Practice Plus Group

Quality Account

2021-2022

Contents

Introduction

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

In Part 2 we have included details of priorities for improvement that we intend to deliver during 2022/23.

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

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

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

Part 1
Statement on quality from the Chief Executive

The ongoing challenges of the COVID-19 pandemic continuing throughout 2021 and into 2022 has placed an unprecedented peace time strain on the health of the nation, the NHS and all healthcare providers.

I am proud to report that throughout this year Practice Plus Group was once again able to support the NHS and all of our patients with consistently high levels of healthcare provision. All of our Hospitals and Surgical Centres remain rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC).

We have continued to focus on delivering high quality care during what has been a very fluid period for service delivery, naturally ensuring stringent infection prevention and control measures have been implemented and maintained in line with national guidance throughout. We had no cases of MRSA bacteraemia across any of the Practice Plus Group sites.

That we were able to deliver the high levels of activity and patient care that we achieved is down to the sterling efforts of our staff, partners and management who were as adaptable, committed and innovative as they were in 2021 in dealing with the fluid and ongoing COVID-19 situation and the challenges it presents. For example, by working with Infection Control & Prevention colleagues on cleaning and disinfection protocols we have maintained the required levels of cleaning while returning to pre-COVID-19 appointment lengths across all our services. Ensuring our teams have been effectively supported throughout this challenging period has been an organisational priority.

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

- Six hospitals
- Three surgical centres
- Two urgent treatment centres and walk-in centres
- Our Ophthalmology Service and its eleven mobile units
- Two county-wide multi-location musculoskeletal services

In the year from April 2020 to March 2021 we carried out:

- 59,443 day case procedures;
- 9,077 inpatient procedures;
- 224,573 outpatient consultations, including telephone consultations.

We continue to invest significantly in the development of our people and technology. The last year has seen significant investment in diagnostic imaging equipment, with DR full equipment upgrades and new DR mobiles at three of our sites with another two to follow this year. We have also extended our imaging modalities with the addition of Coned Beam CT (CBCT) at one site, again with another site to follow this year.

The development of our national wet AMD service has continued, with our fourth mobile unit opening to patients in Hampshire, where patient feedback has been excellent. Our investments in new mobile servies, imaging equipment and the development of day surgery techniques and pathways across our hospitals will boost patient choice and help us contribute to the reduction in the national waiting lists which have grown since lockdown. During the year we also added updates to our robust Health Care wide audit tool - the Safeguarding Assurance Framework, all of which were designed to help mitigate patient risk.

Our Divisional Equality, Diversity, and Inclusion Steering Group continued to lead an active programme of communications and educational activities across the year and a new advisory forum has been developed to expand the 'Freedom to Speak Up' agenda, across all areas of the organisation as we strive to celebrate diversity and become ever more inclusive.

We have also sponsored and assisted our local units in providing the necessary training and any associated funding to establish local wellbeing hubs.

Practice Plus Group's priorities for 2021-22 reflect the five key lines of enquiry set by the Care Quality Commission:

- Safe
- Caring
- Responsive
- Effective
- Well-led

In 2022/23 we have set five priorities:

Priority 1: Quality Standard for Imaging Accreditation

Priority 2: Increase mechanisms to gather patient feedback

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

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

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

I am confident that we have the right overarching strategy, people, processes and plans to drive further improvements in patient care as we continue to strive for excellence.

With this approach, we are recovering strongly from the pandemic and are well placed to support the wider healthcare sector move forward in the future.

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

Jim Easton
Managing Director

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

2.1
Priorities for improvement 2022/23

Due to all services being redeployed to support the NHS during the Covid 19 pandemic and the ceasing of all elective surgery quality priorities identified last year were to be suspended.

Practice Plus Group are committed to returning to these priorities in addition to identifying best practice captured during the pandemic.

Priority 1: Quality Standard for Imaging Accreditation

Why have we chosen this priority?
The quality standard for imaging (QSI) was developed to set out the criteria that defines a quality imaging service. It is against this standard that services should evaluate their performance and make improvements where needed to meet - and continually improve against - the set criteria.
QSI accreditation of imaging services is a patient-focused assessment that is designed to give stakeholders, service users, patients and their carers, confidence in their diagnosis and all aspects of their care. UKAS undertake the assessments for accreditation independently against the QSI.

How will we improve?
Embedding QSI will allow a gradual and meaningful change which will allow us to demonstrate to our stakeholders, service users, patients the high standard of Practice Plus Group Imaging services.

How will we measure our improvement and what are our targets?
Typical time for completion would be 6-12 months dependant on the level of standardisation across our services. The assessment process defined by UKAS usually takes 6-12 months.

How will we report and monitor our progress?
Pre-assessment progress is determined by completing a gap analysis which is available as a traffic light tool from the Royal College of Radiologist or College of Radiographers.
When we are green across approximately 80% of the QSI we will apply to UKAS to begin the assessment process.

Priority 2: Increase mechanisms to gather patient feedback

Why have we chosen this priority?
Patient feedback is integral to identification of improving services. There is a need to look to additional mechanisms for gathering and capturing patient feedback. This will allow triangulation with existing mechanisms. This priority has been carried forward from 2021/22.

How will we improve?
Alternative mechanisms identified and tested with at least one mechanism used across all services. At least one site will enlist the support of Patient Safety Partners in gathering patient feedback.

How will we measure our improvement and what are our targets?
Alternative mechanisms identified and tested with at least one mechanism used across all services.

How will we report and monitor our progress?
Via the patient experience forum, in addition to the Secondary Care Quality and Governance Assurance Committee.

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

Why have we chosen this priority?
The roll-out of a single, unified electronic Health Information System across all Practice Plus Group Secondary Care Hospitals and Surgical Centres presents the opportunity to incorporate additional features to address patient safety risks.
Thematic review of incidents across Secondary Care has identified a heavy reliance on paper-based systems for requesting, reporting and acting on diagnostic tests.

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

How will we measure our improvement and what are our targets?
The success of this quality improvement priority will be measured through the adoption of the electronic process across all Practice Plus Group Secondary Care Hospitals and Surgical Centres.

How will we report and monitor our progress?
Progress with this improvement priority will be monitored through the project documentation and reported to the Secondary Care Quality and Governance Assurance Committee.

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

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

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

How will we measure our improvement and what are our targets?
All services will have Quality Academy in place. Replication of Quality Improvement projects across services.

How will we report and monitor our progress?
Via the Clinical Audit and Effectiveness Group and Secondary Care Quality and Governance Assurance Committee.

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

Why have we chosen this priority?
Staff welfare and wellbeing is of paramount importance. It is more important than ever that workplaces become environments that support staff to do this.

How will we improve?
We will ensure that staff are provided with an environment and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

How will we measure our improvement and what are our targets?
All services will have wellbeing champions in place with appropriate training to support them in their role. The development of a Staff Health and Wellbeing strategy to include training staff as Mental Health first aiders/Champions which is linked to the Employee Value Proposition (EVP) project.

How will we report and monitor our progress?
Monitored via governance meetings, in addition to the Secondary Care Quality and Governance Assurance Committee.

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 2021/22 Practice Plus Group Secondary Care provided and/or subcontracted 10 relevant health services.

Practice Plus Group has reviewed all the data available to them on the quality of care in all 10 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by Practice Plus Group for 2021/22.

2.2.2 Clinical audit

During 2021/22 four national clinical audits and zero national confidential enquiries covered relevant health services that Practice Plus Group provides.

During that period Practice Plus Group participated (or had no qualifying cases) in 75% national clinical audits of the national clinical audits which it was eligible to participate in.

The national clinical audits that Practice Plus Group was eligible to participate in during 2021/22 are identified in table 1.

The national clinical audits that Practice Plus Group participated in, and for which data collection was completed during 2021/22 are listed in table 1.

Table 1 : Participation in national clinical audits and National Confidential Enquiries

National Clinical Audit	Eligible to participate	Participated	Comments
Urology Audits: a. Cytoreductive Radical Nephrectomy Audit; b. Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	No	-	Practice Plus Group does not provide these services
Case Mix Programme	No	-	Practice Plus Group does not provide these services
Chronic Kidney Disease registry	No	-	Practice Plus Group does not provide these services
Cleft Registry and Audit Network Database	No	-	Practice Plus Group does not provide these services
Elective Surgery - National PROMs Programme	Yes	✓	See section 2.3.1 Patient-Reported Outcome Measures (PROMs)
Emergency Medicine QIPs: a. Pain in Children (care in Emergency Departments); b. Severe sepsis and septic shock (care in Emergency Departments)	No	-	Practice Plus Group does not provide these services
Falls and Fragility Fractures Audit programme (FFFAP)	No	-	Currently exploring the possibility of participating in the future
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	No	-	Practice Plus Group does not provide these services
Trauma Audit & Research Network	No	-	Practice Plus Group does not provide these services
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	No	-	Practice Plus Group does not provide these services
National Audit of Breast Cancer in Older People (NABCOP)	No	-	Practice Plus Group does not provide these services

Table 1: Participation in national clinical audits and National Confidential Enquiries

National Clinical Audit	Eligible to participate	Participated	Comments
National Audit of Cardiac Rehabilitation (NACR)	No	-	Practice Plus Group does not provide these services
National Audit of Cardiovascular Disease Prevention	No	-	Practice Plus Group does not provide these services
National Audit of Care at the End of Life (NACEL)	No	-	Practice Plus Group does not provide these services
National Audit of Dementia (Care in general hospitals)	No	-	Practice Plus Group does not provide these services
National Audit of Pulmonary Hypertension (NAPH)	No	-	Practice Plus Group does not provide these services
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	No	-	Practice Plus Group does not provide these services
National Cardiac Arrest Audit (NCAA)	Yes	X	The frequency of cardiac arrests within the services doesn't justify subscription. During the reporting period one cardiac arrest occurred. This incident underwent a comprehensive investigation against the NCAA criteria.
National Cardiac Audit Programme (NCAP)	No	-	Practice Plus Group does not provide these services
National Child Mortality Database	No	-	Practice Plus Group does not provide these services
National Clinical Audit of Psychosis	No	-	Practice Plus Group does not provide these services
National Comparative Audit of Blood Transfusion	No	-	Plan to participate in future audits

