and accessible to support real-time decision-making, and embedding clearer, more consistent streaming processes across the team to improve patient flow and overall efficiency.

What will success look like?

Success will be reflected through improved patient experience, operational performance, and staff engagement. This includes a reduction in complaints relating to waiting times and inappropriate streaming, alongside an increase in positive patient feedback regarding timely and appropriate care. We expect to see improvements in waiting times, particularly for patients requiring onward referral, and enhanced staff morale and retention as a result of clearer processes and improved support. Success will also include active involvement of the whole team in service improvements, supported by better utilisation of IT systems, including upgrades to patient administration software to enable improved data analysis, trend identification, and the development of system flags to support decision-making.

How will we monitor progress?

Progress will be monitored through a combination of quantitative data and qualitative feedback. This will include the monthly audit cycle, with review of pathway effectiveness, waiting times, and streaming accuracy, alongside regular analysis of complaints and Datix incidents to identify trends and learning opportunities. Patient feedback will be reviewed to assess experience and satisfaction, while staff feedback will be gathered through engagement activities and ongoing improvement work. In addition, progress will be tracked through the implementation and utilisation of IT system upgrades, with a focus on improving data quality and enabling trend analysis to support continuous service improvement.

Patient stories

Retrieved from Friends and Family feedback;

“From walking in the receptionist was friendly, helpful and showed great empathy. We were lucky to be seen within about 30 mins and with a poorly child I was very thankful. The staff that dealt with my daughter were also amazing and very friendly and helpful. Nothing was too much trouble. Thank you.”

“I had an emergency medical care and I was dealt with my condition quickly and all staff were amazingly kind and helpful.”

“The service received was excellent. Staff were friendly and caring. Just wish the waiting times were lower.”

“I had an emergency medical care and I was dealt with my condition quickly and all staff were amazingly kind and helpful.”

“Right from arriving, being booked in, being triaged and then seen by a practitioner was all straight forward and done in just over 3 hours. Very professional service. Referred by my GP as they had no appointments until after Christmas so very pleased with the outcome.”

“The journey from check-in to triage to treatment was exceptionally efficient, professional and considerably quicker than anticipated. The reception staff were friendly and informative explaining the process clearly and effectively.”

“Was Monday 08:30, in and out within half hour. Friendly receptionist then seen and checked and told what was what.”

“We didn’t have to wait too long and everyone was helpful and friendly. My son’s ankle actually wasn’t as bad as we thought and no-one made us feel silly for coming in to get it checked.”

Gillingham Surgical Centre

Performance against the priorities set for 2025/26

Priority 1 - Achieved

We said we would:

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

What we have achieved:

Creation of the NatSSIPs2 action plan allowed us to review and monitor progress. Ten observational audits of the WHO Patient Safety Checklist were completed in the year with an overall compliance of 98%. Relevant clinical staff undertook refresher e-learning training via our LMS system on the completion of the WHO checklist. The creation and ratification of the Theatre Manual contains all critical sequential steps of the WHO checks.

Priority 2 - Achieved

We said we would:

Reduce the percentage of avoidable cancellations on the day of surgery from April 2025 to March 2026, compared to the previous year, by 5%.

What we have achieved:

Monthly cancellation data was collated, trends reviewed and information shared to all. Key actions implemented in regards to any trends identified.

During the year there was a good reduction of avoidable cancellations. 14 avoidable cancellations in the year compared to 24 the previous year which exceeded the 5% reduction target.

Priority 3 - Achieved

We said we would:

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

What we have achieved:

The development plan in place is a dynamic and a live resource. All objectives identified followed the SMART format. The plan is reviewed bi-weekly to ensure that all actions are measured, monitored and implemented.

All progress is captured and minuted at the monthly Patient Safety and Quality meeting to ensure visibility and allocation of resource as prioritises determine.