National Clinical Audit	Eligible to participate	Participated	Comments
National Diabetes Audit – Adults	No	-	Practice Plus Group does not provide these services
National Early Inflammatory Arthritis Audit (NEIAA)	No	-	Practice Plus Group does not provide these services
National Emergency Laparotomy Audit (NELA)	No	-	Practice Plus Group does not provide these services
National Gastro-intestinal Cancer Programme	No	-	Practice Plus Group does not provide these services
National Joint Registry (NJR)	Yes	✓	See Part 4: Local quality updates for local site participation details
National Lung Cancer Audit (NLCA)	No	-	Practice Plus Group does not provide these services
National Maternity and Perinatal Audit (NMPA)	No	-	Practice Plus Group does not provide these services
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	No	-	Practice Plus Group does not provide these services
National Paediatric Diabetes Audit (NPDA)	No	-	Practice Plus Group does not provide these services
National Perinatal Mortality Review Tool	No	-	Practice Plus Group does not provide these services
National Prostate Cancer Audit	No	-	Practice Plus Group does not provide these services
National Vascular Registry	No	-	Practice Plus Group does not provide these services
Neurosurgical National Audit Programme	No	-	Practice Plus Group does not provide these services

Table 1: Participation in national clinical audits and National Confidential Enquiries

National Clinical Audit	Eligible to participate	Participated	Comments
Out-of-Hospital Cardiac Arrest Outcomes Registry	No	-	Practice Plus Group does not provide these services
Paediatric Intensive Care Audit Network (PICANet)	No	-	Practice Plus Group does not provide these services
Prescribing Observatory for Mental Health (POMHUK)	No	-	Practice Plus Group does not provide these services
Respiratory Audits a. National Outpatient Management of Pulmonary Embolism	No	-	Practice Plus Group does not provide these services
Sentinel Stroke National Audit programme (SSNAP)	No	-	Practice Plus Group does not provide these services
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	N/A	There were no qualifying incidents during the reporting period
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder cancer treatment	No	-	Practice Plus Group does not provide these services
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	No	-	Practice Plus Group does not provide these services
Child Health Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Learning Disabilities Mortality Review Programme	No	-	Practice Plus Group does not provide these services
Maternal, Newborn and Infant Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Medical and Surgical Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services
Mental Health Clinical Outcome Review Programme	No	-	Practice Plus Group does not provide these services

The reports of one national clinical audits was reviewed by the provider in 2021/22 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

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

National clinical audit report	Actions in response to report recommendations
National Ophthalmic database (NOD) 2020	Results show generally very good surgery with low pre-operative complications; One consultant could report more complications from surgery; Others are within normal limits and there are no outliers.

The reports of six local clinical audits were reviewed by the provider in 2021/22 and Practice Plus Group intends to take the following actions to improve the quality of healthcare provided:

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

Local clinical audit report	Actions in response to report recommendations
Failed spinal anaesthesia, July 2021	Practice in line with Royal College standards and national rates. A curvilinear US probe has been purchased to facilitate difficult spinal anaesthesia
Audit on preoperative echocardiography, Oct 2021	Most common indications similar to practice in other hospitals; Likely due to specific set up of the Centre lower threshold for ECHO referral; In patients with multiple comorbidities and/or frailty decision whether or not to accept likely better based on clinical findings then ECHO; In patients with history of concerning palpitations consider 24 hour tape before ECHO.
Cataract outcome audit, Mar 2021	Audit results are well within the National recommended guidelines; Trials of different phaco machines and use of upgraded tubing; Recommended reduction in incision size.
Preliminary audit of the effect of intra operative Local Anaesthetics in Day Case Tonsillectomy	According to this preliminary study adult tonsillectomies was safely performed as a day case with adequate pain control. Due to COVID-19 there was a small cohort of patients and the audit will be extended to confirm our initial findings and compare our practice with the recently published meta-analysis about the role of Local Anaesthetic agents in controlling post tonsillectomy pain.
Vision audit of immediately sequential bilateral cataract surgery (ISBCS)	ISBCS is a safe and effective technique and shows no increase in complications compared with our standard cataract surgery. With training and associated guidelines this technique can be rolled out across our surgical centres. The audit did highlight some variability in post-operative assessment of patients, which will be addressed with the help of the ophthalmic educational plan.
Safety of primary hip and knee replacements with same day discharge	Introduction of routine same day discharge hip and knee arthroplasty programme at an elective orthopaedic centre is safe and also may confer wider benefits leading to shorter inpatient hospital stays.

The above local clinical audits are in addition to those included in the generic audit schedule described in Appendix 2. Individual actions are created at the time of the scheduled audits to address any areas of non-compliance identified.

2.2.3 Research

The number of patients receiving relevant health services provided or subcontracted by Practice Plus Group in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee zero.

2.2.4 CQUIN framework

Practice Plus Group's income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because there was no CQUIN scheme during 2021/22 as a result of the COVID-19 pandemic.

2.2.5 Care Quality Commission

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

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

Practice Plus Group has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Practice Plus Group during 2021/22.
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

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

100% for admitted patient care; and 100% for outpatient care.

2.2.7 Information Governance

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

The past 2 years since 2020 has seen a majority of support staff working remotely and continue to support the frontline staff in our Business As Usual compliance under our transformed Covid 19 Pandemic work model.

We continued our historic focus on accountability, audit and transparency; this meant that we have been well placed to continually improve our compliance under the modified work model and transformed environment.

We have continued to update internal policies and patient privacy notices to match and address the Pandemic work model changes for all services.

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

For the period Jan 2021 to Jan 2022, we have had a total of:

8 internal IT security incidents,

54 Internal Confidentiality breaches, with 1 being an external SIRI Level ICO reportable incident, which the ICO has closed with no enforcement actions taken against us. We received and responded to 7 reports by data subjects to ICO and all reports have been closed by the ICO after we provided satisfactory responses to the ICO and in all cases, the ICO concluded there was no wrongdoing by PPG and closed the complaints.

We continued our compliance commitments with the mandatory ISO27001 Certification framework of externally audited continual assessment visits (CAVs) by the British Standards Institute (BSI) where there were no non-conformances raised in the most recent CAV in Nov 2021. In 2022 we reach the overall 3 year ISO 27001 full Recertification cycle in October 2022. In order to enhance our compliance program across all the organisations operational units, we have implemented an additional Internal Audit programme through a rigorous self-assessment programme that ensures total coverage of all Practice Plus Group operational units and increase our compliance evidence base.

Practice Plus Group's 2020/21 annual Data Security and Protection (DSP) toolkit submission achieved 100% Standards Exceeded Compliance status for

the first time and we are on track to achieve the same in the 2021/22 DSP Toolkit submission due on the 30th June 2022.

We also obtained our Cyber Essentials Plus Certification recertification in June 2021, demonstrating our high standards in Cyber Security.

We have scheduled an annual independent external audit review in March 2022 of our DSP Toolkit submission using the NHS DSP Toolkit Independent Assessment Framework guidelines. The DSP toolkit audit will be conducted by Teamwork IMS, an Independent assessor against our self-assessment responses to provide an independent review of our responses.

The National Data Guidance Mean score achieved in the last audit in 2020/2021 was 1.35

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

There were no standards rated as 'Unsatisfactory', and none were rated as 'Limited'. However, not all standards are rated as 'Substantial'.

Therefore the results achieved a DSP Toolkit rating of Moderate assurance level for all the National Data Guidance Standards used to measure the DSP Toolkit submission.

We are confident we will improve on this score in the 2021/ 2022 Independent DSP Toolkit Assessment.

2.2.8 Payment by Results

Practice Plus Group was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Practice Plus Group internal clinical coding audit programme is based on the Data Security Guide. The audit programme exceeds the national clinical coding audit requirements as all secondary care services have an audit of a full 200 episodes for each site, all carried out following DSDT guidance and NHS Digital clinical coding audit methodology.

All of the Practice Plus Group secondary care site have met the Terminology and Classifications Delivery Service standards for primary and secondary diagnosis and primary and secondary procedure, with all but one site having exceeded the standards.

2.2.9 Data quality

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

- We have updated the Practice Plus Group Records Retention and Archiving policy to align with the September 2021 NHSX Updated guidelines;
- We have continued with transformation of all records archiving from paper to electronic archiving for existing and all new records;
- We have conducted a Cyber Security incident Response Table top exercise with an external Testing consultancy. The findings have been added to the Practice Plus Group Continual System Improvement plan and new tools have been implemented to enhance our Cyber Security responses.

2.2.10 Learning from deaths

During 2021/22 seven of Practice Plus Group patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

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

By 04 April 2022, seven case record reviews and three investigations have been carried out in relation to the seven deaths included above.

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

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

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

Five of the seven deaths within 30 days of receiving treatment were not attributable to any aspect of care provided by Practice Plus Group. One patient death during the reporting period is 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:

0 representing 0% for the first quarter;
1 representing 100% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.

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

- The presenting condition of the patient did not trigger staff considering the possibility of sepsis;
- A fluid challenge failed but escalation did not take place immediately in response to this;
- Clinical records being written retrospectively.

The actions taken in consequence of what the provider has learnt during the reporting period include:

- The Standard Operating Procedure has been amended to include the need for a septic screen, blood investigations and escalation to a consultant for all patients with a NEWS score of 5 or more;
- The fluid challenge protocol has been shared with all staff and is on display in clinical areas;
- Documentation audit to identify and address whether records closed when patients discharged to improve accuracy of timings and quality of clinical records.

0 case record reviews and 0 investigations completed after 31 March 2021 related to deaths which took place before the start of the reporting period.

2.3
Reporting against core indicators

2.3.1 Patient-Reported Outcome Measures (PROMs)

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

The procedures measured include:
- Hip replacements;
- Knee replacements.

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

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

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

Participation rates		
	Pre-op participation rate	Post-op participation rate
Practice Plus Group	112.18	79.78
England	88.4	68.5

Finalised data for Apr 2019 – Mar 2020

Health Gains						
Average adjusted health gains – Total HIP Replacement						
	Oxford hip		EQ VAS		EQ-5D index	
	Health gain	Improved	Health gain	Improved	Health gain	Improved
Practice Plus Group	23.94	98.6%	14.00	69.6%	0.47	92.2%
England	22.30	96.9%	14.00	69.4%	0.45	89.4%
Average adjusted health gains – Total KNEE Replacement						
	Oxford knee		EQ VAS		EQ-5D index	
	Health gain	Improved	Health gain	Improved	Health gain	Improved
Practice Plus Group	18.31	95.8%	7.49	56.3%	0.34	84.5%
England	17.40	94.3%	7.81	59.5%	0.33	82.4%

Finalised data for Apr 2020 – Mar 2021

Health Gains			
Average adjusted health gains – Total HIP Replacement			
	Oxford hip	EQ VAS	EQ-5D index
	Improved	Improved	Improved
Practice Plus Group	98.7%	68.4%	92.2%
England	97.2%	69.7%	89.8%
Average adjusted health gains – Total KNEE Replacement			
	Oxford knee	EQ VAS	EQ-5D index
	Improved	Improved	Improved
Practice Plus Group	97.2%	56.2%	81.4%
England	94.1%	58.6%	82.2%

Data source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/finalised-hip-and-knee-replacement-procedures-april-2020-to-march-2021

NHS Digital have not published health gain data for Practice Plus Group sites for 2020/21.

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

It is taken from the finalised Patient Reported Outcome Measures in England data published by NHS Digital.

Practice Plus Group intends to take the following actions to improve this indicator, and so the quality of its services, by standardising the patient pathway as part of the enhanced recovery programme so that there is a clear understanding of the documentation to be completed and responsibilities for doing so at the relevant points of the pathway.

2.3.2 Emergency readmissions

	2019/20	2020/21	2021/22
Practice Plus Group (local data)	0.002% (12/5004)	0.24%	
Best performance nationally	11.70%	*	*
National average	14.40%	*	*
Worst performance nationally	17.20%	*	*

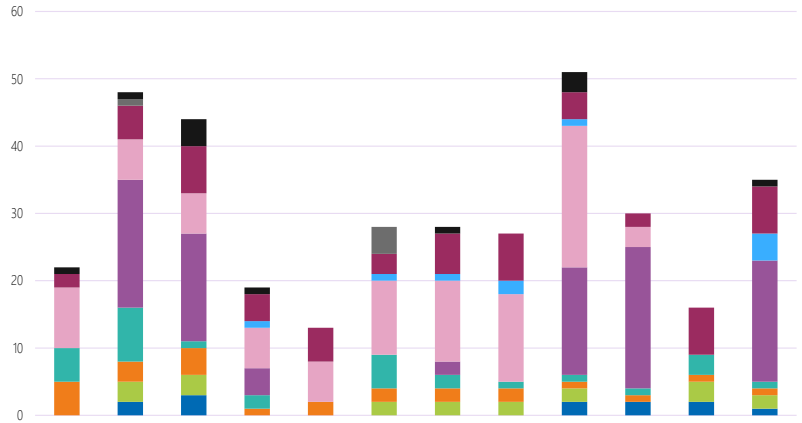
Data source: www.digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current

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

The figure may be higher than stated as patient may be admitted to their local NHS hospital within 28 days of discharge from a Practice Plus Group, but Practice Plus Group not be made aware

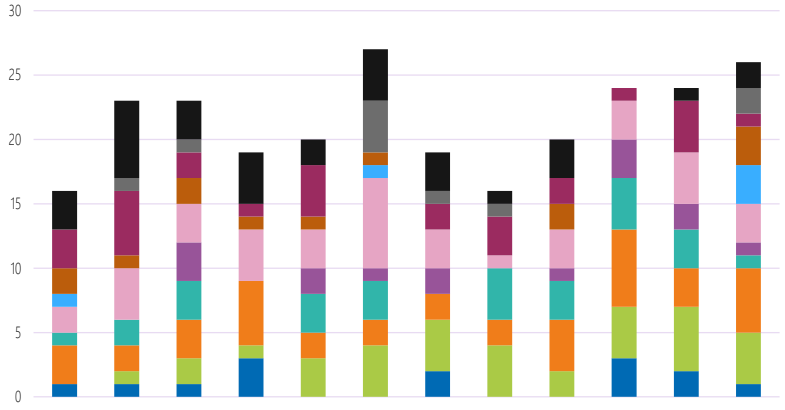
2.3.3 Responsiveness to the personal needs of patients

Number of compliments received by each site



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Barlborough Hospital	0	2	3	0	0	0	0	0	2	2	2	1
Emerson's Green Hospital	0	3	3	0	0	2	2	2	2	0	3	2
Ilford Hospital	5	3	4	1	2	2	2	2	1	1	1	1
Plymouth Hospital	5	8	1	2	0	5	2	1	1	1	3	1
Shepton Mallet Hospital	0	19	16	4	0	0	2	0	16	21	0	18
Southampton Hospital	9	6	6	6	6	11	12	13	21	3	0	0
Devizes Surgical Centre	0	0	0	1	0	1	1	2	1	0	0	4
St Mary's Portsmouth	2	5	7	4	5	3	6	7	4	2	7	7
UTC, Southampton	0	1	0	0	0	4	0	0	0	0	0	0
UTC, St Mary's Portsmouth	1	1	4	1	0	0	1	0	3	0	0	1
UTC, St Mary's Portsmouth	3	6	3	4	2	4	3	1	3	0	1	2

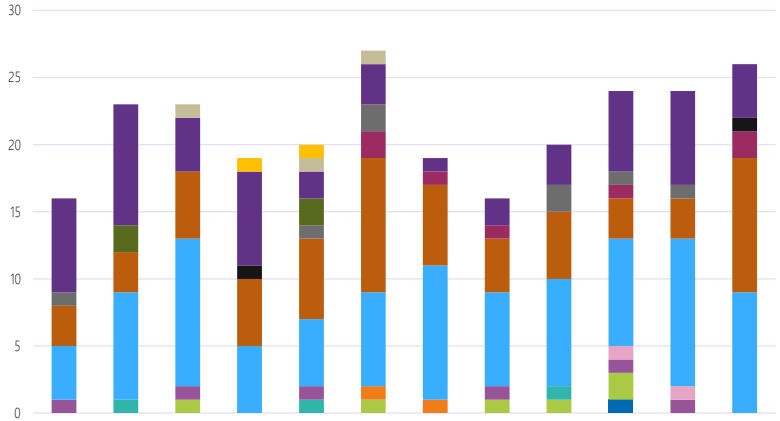
Number of complaints received by each site



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Barlborough Hospital	1	1	1	3	0	0	2	0	0	3	2	1
Emerson's Green Hospital	0	1	2	1	3	4	4	4	2	4	5	4
Ilford Hospital	3	2	3	5	2	2	2	2	4	6	3	5
Plymouth Hospital	1	2	3	0	3	3	0	4	3	4	3	1
Shepton Mallet Hospital	0	0	3	0	2	1	2	0	1	3	2	1
Southampton Hospital	2	4	3	4	3	7	3	1	3	3	4	3
Devizes Surgical Centre	1	0	0	0	0	1	0	0	0	0	0	3
Gillingham Surgical Centre	2	1	2	1	1	1	0	0	2	0	0	3
St Mary's Portsmouth Surgical Centre	3	5	2	1	4	0	2	3	2	1	4	1
UTC, Southampton	0	1	1	0	0	4	1	1	0	0	0	2
UTC, St Mary's Portsmouth	3	6	3	4	2	4	3	1	3	0	1	2

A total of 257 complaints were received during the reporting period, 249 of which provided the complainant with a satisfactory resolution from the initial investigation and response at stage 1. Eight complaints (i.e. 3.1% of complaints made) were escalated to stage 2, whereby the complaint was not resolved to the complainant's satisfaction at stage 1 and a review of the complaint was requested by the Managing Director. Three of the complaints during the reporting period were escalated to the Parliamentary and Health Service Ombudsman as stage 3 complaints. 81% of complaints (180/221) were acknowledged within 3 working days while 54% (45/83) of complainants received a response with the outcome of the investigation within 20 working days.

Subjects of complaints received



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Appointments	0	0	0	0	0	0	0	0	0	1	0	0
Clinical	0	0	1	0	0	1	0	1	1	2	0	0
Documentation	0	0	0	0	0	1	1	0	0	0	0	0
Pathway	0	1	0	0	1	0	0	0	1	0	0	0
Patient perception	1	0	1	0	1	0	0	1	0	1	1	0
Telephone/IT	0	0	0	0	0	0	0	0	0	1	1	0
Clinical treatment	4	8	11	5	5	7	10	7	8	8	11	9
Communication (oral)	3	3	5	5	6	10	6	4	5	3	3	10
Communication (written)	0	0	0	0	0	2	1	1	0	1	0	2
Date for appointment	1	0	0	0	1	2	0	0	2	1	1	0
Date of admission/ attendance	0	0	0	1	0	0	0	0	0	0	0	1
Failure to follow agreed procedures	0	2	0	0	2	0	0	0	0	0	0	0
Staff attitude/behaviour	7	9	4	7	2	3	1	2	3	6	7	4
Staff competence	0	0	1	0	1	1	0	0	0	0	0	0
Test results	0	0	0	1	1	0	0	0	0	0	0	0

Practice Plus Group considers that these data are 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 these data, and so the quality of its services, by:
- Developing data quality validation dashboards on Datix to promote accuracy of records.