Local outcomes

Gillingham	#	%	Comments
Transfers to NHS trusts	7/6,706	0.10%	May 2025 – x2 Oct 2025 – x1 Dec 2025 – x1 Jan 2026 – x2 Feb 2026 - x1
Readmissions and/or return to theatre	7/6,706	0.10%	Unplanned re-admission – 4 Unplanned return to theatre - 3
Surgical Site Infections (SSIs)	16/6,706	0.24%	All SSIs were superficial.
Endophthalmitis	2/4,126	0.05%	May 2025 - x1 August 2025 - x1
Delay in diagnostic/treatment pathway	15/6,706	0.22%	There was no patient harm as a result in the delays
Incidents relating to patient harm	8/463	1,72%	No harm - 387 Low harm - 68 Moderate harm - 7 Severe harm - 1
Patient Safety Incident Investigations (PSIIs)	1/463	0.21%	
Complaints received	4/6,706	0.06%	4 x stage 1 – local resolution
Complaints upheld/partially upheld	4/6,607	0.06%	Upheld – 2 Partially upheld – 2 Not upheld - 0

Learning from Practice Plus Group 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:

We have one Patient Safety Incident Investigation (PSII)

The key learning from this review included:

- Importance of embedding key processes and procedures regarding incident management;
- Ensure timely review and change for medication;
- Clear documentation for all clinical referrals.

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

- All incidents reported within 24 hours of the incident occurring;
- All swab results are acted upon immediately to ensure no delay in prescribing suitable medication;
- Onward referrals are clearly documented and stored on our Patient Administration System;
- Any period of closure, patients are given documented information advising what action to take if assistance is required.

7 Emergency Transfers supported by SWARM huddles and SEIPS analysis

The key learning from these reviews included:

- Ensure that relevant clinical situation is escalated to clinical leadership so if required additional support can be given;
- SBAR tool to be used when communication patient safety events;
- Ward thermometers identified as not giving consistent readings.

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

- Clinical escalators for each area are identified daily and shared at the 10@10 daily huddle;
- SBAR tool is used to communicate key information. It is also used to record incidents on Datix;
- New ward thermometers obtained and implemented; all clinical departments now have the same equipment.

Three Unplanned return to theatre reviews

The key learning from these reviews included:

- Importance of following the correct escalation process for a patient who required returning to theatre;
- On discharge continue to advise patients if they have any post-operative problems to call us either for advice or to let us know action taken.

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

- Any return to theatre incident will be reported and a SWARM huddle is undertaken within a timely manner.

Four Unplanned re-admission reviews

The key learning from these reviews included:

- Review of pathway for patients who do not pass urine prior to discharge;
- On discharge continue to remind patients to call us if they have any post-operative complication.

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

- All post-operative advice included in discharge education given to patients;
- To continue undertaking post-operative phone calls within 24 hours of discharge.

0 - Venous Thromboembolism (VTE) reviews

0 Post Infection Reviews (PIRs)

16 Superficial SSI - thematic reviews completed

The key learning from these reviews included:

- After surgery some patients were having their wound checks at different healthcare facilities, we were not always being updated on patient wound issues;
- All information given to patients on discharge however patients were not retaining all wound information.

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

- All wound appointments now being completed at Practice Plus Group Gillingham;
- New separate wound leaflet written and implemented;
- Sutures being removed following consultants' instruction / appointments given at the end of the time frame documented.

Two Endophthalmitis-Specific PIRs (E-PIRs)

The key learning from these reviews included:

- A patient struggled giving their own eye drops, they did not raise their concerns with us;
- To ensure daily monitoring of the temperature in the Outpatient procedure room.

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

- We now supply aids for any patients who may struggle administering their own eye drops;
- Daily temperature monitoring has been implemented to ensure room is a reasonable temperature. We also have a TOUL which ensure that clean air is directed at surgical instruments. A TOUL is an ultra-clean airflow unit designed to prevent post-operative infection by blowing directed, non-turbulent sterile air over surgical field and sterile instruments.

Learning from local Patient Safety Priorities

A Patient Safety Learning Team approach will be taken in response to five or more avoidable cancellations in a month.

During the year there was 1 occasion when five or more avoidable cancellations occurred during the month. Discussions were held at the Patient Safety and Quality Meeting; this was due to difference in clinical opinion between consultant performing the consultation and consultant performing the surgery. Since the employment of more regular consultants, we try to ensure where possible the same consultant will perform the consultation and the surgery which is great for patient continuity of care.

A Patient Safety Learning Team approach will be taken in response to three or more laterality incidents in a month.