2.3.4 Percentage of staff who would recommend Practice Plus Group

The data used to inform the response to this section is taken from the Practice Plus Group annual staff survey, *Over to You*, which is administered and analysed by an independent, external agency. All respondents are categorised as either detractors or promoters and the Net Promoter Score is calculated by subtracting the percentage of detractors from the percentage of promoters. The Net Promoter Score for staff employed by, or under contract to, Practice Plus Group during the reporting period who would recommend Practice Plus Group as a provider of care to their family or friends is as follows:

	2019/20	2020/21	2021/22
Practice Plus Group	56	64	*

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

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

2.3.5 Venous thromboembolism risk assessment

	2019/20	2020/21	2021/22
Practice Plus Group (local data)	99.4%	98.9%	99.1%
Best performance nationally	100%	*	*
National average	95.5%	*	*
Worst performance nationally	58.7%	*	*

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

* The national VTE data collection and publication has been suspended since 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 2020/21 or 2021/22.

Practice Plus Group considers that this data is as described for the following reasons:
All sites record data for this measure and patients missed are followed up.

2.3.6 C. difficile infection

Clostridium difficile can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel. Patients are more vulnerable to infection when they are in hospital however in a number of cases the infection can be preventable therefore reducing the risk of this is a top priority.
In the last year there have been no cases of CDT across all of the PPG sites. We will continue to be vigilant to prevent any cases within our hospitals.

	2019/20	2020/21	2021/22
Practice Plus Group (local data)	0	0	0
Best performance nationally	0	0	*
National average	23.5	22.2	*
Worst performance nationally	142.8	140.5	*

Data source: PHE, C. difficile infections: financial year counts and rates by acute trust and CCG, up to financial year 2020-2021

** National data for 2021/22 not yet made available*

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

- All surgical site infections within the mandatory reporting are reported externally to the National surveillance system and incident reported and investigated internally;
- All surgical site infections are reported to the Board in the monthly KPIs;
- Each investigation is reviewed by a senior member of the infection prevention and control team.

2.3.7 Patient safety incidents

Patient safety incidents that...	2019/20		2020/21		2021/22	
	#	%	#	%	#	%
...resulted in severe harm	1	0.07%	0	-	8	0.41%
...resulted in death	1	0.07%	0	-	2	0.10%
...were classified as never events	4	0.29%	0	-	1	0.05%
...were classified as serious incidents requiring external reporting	6	0.43%	5	0.59%	12	0.61%
Total number of incidents reported	1,556		854		1,970	

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

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

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

- Developing a quarterly newsletter that provides benchmarking across all Secondary Care sites;
- Developing data quality validation dashboards on Datix to promote accuracy of records;
- Undertaking a Patient Safety Culture Survey across all Secondary Care services during June 2021;
- Holding an incident reporting promotional campaign and competition throughout July 2021;
- Offering a four-module e-learning package on Human Factors to augment the face-to-face training already provided.

2.3.8 Friends and Family test

	2019/20	2020/21	2021/22
Practice Plus Group (local data)	99.3%	95.7%	97.6%
Best performance nationally	100%	100%	100%
National average	96%	95%	94%
Worst performance nationally	83%	84%	78%

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

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

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

NHS comparison data

- 2021/22 is as at Dec 2021 Inpatient data at Trust Level, (last published month).
- 2020/21 is at March 2021 at Trust Level
- 2019/20 is at Jan 2020, (due to the suspension of collection due to Covid 19).

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.

2.3.9 Seven day services

As part of the requirements of the quality accounts NHSI have indicated that providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services.

Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

These standards relate to emergency admissions and as such are not applicable to Practice Plus Group Hospitals who only undertake elective care services.

2.3.10 Freedom to Speak Up

The Directors of Practice Plus Group are committed to running the organisation in the best way possible and creating a safe culture and environment in which everyone feels able to highlight potential problems and make suggestions for improvement. As part of the framework that enables us to do that, a Whistleblowing policy is in place which is designed to reassure everyone at practice Plus Group that it is safe and acceptable to speak up and raise any concern at an early stage and in the right way. Rather than waiting for proof, our preference is that matters are raised when they are still a concern. These could be to do with alleged physical abuse or neglect, criminal activity, health and safety, fraud, any possible failure to comply with a legal, professional, or regulatory requirement, or any attempt to conceal such matters. The Secondary Care Human Resources Director acts as our Freedom to Speak up Guardian and, along with the Chief Nurse, he ensures the policy and its associated content is routinely and widely communicated across the organisation. This on-going communication assures everyone at Practice Plus Group that if in any doubt the issue should be raised and, provided that it relates to a genuine concern, it does not matter if an individual is mistaken. Anyone who raises an issue in good faith will not suffer any form of reprisal as a result. In addition, we would not tolerate the harassment or victimisation of anyone raising a genuine concern and we would consider it a disciplinary matter to victimise anyone who has raised a genuine concern. Whilst formal complaints are relatively few and far between, our exit interview data consistently conveys that staff at Practice Plus Group know how to make a complaint if it was felt necessary and are confident that it would be taken seriously and acted upon.

A new advisory forum has been developed to expand the Freedom to Speak Up agenda across all areas of the organisation. Representatives from Primary Care, Secondary Care and Health in Justice are reviewing the training framework for staff and the introduction of an expanded group of Freedom to Speak Up champions within services. This forum has a number of objectives identified with the ability to demonstrate the organisation commitment to Freedom to Speak Up by evidencing actions that create an open and honest culture and to enable behaviours that encourage employees and patients to speak up.

There has been one reported relating to whistleblowing in the past year. This is currently under investigation.

Part 3
Other information

3.1
Performance against the priorities set for 2020/21

3.1.1 Implementation of Serious Incident Review Panel

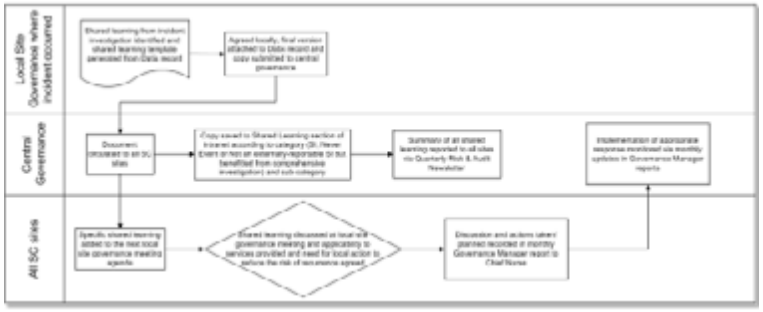
We said we would:

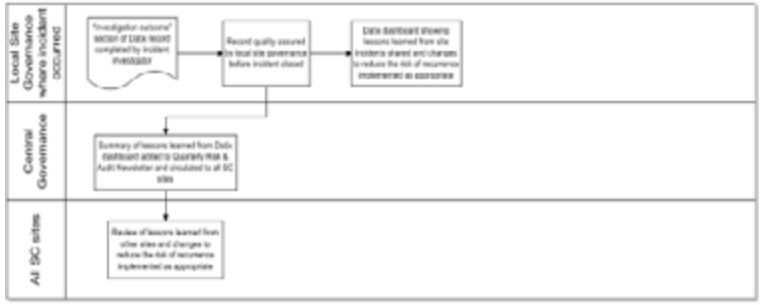
- Establish a Serious Incident Review Panel and identify audit to measure the impact of resultant changes;
- Shared learning will be generated and implemented across the organisation as applicable for all serious incidents;
- There will be no recurrence of serious incidents of a similar nature that could have been prevented had the learning from previous incidents been implemented;
- We will produce consistently robust incident investigations and high quality final investigation reports.

What we have achieved:
Establishment of the Serious Incident Review Panel has been delayed pending the introduction of the new, national Patient Safety Incident Reporting Framework (PSIRF), as this will have a significant impact on incident management across the country. We will therefore carry forward this quality improvement priority into 2022/2023, with adjustments to incorporate the implementation of PSIRF.

In the meantime, a panel comprising the Medical Director and Chief Nurse for Secondary Care, Head of Risk and Audit and subject matter specialists is convened to discuss every potential serious incident within 48 hours of identification. Learning from incident investigation is shared across Secondary Care according to the following processes:

Sharing of lessons learned from comprehensive incident investigations





Sharing of lessons learned from concise incident investigations

3.1.2 Increase mechanisms for gathering patient feedback

We said we would:
Identify alternative mechanisms and test, with at least one mechanism used across all services.

What we have achieved:
Due to services being redeployed to support the NHS during the Covid 19 pandemic this quality priority was suspended and will be reinstated for the coming year.

We have taken the opportunity to review the questions asked within the patient survey to ensure we are capturing information related to the cleanliness of the services.

We are implementing patient partners as part of the incident management framework and will ensure feedback is captured as part of that process.

3.1.3 Expand enhanced recovery (PRO recover) programme

We said we would:

- Train 50% of our joint surgeons to deliver day case surgery;
- Undertake 200 day case arthroplasty in the year;
- Have less than 5% readmission or failure to discharge;
- Achieve mean length of stay (LOS) below 48 hours for hips and knees for 50% of months across Practice Plus Group.

What we have achieved:

We have established enhanced recovery pathway for all patients. In addition, we have the Day Case Arthroplasty Pathway for a certain subset of patients which is the modification of routine enhanced recovery. This is fully functional and daily practice in Barlborough and initial steps have been taken in the rest of our hospitals. The most advanced site after Barlborough is Ilford. The goal is to discharge more medically fit and motivated patients on the day of surgery. The expected maximum volume would be around 15-20% (goals set by BADS). At the moment, the rate in Barlborough is around 8-10%. Hospital teams (including all joint replacement surgeons, anaesthetist, nurses and physiotherapist) not only surgeons and anaesthetists need to be trained – this is all in progress.

The success of enhanced recovery is supposed to be monitored by monthly key performance indicators including length of stay of patients who have undergone joint replacements and we may add rate of next day discharges (NDD) which should be minimum 25%, and 50% within 48 hours. Readmission rates of day case joint replacements should remain below 5%. Failure to discharge on the same day rate should be less than 20% for those who are agreed to be day case joint replacement on the morning of surgery.

3.1.4 Development and introduction of a Quality Academy within each Secondary Care service

We said we would:

- All services will have a Quality Academy in place;
- Replication of Quality Improvement projects across services.

What we have achieved:

Due to services being redeployed to support the NHS during the Covid 19 pandemic this quality priority was suspended and will be reinstated for the coming year.

Sites have taken an opportunity to review new processes implemented during Covid 19 pandemic to determine if these can be incorporated into normal working when the services return to the elective surgery remit.

Sites have identified some quality initiatives they wish to implement and will work over the coming year to embed the quality academy methodology to projects.

3.1.5 Introduction of wellbeing champions for staff in each Secondary Care service

We said we would:

- All services will have wellbeing champions in place with appropriate training to support them in their role;
- The development of a Staff Health and Wellbeing strategy to include training staff as Mental Health first aiders/ Champions which is linked to the Employee Value Proposition (EVP) project.

What we have achieved:

As an organisation Practice Plus Group is committed to enriching the experience of our workforce and to taking all reasonable steps to attract and retain staff. Alongside other planned activities, including a comprehensive internal communications timetable based on two-way dialogue, an on-going review process in relation to both our pay and our benefits, and extensive leadership and management developmental programmes, a significant element of how we do this is linked to supporting and facilitating employee wellbeing from an all-round perspective incorporating both physical and mental health. To this end, and underpinned with expertise provided by our outsourced Occupational Health and EAP providers, we have sponsored and assisted our local units in providing the necessary training and any associated financing to establish local wellbeing hubs providing support, guidance, and advice to help our people live full, fulfilling, and healthy lives. Moving forward we are actively engaged with a number of external providers regarding how we might consolidate and improve this position to ensure we have an end to end wellbeing offering encompassing the seven domains as recommended by the Chartered Institute of Personnel and Development including health, good work, values/principles, collective/social, personal growth, good lifestyle choices, and financial wellbeing.

3.2 Diagnostics

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

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

Our team of dedicated imaging staff, made up of consultant radiologists, radiographers, sonographers and support staff, are all highly experienced healthcare professionals, registered with their respective professional bodies where required. We are also employing our first two apprentice radiographers with a view to “growing our own” workforce.

We now have three qualified reporting radiographers who are reporting plain film x-ray cases in-house, with another reporting radiographer training in MRI reporting due to qualify in spring 2022

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

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

This framework ensures that services delivered by our operational teams are safe and clinically effective. Service-based teams have been supported by an experienced divisional team which includes: a clinical director & advisor for Radiology; and a diagnostic imaging lead who oversees all diagnostic imaging services within Practice Plus Group‘s Health Care Division.

In addition support can be obtained from external providers, such as Alliance Medical, Cobalt, Hexarad Radiology, Xyla Diagnostics and the various NHS trusts we work in conjunction with. Our QA programme comprises an enhanced quality improvement and audit tool that we use to review and evaluate the quality of three key components of the clinical pathway for imaging examinations, namely: referral; imaging; and reporting. We review a minimum of 5% of completed imaging cases, scoring each of the three key components against Royal College of Radiologists recommended reporting and discrepancy management standards which provides the basis for a 5 level quality assurance and discrepancy management guideline. We have our own in-house QA programme to include sonographer and reporting radiographer peer-review. To support this we also have three robust modality working groups which function to review protocols, share experiences and to provide a forum to discuss interesting cases, review discrepancies and any shared learning supporting our drive towards clinical excellence. As our in-house reporting compliment grows we have introduce in-house MDT/Discrepancy review meetings along the lines of RCR REALM meetings to support our reporting radiographers. We have introduced dedicated job plans for all imaging staff that undertake image reporting as part of their job role to make sure that all of our staff are supported with appropriate time for CPD, peer review and role relevant learning.

Our QA programme in combination with the modality working groups allows us to track any trends in reporting errors and to identify where additional training or education may be indicated. Our discrepancy/error rates for the reporting of imaging examinations remain at a very low rate and we are wholly assured that the quality of our reporting is well above any suggested threshold within the published evidence on this topic, and that we continue to provide a high standard imaging service to our patients. Any identified discrepancies are robustly investigated and learning shared amongst all teams and with external providers if appropriate.

The last year has seen significant investment in diagnostic imaging equipment DR full equipment upgrades and new DR mobiles at three of our sites with another two to follow this year. We have also extended our imaging modalities with the addition on Coned Beam CT (CBCT) at one site with another site to follow this year.

Working with Infection Control and Prevention colleagues cleaning and disinfection protocols we have been able to move to pre-COVID appointment lengths across all of our services and this has enabled us to increase our activity levels whilst also maintaining the required high levels of cleaning required.

Communication and inclusivity is a key focus for Diagnostic Imaging and we are developing improved communication methods for patients that engage with our services that suffer from dementia to improve their experience and aid the consent process.

We are also developing an inclusive pregnancy status policy which will include gender neutral information aimed at making sure that no patient feels discriminated against whilst also being sensitive to the needs of all of our patients.

3.3 Equality, diversion and inclusion

We carried on our important work in this area over the course of this year. Our Divisional Equality, Diversity, and Inclusion Steering Group continued to lead our progress with energy and enthusiasm, including representation from across all of our service lines, representing and celebrating our diverse workforce.

The group has led an active programme of communications and educational activities across the year.

3.4 Same sex accommodation

In line with Department of Health guidance on mixed sex accommodation, it is standard practice in Practice Plus Group facilities to provide separate accommodation for men and women throughout the process of admission, treatment and discharge. Practice Plus Group can confirm that there have been no breaches of the Department of Health guidance during the past year and this has been reported to the Health and Social Care Information Centre (HSCIC) as required. We are proud of this achievement and intend to maintain this standard in the future.

"Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity"

3.5 Safeguarding annual review

Practice Plus Group produced a joint Safeguarding Adult and Children Annual Report which reflected upon the period April 2022.

The report sets out the effective work of Practice Plus Group, demonstrating an understanding of its duties and responsibilities to the statutory partnership arrangements and the legislative changes regarding the Children Act 2004, the Children and Social Work Act 2017, Working Together to Safeguard Children 2018 and the Care Act 2014.

It was intended to highlight the diversity of services delivered and how the corporate frameworks are adapted to meet the needs of each service.

The report also aims to give patients, employees and commissioners alike an indication of how Practice Plus Group services are supporting the wider national safeguarding agenda.

Practice Plus Group key areas of work over the year have included:

- The development of a dedicated safeguarding page on Mypracticeplus intranet facilitating direct access to a range of safeguarding resources and updated Practice Plus Group Policies. This includes a link to the NHS safeguarding app.
- Updates to our robust Health Care wide audit tool, namely the Safeguarding Assurance Framework.
- In light of the updated child intercollegiate document and the RCN adult safeguarding roles and competencies for health care staff 2018.

Practice Plus Group have undertaken a review of staff training requirements. Over the next year this will this will lead to the development of a robust training matrix for all staff groups and include a range of training resources

- Review of reporting and referral requirements for services.

Practice Plus Group are committed to ensuring all safeguarding policies and procedures throughout primary and secondary Health Care reflect current legislation, statutory guidance, good practice guidance and variations identified by safeguarding partnerships, Local Safeguarding Children's Boards (LSCB) or Safeguarding Adults Boards (SAB). Both the adult and child policies have been updated to reflect recent changes.

Whilst a great deal of work has been undertaken in safeguarding over the report period, we acknowledge the detail within this report is generic in nature.

This is due to:

- The diversity of services
- Service lines recording incidents and concerns in differing ways both internally and against commissioner requirements

3.6 Duty of candour

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems.

It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident.

It encompasses communication between healthcare organisations, healthcare teams and patients and/ or their carers. Practice Plus Group have robust appropriate processes for communicating with a patient and/or family/carer following a reportable patient safety incident and these are followed in conjunction with Practice Plus Group Incident Reporting Policy and Procedure.

There is clear guidance for staff which outlines Practice Plus Group's policy on its duty of candour and the processes by which openness will be supported.

This support allows practice Plus Group to meet its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst Practice Plus Group employees care for and treat patients.

3.7 Quality visit schedule

To support the CQC requirements and to provide assurance for the CQC, a schedule of quality visits is arranged internally within Practice Plus Group.

These visits follow a regime of a visiting team comprising heads of service who visit all Secondary Care services at least once in a 12 month period complete an observational quality visit and provide a report to support observations on the day with a series of recommendations.

To support shared learning between services and peer review a Hospital Director, Head of Nursing and a Governance Manager join the team to visit another service and provide additional review.

The quality visit consists of visits to each department following a set format aligned to NHS fifteen step challenge to provide assurance of implementation of national and local procedure and process.

Any actions identified during the visit are allocated using the real-time audit tool i-Auditor. These are monitored and managed via an action plan which is reviewed as part of the monthly performance meetings chaired by the managing director. Any immediate concerns highlighted during the visit will be shared with the local site at the feedback session at the end of the day.

The final quality report is provided within six weeks of the visit and shared with the senior leadership team locally in addition to the Medical Director for Secondary Care.

The quality visit report is able to provide assurance to both CCG and CQC of regular review of processes and procedures at a national level by the organisation.

3.8 Infection Prevention and Control

Over the last year, in line with the rest of the NHS and independent sector, the services we deliver have changed considerably and we have been responding to the COVID-19 pandemic. Additional stringent infection, prevention and control measures were put in place which included our staff having to use additional Personal Protective Equipment (PPE), changes to the way we saw patients and how we managed our care environments.