During the reporting period there was never a time when there were three or more laterality incidents in a month. After the Quality Initiative project for laterality incidents, these have reduced significantly (three reported in the year).

A Patient Safety Learning Team approach will be taken in response to two or more non infected wound complications in a month.

During the reporting period there has not been an occasion where there were two or more non-infected wound complications in a single month.

2026/27

A Patient Safety Learning Team approach will be taken in response to three or more delay in diagnostic incidents in a month. A more detailed investigation will be undertaken where causation factors are more complex or there is a potential / actual harm caused.

A Patient Safety Learning Team approach will be taken in response to two or more SSIs in a month.

Priorities for 2026/27

Priority 1

What are we trying to improve?

To further solidify the implementation of any learning opportunities identified from Patient Safety learning responses are embedded, understood and demonstrated.

What will success look like?

A reduction year on year on incident trends.

How will we monitor progress?

Where learning is identified and needs to be shared and embedded. An action will be recorded on Datix as a failsafe and a reminder to review the effectiveness of the embedded action.

Priority 2

What are we trying to improve?

As a key NHS partner, the NHS is aiming to reduce emissions by up to 80% between the years 2028-2032. Practice Plus Group Gillingham Surgical Centre is committed to reducing its carbon footprint driven by our Practice Plus Group Sustainability Green Plan.

What will success look like?

Activation and implementation of the Centre's Sustainability Green Plan which is monitored and driven the Sustainability group.

How will we monitor progress?

The Secondary Care Sustainability Group will lead companywide objectives which get embedded by local champions. Local monthly Sustainability meetings will monitor categories from the Sustainability Green Plan.

Priority 3

What are we trying to improve?

To improve and bring to life clinical excellence through medicine management.

What will success look like?

All Medicine Management audits and incidents will be captured and evidence of remedial action plans.

Controlled Drugs Accountable Officer will attend Quarterly Controlled Drug Local Intelligence Networks, sharing any learning and resources.

How will we monitor progress?

By utilising a Third-Party provider for our Pharmacy Services this is give an impartial view on compliance, areas for improvement and areas to celebrate.

Patient stories

All the staff were so kind and patient when I had my Endoscopy procedure. I was very nervous but everyone helped ease my stress.

I have been attending this hospital for a few years now and want to say a huge thank you for all you do in arranging my appointments and for the care you give me. I am always greeted with a smile.

Appendix 1: Local clinical audit schedule

Audit	Purpose	Frequency
Emergency Response Audit	All services must hold a 'planned' emergency scenario every three months. It is also good practice to incorporate an 'unplanned' scenario on an annual basis (MHRA (2007) and ABPI (2007). All emergency scenarios should be seen as learning exercises and all of the outcomes shared with the entire team, regardless of whether they were present during the scenario or not.	Monthly
Documentation	Supports best practice in clinical documentation and guidance from professional bodies. Various versions according to the department being audited e.g. ward, pre-op, theatre, physio etc.	6-Monthly
Safeguarding Assurance Framework Audit	To ensure that safeguarding concerns are referred and logged, providing assurance that safeguarding responsibilities are discharged.	Quarterly
Accessible Information Standard	The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so they can communicate effectively with health and social care services.	Annually
Site assurance tool - non facilities	Log of the key people required to comply with legislation.	Annually
Endoscopy Decontamination QMS	To determine whether endoscopy decontamination is undertaken in accordance with policy.	Quarterly
CSSD QMS	To assess compliance with standards for decontamination of reusable sterile equipment.	Monthly
Controlled Drugs	Compliance with the documentation element of Controlled Drugs.	Quarterly
Inpatient medication chart documentation	To ensure compliance with NICE guidance, focusing on reconciliation of medicines.	Quarterly
Antibiotic Stewardship audit	To reduce the risk of inappropriate antibiotic usage in line with Practice Plus Group policy and national Antibiotic Stewardship guidelines.	6-Monthly
Pre-labelled TTO medication audit	To ensure medication management processes and arrangements are robust and that documentation and audit trails are comprehensive.	6-Monthly
Diagnostics X-Ray Interpretation	Data collection to determine the percentage of correctly-interpreted images to identify trends.	Monthly
Diagnostics Reject Analysis Monthly Data	An overview of the monthly rejection rate from each site.	Monthly
Diagnostics Reject Analysis 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 & Safety and Environment Departmental Audit Tool	Routine H&S inspections of departments and offices by individual department H&S Representatives.	Monthly
Annual Fire Check		Annual
IPC assurance tool	Assessment of compliance with the IPC Strategy.	Monthly
Hand Hygiene Technique	Hand hygiene is performed by staff at every appropriate opportunity according to the Five Moments of Hand Hygiene.	Quarterly
Cleaning and Decontamination of Reusable Equipment	To ensure that re-usable equipment is managed in accordance with best practice to reduce the risk of infection.	6-Monthly
Aseptic Technique	The risk of infection is minimised through implementation of evidence-based practice.	6-Monthly
Peripheral Vascular Devices	Evidence-based best practice is being consistently applied to prevent peripheral vascular device infections.	6-Monthly
Urinary Catheter Care	Evidence-based best practice is being consistently applied to prevent urinary catheter infections.	Annually
Ward environmental audit tool	To assess the cleanliness of areas, both clinical and non-clinical.	Monthly
Theatre, minor ops, endoscopy environmental audit	To assess the cleanliness of areas, both clinical and non-clinical.	Quarterly
OPD, UTC, Diagnostics & Physio environmental audit	To assess the cleanliness of areas, both clinical and non-clinical.	6-Monthly
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 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 2025/2026. 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 2025/26 period.

This Quality Account has highlighted progress against both the organisational and local Quality Priorities chosen for 2025/26 and sets out the priority areas and priorities identified for 2026/27 across all Practice Plus Group Hospitals and the Plymouth Hospital. Additionally, the Quality Account provides information around other areas of achievement and progress across the organisation, such as the Venous thromboembolism (VTE) risk assessment compliance of 97% exceeding the national target and the learning and improvement actions from participation in national and local audits, where learning includes an update of audits to align with the World Health Organisation (WHO) surgical safety checklist which reflects NATSIPPs 2. The ICB welcomes the level of detail provided in the Quality Account.

Organisational Quality Priorities Review 2025/26:

1. **Co-production and communication of learning from harm with patients and families** Partially implemented and therefore carried forward into the coming year as a Quality Priority to ensure patient and family engagement in processes to share learning and contribute to meaningful change are fully embedded. Significant improvement targets to measure progress include ensuring that at least three co-produced actions are implemented per quarter in response to patient safety incident investigations.
2. **Achieve the Quality Standard in Imaging** Continues as an ongoing priority area for 2026/27 aligning with the programme of work to strengthen diagnostic imaging services in preparation for Quality Standard for Imaging (QSI) accreditation. Preparedness for assessment has been rolled out across all sites.
3. **Enhance the perioperative pathway** Continues as an ongoing priority area for 2026/27 which sets out to improve patient preparation, digitalise pathways and commence electronic pre-operative assessment. Achievements to date include the completion of health guidance training to offer enhanced support to patients progressing to fitness for surgery.
4. **Surgical Site Infection Risk Assessment** This quality priority for 2025/26 was achieved with the revision of the internal surgical site risk assessment and its inclusion on the electronic patient record system. The programme of work is taken forward both as a part of the overarching priority area around Infection Prevention and Control for 2026/27 and as a specific focussed Quality Priority, to ensure the surgical site risk assessment tools are embedded and both training and updating the electronic patient administration system are evidenced and completed in full.
5. **Participation in the National NHS Foundation Pharmacist Training Programme** This priority was achieved through the successful hosting of five trainees and a 100% fill rate for trainee roles in 2026/27.
6. **Utilisation of Point of Care Testing (POCT)** The priority was partially achieved with the establishment of the national POCT Committee and local site level committee meetings. This general programme of work including audit, self-assessment and routine on-site inspections will continue to ensure embeddedness and does not map to a specific quality area or priority.