We have continued to focus on delivering high quality care, ensuring stringent infection prevention and control measures as well as rapidly responding to the ever changing National picture and ensuring continued support for our staff. Throughout the COVID-19 pandemic there has been extensive work around infection, prevention and control.

PPG have maintained surveillance of mandatory reportable infections and completed detailed root cause analysis on all cases.

We have a quarterly Infection Prevention and Control Committee (IPCC) and have held Covid meetings frequently throughput the pandemic.

The infection prevention and control service is led by the Director of Infection Prevention and Control (DIPC) who is the Medical Director, supported by the Deputy DIPC. Each secondary care site has an infection prevention and control (IPC) lead who is supported by IPC champions within each department who have all received additional training in IPC.

Mandatory Surveillance

PPG undertakes continuous surveillance of target organisms and alert conditions. Pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by staff. The IPC lead advises on the appropriate use of infection control precautions for each case and monitors overall trends.

HCAI Performance

HCAI performance is monitored via IPCC and theme trends identified and actioned at a local site based level with shared learning across the Group. All healthcare associated infections are subject to an in depth review and action plans are required from the clinical teams where there has been an identified area for improvement.

MRSA bacteraemia

There continues to be zero tolerance to bacteraemia with lapses in care. We continue to work to prevent bacteraemia (blood stream infections), including MRSA with an extensive programme of screening and decolonisation which is in line with National requirements.

In addition, we ensure high standards of infection prevention and control practices including hand hygiene and aseptic procedures.

In the last year there have been no cases of MRSA bacteraemia across all of the Practice Plus Group sites.

3.9 Endoscopy

Practice Plus Group runs eight endoscopy units in many of its surgical sites across the South of England. These carry out urgent, routine and surveillance gastroscopy, flexible sigmoidoscopy and colonoscopy. For colonoscopy and flexible sigmoidoscopy, this includes removal of polyps of up to 2 cm diameter when safe and feasible. To maintain accreditation, sites need to carry out urgent or two week wait (suspected cancer) cases within two weeks and routine cases within six weeks. Surveillance cases are booked according to national guidelines from the British Society of Gastroenterology.

Endoscopy referrals are received from local GP practices, local NHS Trusts and internally from Practice Plus Group clinicians. Over the last year, PPG endoscopy units have assisted with the NHS response to the pandemic by providing additional endoscopy capacity for local NHS Trusts as part of the NHS England requisition of private healthcare facilities.

Practice Plus Group endoscopy units upload directly to the National Endoscopy Database using a selection of key performance indicators (KPI) which combine endoscopists practice at PPG with other units to create whole of practice data for each individual. As part of the appraisal process, we are able to look at PPG and whole of practice to assure quality, that they meet standards and are carrying out the required number of over one hundred gastroscopy and/or colonoscopy procedures and maintaining a high quality assessed by their KPI as they do so. Currently patients are Covid-swabbed within the 72 hours pre-procedure then isolate, although we plan to change to on the day lateral flow tests over the next month.

Numbers of cases are back towards normal levels in the third and fourth quarter of 2,021 with 4,780 gastroscopies, 969 flexible sigmoidoscopies and 2,580 colonoscopies carried out in these 6 months. Quality indicators across Practice Plus Group are excellent with operators achieving excellent comfort ratings with safe use of conscious sedation, and averaging a high percentage of polyp detection and retrieval and over 95% caecal intubation rate (a marker of completeness of procedure).

Each of the eight endoscopy units has accreditation from the national Joint Advisory Group for Gastrointestinal Endoscopy (JAG). To achieve this, endoscopy units undergo a full site visit by a team comprising a medical, nursing, managerial and lay representative once every five years. Sites need to demonstrate compliance with many standards, show evidence for clear policies and operating procedures, monitor and act on endoscopist KPI and collect patient and staff feedback, using results to improve the service. Sites maintain accreditation by filling in an annual report card allowing virtual review for the intervening four years.

Since July 2021, two units (Shepton Mallet and Devizes) have had excellent reports from their full JAG assessments which provides high level assurance around the quality of endoscopy provided.

Each unit carries out a local Endoscopy Users group at least quarterly to discuss local issues as well as physically or virtually attending the Endoscopy Quarterly Forum which is chaired by the Endoscopy Clinical Director. This allows sites to bring their incidents, complaints and issues along for discussion across all eight units to ensure learning is disseminated. It also enables standardisation of management so that the same high quality of care can be assured whichever site is carrying out the endoscopy.

Finally, we have been chosen to represent the Independent Sector in the national post-colonoscopy colorectal cancer pilot, which aims to see if colon cancers could have been picked up earlier, and features which may improve quality of endoscopy further.

Part 4
Local quality updates

Explanatory notes

The data are provided for each site during the period 01 April 2021 – 31 March 2022, according to the following calculations:

	#	%
VTE incidents	Number of venous thromboembolism (VTE) incidents recorded on the Datix incident reporting system	Number VTE incidents / number inpatients x 100
Complaints received	Number of complaints recorded on the Datix complaint reporting system	Number complaints received / total number day cases and inpatients x 100
Complaints upheld/ partially upheld	Total number of complaints recorded as being upheld and partially upheld on the Datix complaint reporting system	Number complaints upheld and partially upheld / total number of complaints reported x 100
Incidents relating to patient harm	Total number of patient safety incidents that resulted in patient harm, as recorded on the Datix incident reporting system	Number patient harm incidents / total number patient safety incidents x 100
Serious patient safety incidents	Total number of serious patient safety incidents recorded on the Datix incident reporting system	Number serious patient safety incidents / total number incidents relating to patient harm x 100

Data include both NHS and private pay patients due to sites not always differentiating between the two in the Datix records. Identification of the source of patient funding has recently been made a mandatory field and therefore accurate distinction between the two will be possible in future Quality Accounts.

The PROMS data are the finalised data for April 2020 – March 2021, as published by NHS Digital, Patient Reported Outcome Measures.

Barlborough Hospital

Performance against the priorities set for 2021/22

Priority 1

We said we would:
Continue with Always Events.

What we have achieved:
Continue to build on the success of last year with Medication Administration Records and patient feedback forms.

Priority 2

We said we would:
Aspire to excellence – Build on our existing successes to ensure high quality patient centred care.

What we have achieved:
Derbyshire Dignity Award achieved

Priority 3

We said we would:
Staff Health & Wellbeing and Mental Health Awareness.

What we have achieved:

- Lateral Flow testing for all staff
- Staff supported to work from home where possible
- Celebrated World Mental Health Day
- Mental health first aider training with designated people to signpost
- Support staff through the COVID pandemic
- Support for staff isolating due to COVID
- Developed a Health & Wellbeing information board
- Staff walking groups set up – with social distancing
- Drop in sessions for staff to chat about any issues.

Local outcomes

Barlborough		#	%	Comments
NJR submission			100%	
PROMS submission	hips	672/883	76.1%	2020-2021 data
	knees			
PROMS health gain	hips		97.2%	
	knees		96.7%	
VTE risk assessment		3,000	100%	
VTE incidents		3/2,186	0.14%	Patient had pulmonary embolus 10 days post-surgery.
Complaints received		14/6,887	0.20%	
Complaints upheld/partially upheld		10/14	71%	Five complaints upheld, five partially upheld, four not upheld
Incidents relating to patient harm		60/369	16%	36 low harm, 14 moderate harm
Serious patient safety incidents		0	0%	

Priorities for 2022/23

Priority 1

What are we trying to improve?

- Introduce general surgery service
- Introduce ophthalmology service
- Continue to support NHS trusts with managing their waiting lists by hosting their services and allowing them to transfer whole patient pathways.

What will success look like?
Successful introduction of general surgery and ophthalmology and reduced NHS Trust waiting lists.

How will we monitor progress?

- Referral rates and procedure volumes for new services
- Support provided to NHS Trusts
- Volume of patients transferred and treated from NHS Trusts

Priority 2

What are we trying to improve?

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

What will success look like?

- Excellent patient experience
- Successful CQC Visit with an outstanding rating
- No serious incidents or never events
- Staff retention and resilience
- Keeping up to date with evidence based practice
- Growing the business with new specialities
- Learning from incidents and sharing good practice
- Build on links with other Practice Plus Group hospitals and other trusts/ providers
- Build on our success with Day case HIPS/KNEES and work with other Practice Plus Group hospitals to achieve similar results
- Continue to drive innovation

How will we monitor progress?

- Patient feedback
- CQC Feedback
- CCG Feedback
- Place Audit results
- NHS Choices
- PROMS Data
- NJR Data
- CQC Feedback
- Feedback from partners – One Health Group, Sheffield Teaching Hospitals,
- Chesterfield Royal Hospital, New Medica
- Audits
- Quality Visits
- Staff retention
- Over to You (staff) Survey results

Priority 3

What are we trying to improve?

- Staff wellbeing and work life balance
- Mental health awareness

What will success look like?

- Excellent uptake of flu and COVID vaccination
- Reduction in non COVID staff sickness
- Reduction in staff turnover and vacancies
- Excellent OTY survey results
- Excellent staff feedback
- Mental Health First aiders trained staff and utilised
- Improved resilience
- Flexible working and work life balance
- Staff social events – summer party, departmental gatherings (COVID permitting)
- Team Building

How will we monitor progress?

- Over to You survey
- Staff retention
- Staff feedback
- Performance Conversation Records
- Feedback

Emerson's Green Hospital and Devizes Surgical Centre

Performance against the priorities set for 2021/22

Priority 1 - Quality Improvement Academy

We said we would:

Continue the projects implemented in 2020/21 and restart the projects which were paused during the pandemic.

Building on the success of previous Quality Academy initiatives, we aimed to re-launch the Academy. Most of our priorities were fully implemented although some were paused due to the COVID-19 pandemic.