The ICB also notes and welcomes the seven 2026/27 cross organisational priority areas outlined by Practice Plus Group in their Quality Account, and will look forward to seeing achievements related to:

1. **Strengthen patient involvement in safety learning**
2. **Strengthen quality governance and patient representation**
3. **Achieve Quality Standard in Imaging (QSI) accreditation**
4. **Enhance the perioperative pathway**
5. **Strengthen Infection Prevention and risk management**
6. **Strengthen medical device governance**
7. **Digitise safer staffing rota management**

In conjunction with the seven priorities for improvement:

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

Priority 2: Recruit additional Patient Safety Partners

Priority 3: Quality Standard for Imaging (QSI) accreditation

Priority 4: Electronic Pre-Operative Assessment (e-POA)

Priority 5: Surgical Site Infection risk assessment tool

Priority 6: Medical Device Governance

Priority 7: Introduction of Penthrox as an alternative to Nitrous Oxide in both Endoscopy and Urgent Treatment Centres

Additionally, Practice Plus Group identify Quality Priorities specific to their local sites, Plymouth Hospital has demonstrated progress across the following in 2025/26:

1. **Referral to admissions - to improve pathway efficiency** Achieved, with patients receiving information about the first appointment processes to ensure they can plan for the time needed and importantly know what to expect and who they will meet. The opportunity to adjust first appointments to individual needs is built in if required. Other improvements include the offer of attending Joint School to all major arthroplasty patients.
2. **To implement Getting It Right First Time (GIRFT)** While GIRFT is considered business as usual, this priority is assessed as partially achieved to enable the implementation of a structured plan in 2026/27. This will ensure that practice continues to align with national best-practice standards and these are used to drive local improvements.
3. **Patient Information Leaflets Review** Achieved, through the quarterly Patient Forum Group patients have had the opportunity to feed back on all information shared with patients as they progress though the respective care pathways.

Plymouth Hospital Quality Priorities for 2026-27 include;

Priority 1: Increase the number of patients who can be safely and successfully treated as day-case major arthroplasty procedures

Priority 2: Strengthen the rigour and consistency of reporting and recording surgical site infections (SSIs). As part of this work, there will also be a focus on enhancing the quality of wound-care practices, with the aim of achieving formal wound care accreditation

Priority 3: Increase the rates of medicines reconciliation and optimisation across all stages of the patient pathway

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 2025/26.

Care Quality Commission (CQC) involvement: As Commissioners, we have worked closely with Practice Plus Group during 2025/26 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 2025/26 and all Practice Plus Hospitals and Surgical Centres remain rated either ‘Good’ or ‘Outstanding’ by the CQC with no enforcement action during the reporting period. Practice Plus Group Plymouth Hospital received an overall rating as 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.

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.

NHS Kent and Medway Integrated Care Board (ICB)

We welcome the Quality Account for Practice Plus Group.

The annual account demonstrates an overview of quality of care in your focus areas, looking at improving the safety, and effectiveness of your services, as well as improving patient experience. The report has a clear flow that would be easy to follow for member of the public.

We pleased to see your progress with your quality priorities from 25/26, particularly creation of the NatSSIPs2 action plan, a good reduction of avoidable cancellations noting 14 avoidable cancellations in the year compared to 24 the previous year which exceeded your 5% reduction target. Your aim was to complete SMART objectives identified on your quality improvement plan.

We commend your choice of quality priorities for 26/27. We welcome your effort to further solidify the implementation of learning opportunities identified from your Patient Safety learning responses, that you are committed to reducing your carbon footprint driven by your Practice Plus Group Sustainability Green Plan and to improve clinical excellence through medicine management.

You have set clear priorities for the coming year, aligned to the aims of the organisation's strategy, objectives and values as an organisation. We invite you to update us on your progress with your quality priorities in the contract management meetings.

Jennie Hall OBE
Chief Nursing, Experience and Quality Officer
NHS Kent and Medway

NHS Hampshire and Isle of Wight Integrated Care Board (ICB)

NHS Hampshire and Isle of Wight Integrated Care Board (ICB) welcome the opportunity to comment on the Quality Account for the 2025/26 reporting period, as part of its statutory commissioning and quality oversight responsibilities.

Through ongoing engagement with Practice Plus Group we are satisfied that the Quality Account meets the mandated requirements and provides an appropriate overview of the quality within the commissioned services.

As you have highlighted in your Quality Account, Practice Plus Southampton Hospital and Portsmouth Surgical Centre successfully achieved all three of their 2025/26 priorities with Portsmouth Urgent Treatment Centre improvements in mandatory training compliance of over 90%. Whilst Southampton Urgent Treatment Centre did not fully achieve all 2025/26 priorities, the Quality Account highlights delivery of increased electronic prescribing.