What we have achieved:

- Deafness Awareness

  All staff received Deafness Awareness training in how to best support deaf patients and some staff have learnt basic British Sign Language.
- Endoscopy patients

  A review of the causes of abandoned endoscopy procedures was undertaken and an improvement project taken through the Quality Academy. This resulted in changes being made to pre-procedure patient information, bowel preparation and the Endoscopy pathway, which significantly reduced the number of abandoned procedures.
- Dementia patients identification

  Dementia Champions have implemented a communication system to raise awareness of patients dementia status so that patients are communicated to in a way that is understandable to them, ensuring that their dignity and privacy are respected at all times.
- Recycling

  A range of recycling projects have been implemented which have included clothes being recycled or donated to charity and domestic waste being segregated and recycled by our Waste Management provider. These initiatives reduced environmental waste and reduced our impact on climate change.
- Simulation scenarios

  Simulation training and simulated scenarios have taken place to ensure staff are well rehearsed and able to respond to a range of emergency situations, improving patient safety.
- Sleep promotion

  Patients undergoing knee replacement surgery have been given information before their operation about the positive affect of sleep promotion on post-operative recovery and pain management.

Priority 2 - Flu vaccinations

We said we would:

Introduce a team of flu champions to actively promote, encourage and administer the flu vaccination to all patient facing staff and increase the uptake of the vaccination to over 90%.

What we have achieved:

Flu champions were successfully recruited and led the annual Flu Campaign. This involved delivering flu awareness training, "myth busting" and providing updated information to all staff.

They also positively influenced colleagues to receive the vaccination by establishing a culture of care to protect themselves, their families, their colleagues and our patients. The flu vaccination uptake achieved was 86% significantly ahead the national average of 74.3% for all frontline with direct patient care reported in the 2019-20 influenza season.

Priority 3 - Aseptic Non Touch Technique (ANTT) accreditation

We said we would:

Improve staff compliance with practicing safe and effective aseptic techniques by applying the ANTT implementation cycle to meet the national standards for ANTT.

What we have achieved:

We followed the ANTT implementation cycle and audited practice, developed ANTT Train the Trainers to assess the knowledge and practice of staff, monitored compliance and evaluated outcomes. We achieved standardisation of aseptic techniques which successfully reduced variability in practice and further protected patients from avoidable infections. Audit results for ANTT were 100% for both sites.

Priority 4 - Staff health & wellbeing

We said we would:

Implement steps to facilitate staff to work in a supportive environment that includes making them feel valued, able to successfully manage stress, have a greater awareness and access to mental health support and to support their physical health and wellbeing.

What we have achieved:

Feeling valued

We relaunched the Quality Academy for all staff to be able to present their ideas for improvement and implement changes to benefit staff and patients.

All staff are offered a free breakfast once a month.

Staff received a cereal bar or healthy snack with a “Thank You” message attached distributed by our volunteers.

Healthcare Hero monthly awards were issued in recognition and acknowledgement of outstanding contributions by staff.

Individual staff and teams received regular feedback from patients on their positive experience.

“I appreciate” was implemented in team departmental meetings where each member identifies a colleague that they have appreciated over the prior month and then give reasons why. This has aided team building, inclusion and boosted morale.

Managing stress

Mental Health First Aiders have provided support and guidance to help staff improve, avoid, identify and manage stress.

Access to the Employee Assistance Programme has been encouraged and individualised support has been provided when required.

Mental health awareness and support

Ongoing projects are being developed to train a team of Mental Health Awareness Champions from all staff groups and disciplines and further training for Managers in recognising stress in the workplace

Mental health awareness information has been developed for staff who are now able to seek information, be signposted to support available and to speak to someone.

Physical health

Lunchtime walking groups are in place.

Posture exercise sessions have been held for staff by the Physiotherapy Department.

Unhealthy snacks have been removed from the vending machines to encourage healthy food choices.

Communication

The Senior Management Team (SMT) regularly meet with Heads of Department and Clinical Leads to discuss issues in a problem solving environment. “Table Talk” meetings were designed to break down hierarchical barriers and enable staff to feel empowered to voice an opinion, feel listened to and feel both supported and part of the decision making process.

A monthly “Team Talk” newsletter is circulated with updates and communication, shared learning and patient feedback and information for all staff.

“All Hands” meetings have been introduced for all staff to come together and share information in a top-down and bottom-up forum.

Local outcomes

Emerson's Green & Devizes	#	%	Comments
NJR submission			
PROMS response rate	140/207	67.6%	2020 - 2021 data
PROMS improvement rate in Oxford hip/knee score hips		98.7%	
knees		100%	
VTE risk assessment			
VTE incidents	0/1,203	0%	
Complaints received	39/14,259	0.27%	
Complaints upheld/partially upheld	16/39	41%	6 not upheld, 17 with outcomes not recorded
Incidents relating to patient harm	23/118	19%	18 low harm; 3 moderate harm; 2 severe harm
Serious patient safety incidents	2/118	1.7%	

Priorities for 2022/23

Priority 1

What are we trying to improve?
The 24 hour helpline to improve patient access to advice and contact with the hospital if they have a concern post-operatively.

What will success look like?
Patient's calls and queries being answered rapidly and responded to by the relevant clinician within an hour.

How will we monitor progress?
Call records will be audited and reviewed and patient feedback sought.

Priority 2

What are we trying to improve?
Patient optimization.

What will success look like?
Patients will experience maximized pre-operative preparation for surgery, enhanced recovery, reduction in levels of post-operative pain and shorter lengths of stay.

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

Priority 3

What are we trying to improve?
Awareness and understanding of patients with special needs, i.e. dementia, autism, delirium, acute anxiety and people with learning difficulties.

What will success look like?
Development of a training programme for all staff and Standard Operating Procedures (SOPs) to improve education and awareness.

How will we monitor progress?
Review staff attendance at training sessions and assessed competency of their awareness.

Priority 4

What are we trying to improve?
Our "Commitment to Cleanliness"

What will success look like?
Increased levels of cleanliness, standardization of cleaning regimes across all areas, high audit score results and full compliance with National Standards of Cleanliness 2021.

How will we monitor progress?
Cleanliness will be audited and will meet Infection Prevention and Control Standards of no less than 95%.

Ilford Hospital

Performance against the priorities set for 2021/22

Priority 1

We said we would:
Increase our day case hip and knee cases.

What we have achieved:
In the past 12 months we have undertaken 42 day case hip/knee procedures.

Priority 2

We said we would:
Improve our PROMS participation rate.

What we have achieved:
In the previous 2 years April 2019 – March 2020 218/491 forms were submitted= 44%
In the year April 2020 – March 2021 206/429 forms were submitted = 48%
We are logging our Proms forms returns and from April 2021 to date we have submitted 474 forms, so we have doubled our form returns, with still 8 weeks of this data period to add to the submitted forms. The reporting period will end in March 2022.

Priority 3

We said we would:
Improve our Datix Incident reporting investigation timescales.

What we have achieved:
We did not have a Governance manager until October 2021 so this target was difficult to achieve and is being rolled over to 2022.

Local outcomes

Ilford	#	%	Comments
NJR submission	536	100%	In the NJR reporting period April 2019 – March 2020 the Ilford Hospital exceeded the national average with the number of procedures undertaken at our hospital. 100% of our patients were consented to take part in the NJR data collection, 100% of submissions had a valid NHS number and 100% of the data was entered on the day of surgery. Patient outcomes for both hips and knees were within the expected ranges with less patients requiring revisions than the national average and 90 day mortality above the national average. The patients who were treated were aligned with the national patient profile for these procedures. We also were awarded NJR data Quality Provider status. The NJR Quality Data Provider' award scheme has been developed to offer hospitals a blueprint for reaching standards relating to patient safety through National Joint Registry (NJR) compliance and to reward those who have met targets in this area.
PROMS response rate	83/196	42.3%	2020 - 2021 data
PROMS improvement rate in Oxford hip/knee score hips	82	100%	
knees	124	97.6%	
VTE risk assessment	6565/6633	99%	
VTE incidents	2/1,190	0.17%	We had 2 VTE incidents in 2021 – the learning identified from one of the RCAs was that the patient appeared to have missed a dose of anti-thrombolytic medication on the evening she was discharged so the action is to ensure that all patients are aware of what medication they need to take for the remainder of discharge day. The other RCA did not identify any causative factor.
Complaints received	39/7,980	0.49%	5 Clinical treatment 21 Communication (oral) 1 Communication (written) 1 Date of appointment 1 Failure to follow agreed process 9 Staff behaviour/attitude 1 test results
Complaints upheld/ partially upheld	15/39	38.5%	10 Upheld, 5 Partially Upheld, 20 Not Upheld and 4 outcome not recorded
Incidents relating to patient harm	17/81	22%	15 (Low (Minimal harm - patient(s) required extra observation or minor treatment), 1 (Moderate (Short term harm - patient(s) required further treatment, or procedure), 64 (No Harm); 1 death
Serious patient safety incidents	0	0%	

Priorities for 2022/23

Priority 1

What are we trying to improve?
Improve our Datix Incident reporting investigation timescales.

What will success look like?
All Datix will be closed off within the allocated timeframe

How will we monitor progress?
Monthly reporting

Priority 2

What are we trying to improve?
Reduction in Infection rates – there has been a recent increase in the number of infections our patients have experienced.

What will success look like?
No reported infections

How will we monitor progress?
Monthly KPI reporting data

Priority 3

What are we trying to improve?
Reduction in number of complaints

What will success look like?
The number of complaints will be 50% lower than 2021

How will we monitor progress?
Monthly KPI reporting

Plymouth Hospital

Performance against the priorities set for 2021/22

Priority 1 - Introduction of perioperative medicine

We said we would:
Reduce the number of clinical cancellations.

What we have achieved:
Clinical cancellations have reduced, however, the main reason for a clinical cancellation on the day is as a result of the patient failing to inform staff on pre-operative call of cuts/lacerations which result in surgeons being unable to operate.