The ICB values the positive and collaborative approach to partnership working with Practice Plus Group Portsmouth and Southampton in relation to effective quality oversight and assurance arrangements, through attending internal quality meetings and annual quality visits for transparency, risk identification and mitigation, and insights into experiences of people and staff and examples of continuous improvement including:

- 41% increase in incident reporting compared with the previous year in Southampton, exceeding 10% target increase.
- A reduction in complaints arising from unmet expectations through increasing the understanding of the services at the Urgent Treatment Centre.
- Use of Patient-Reported Outcome Measures (PROMS) and Friends and Family feedback in Portsmouth Surgical Centre,
- Positive improvement in recruitment and associated reduction in agency spend in Portsmouth Urgent Treatment Centre

We welcome the Practice Plus Group's 2026/27 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 endorse the Quality Account in relation to the services we commission for 2025/26 and will continue to oversee quality for commissioned services throughout 2026/27.

Wendy Newnham
Interim Chief Nursing Officer

NHS North East London Integrated Care Board (ICB)

Commissioner's Statement for Practice Plus Group (Ilford Hospital)
Quality Account 2025/26

NHS North East London Integrated Care 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 2025/26 Quality Account and priorities for 2026/27.

North East London Integrated Care Board welcomes the opportunity to comment on Practice Plus Group's Quality Account for 2025/26, with particular reference to Practice Plus Group Hospital Ilford. We recognise the important role that Practice Plus Group continues to play as an NHS partner, supporting access to elective care and helping to increase capacity for patients at a time of sustained pressure across NHS waiting lists. We thank Practice Plus Group staff for their continued efforts to deliver safe and high-quality care during a period of ongoing operational demand across the NHS and their continued efforts to maintain strong clinical performance and deliver several positive quality indicators reported during the year.

Ilford Hospital demonstrated a number of positive achievements during 2025/26, particularly in relation to clinical audit participation, pathway improvement and responsiveness to patient feedback. The achievement of 100% National Joint Registry submission and Gold status provides strong assurance about the hospital's commitment to data quality, transparency and participation in national audit. The development of one-stop clinics also represents a clear example of practical service improvement, reducing the number of patients waiting for a second nurse-led clinic appointment and improving clearance rates for both orthopaedic and general surgery patients. We also note positively that Ilford Hospital reported no deaths, no endophthalmitis cases and a low transfer rate to NHS trusts during the reporting period. Complaints handling performance was also strong, with all complaints acknowledged within three working days and the majority responded to within 20 working days. Taken together, these achievements suggest a hospital that is actively using local governance, operational improvement and patient experience processes to support safe, responsive and efficient care.

The Quality Account also provides a clear basis for targeted improvement, and we would expect the next reporting period to show measurable progress in the areas identified as partially achieved or below expected thresholds. In particular, further work should demonstrate sustained improvements in local VTE compliance, flu vaccination uptake, PROMs completion, surgical site infection learning, and the consistent translation of patient safety learning into embedded change at Ilford Hospital.

We welcome the progress described against Practice Plus Group's 2025/26 quality priorities, particularly the continued embedding of the Patient Safety Incident Response Framework, the increased focus on patient and family involvement in learning from harm, preparation for Quality Standard for Imaging accreditation, improvements to perioperative pathways, and the strengthening of medical device governance, infection prevention and safer staffing arrangements. We do however note that locally, two of the three priorities for Ilford Hospital were partially achieved. We would welcome clear milestones, measurable trajectories and evidence of impact against the proposed 2026/27 priorities to gain assurance these will be achieved.

Overall, North East London Integrated Care Board is assured by the breadth of quality improvement activity described in the Quality Account and by the positive contribution Practice Plus Group Hospital Ilford continues to make to elective care capacity and patient choice for our population. We would encourage Practice Plus Group to maintain its focus on patient safety, infection prevention, patient involvement, data quality and equitable access, and to ensure that learning from incidents, complaints and patient feedback is clearly translated into measurable improvement. We look forward to continued engagement with Practice Plus Group during 2026/27 as these priorities are progressed.

Dr. Nnenna Osuji
Chief Executive Officer
North East London Integrated Care Board