Priority 2 - Reduce length of stay and introduce major surgery as day cases

We said we would:
Reduce length of stay from 2 days to day 0 or day 1.

What we have achieved:
Our average length of stay remains at 1-2 days. This is primarily due to patients having had to wait longer than would normally be expected at Practice Plus Group Plymouth due to the Covid pandemic. Patients are presenting with more comorbidities and have considerable mobility problems prior to admission.

Priority 3 - Always Events

We said we would:
We will identify areas where improvement required. A steering group within the hospital to be appointed to meet on a monthly basis to share required improvement.

What we have achieved:
We have implemented a Quality Academy group meeting on a monthly basis. Each Head of Department has 'mind mapped' ideas within their department and completed SMART templates. Status, implementing their plans with the next meeting planned or February.

Local outcomes

Plymouth	#	%	Comments
NJR submission		100%	We now have dedicated link nurse to ensure all data recorded for NJR register
PROMS response rate	110/167	65.9%	2020- 2021 data
PROMS improvement rate in Oxford hip/knee score hips		98.0%	
knees		98.2%	
VTE risk assessment	5,206	99%	Total number recorded against total number of procedures.
VTE incidents	3/1,721	0.17%	Being investigated
Complaints received	27/6,011	0.45%	Resolved at local level
Complaints upheld/partially upheld	2/27	7.4%	Two partially upheld; 8 not upheld; 1 remains ongoing; 16 outcome not recorded
Incidents relating to patient harm	47/117	40.17%	All Datix completed by department Manager. Any learning shared with team and wider Practice Plus Group, if required. 32 low harm; 11 moderate harm; 3 severe harm; 1 death
Serious patient safety incidents	4/47	8.5%	Being investigated

Priorities for 2022/23

Priority 1

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

What will success look like?
We will be able to increase number of major joint replacements. Patient experience will be monitored.

How will we monitor progress?
Progress will be monitored via business review, Scheduling, Pisces

Priority 2

What are we trying to improve?
Improve productivity within theatres.
Currently have staffing issues which limit or restrict the lists we are able to complete.

What will success look like?
More patients treated.
Improved staffing.

How will we monitor progress?
Weekly meetings with Theatre manager to discuss vacancies/training needs of staff.

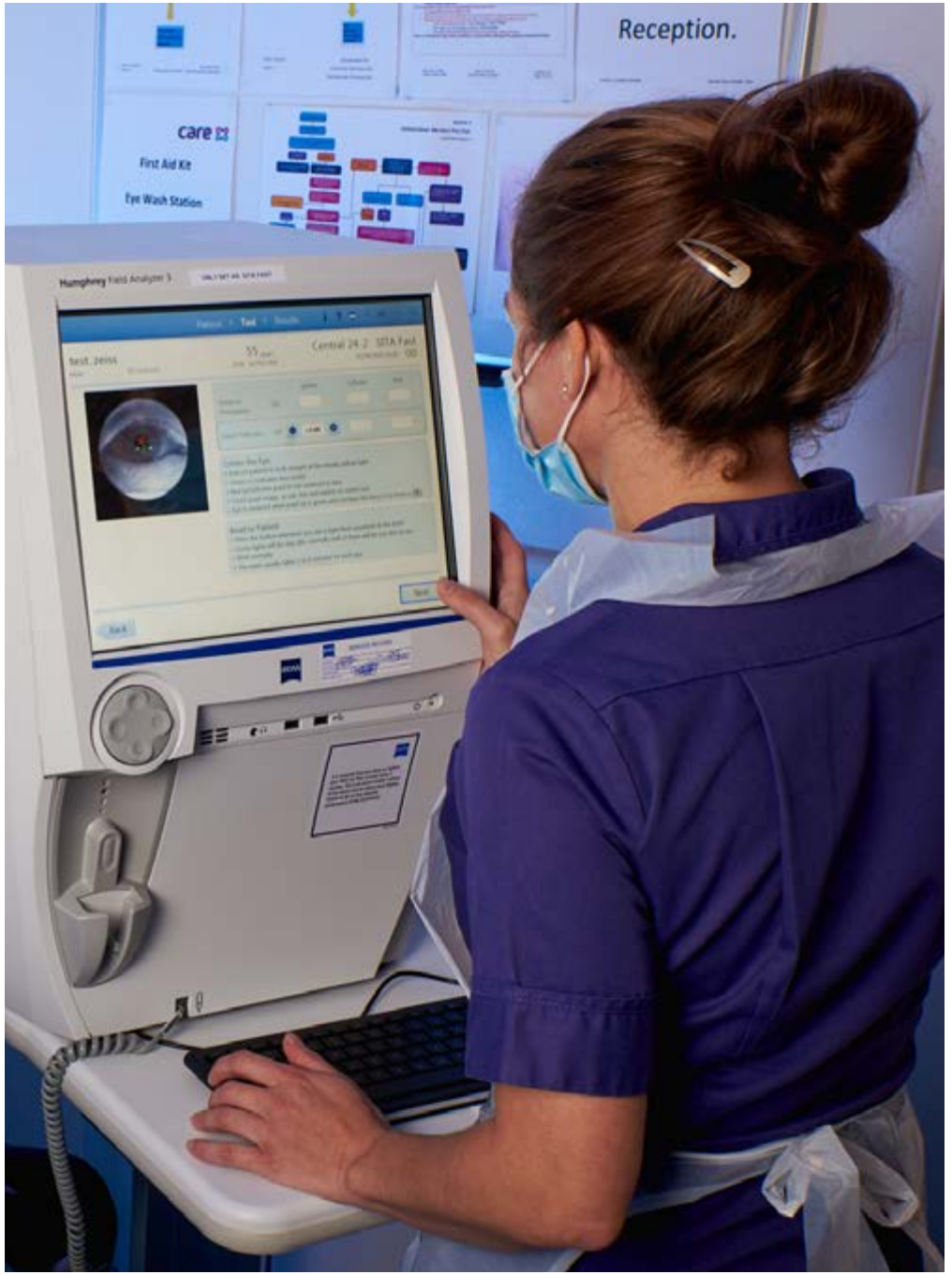
Regular update meetings with recruitment team. Ensuring all potential staff interviewed and on boarded in timely manner.

Priority 3 - Introduction of the Quality Improvement Programme

What are we trying to improve?
Improve patient pathway via Enhanced Recovery.

What will success look like?
Further reduction in length of stay and improved patient feedback on postoperative results.

How will we monitor progress?
Monitored via Friends and Family feedback and length of stay KPIs.



Shepton Mallet Hospital

Performance against the priorities set for 2021/22

Priority 1 - Day cases

We said we would:
Improve the management of day case patients who require a length of stay greater than 1 hour and not more than 8 hours post-surgery. We plan to introduce a Day Unit within our inpatient ward to ensure that there are no unnecessary overnight stays following day case surgery. Introduction of specific day case risk assessment tools for patient monitoring.

What we have achieved:
We have successfully introduced our Day Unit, protocols, risk assessments and staff training. The Day Unit has 6 beds with the potential to go up to 9 beds depending on same sex requirement and patient need.

Priority 2 - Getting It Right First Time

We said we would:
Increase compliance with Getting It Right First Time (GIRFT): institute six monthly NJR review meetings to be attended by all surgeons. At these meetings, the Shepton Mallet Hospital NJR dashboard indicators are reviewed. All arthroplasty cases that have undergone revision are discussed. Changes to process or practice are proposed and implemented.

What we have achieved:
We routinely discuss each revision case as part of our Orthopaedic Speciality Meeting (OSM) which is held monthly. Our orthopaedic surgeons meet with the Medical Director and peer review cases including X rays. Learning from cases is shared and through this group a pathway has been developed and implemented to ensure consistent management of suspected deep infections.

Priority 3 - Recognition and treatment of deteriorating patients

We said we would:
Reaffirm the nursing staff situational training and improve nursing skills in the recognition and monitoring of a deteriorating patient.

What we have achieved:
With the support of our Intermediate Life Saving (ILS) trainer we have introduced a focus on the deteriorating patient. We have also reviewed out major haemorrhage protocol which included a real time emergency scenario involving all departments, our site transfusion lead, point of care testing lead, theatre, PACU and ward staff, Medical staff and the transfusion/ pathology department at Taunton Foundation Trust.

Local outcomes

Shepton Mallet	#	%	Comments
NJR submission	1,142	97	
PROMS response rate	347/613	59.6%	2020- 2021 data
PROMS improvement rate in Oxford hip/knee score hips		98.0%	
knees		95.7%	
VTE risk assessment	4,550	98%	
VTE incidents	6/1,769	0.34%	
Complaints received	15/5,905	0.25%	
Complaints upheld/partially upheld	5/15	33.3%	1 at Stage 2 – not yet concluded;
1 still open; 8 outcome not recorded	20	0.8%	Incidents related to medication, infection, slips, trips and falls.
Incidents relating to patient harm	34/112	30.4%	16 low harm; 16 moderate harm; 2 severe harm
Serious patient safety incidents	2/34	5.9%	1 Never Event

Priorities for 2022/23

Priority 1

What are we trying to improve?

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

What will success look like?

In conducting this exercise we will improve our communication with both patients and GP's in ensuring that those patients who are fit for surgery are kept fit and receive their treatment more quickly and where patients are unlikely to be fit for this hospital, will be notified in a timely fashion and either referred on to a more appropriate provider or be referred back to the GP for more investigations / interventions. We will also see a reduction in patient queries / complaints, linked to inefficiencies and communication in their pathways at the hospital.

How will we monitor progress?

We will monitor complaints and incident rates linked to communication / inefficiencies themes. We will update our induction pack to ensure updated SOPs / pathway information is followed. We will hold regular meetings throughout the year to involve colleagues from all aspects of the hospital to fully participate in the Remind, Review and Renew processes.

Priority 2

What are we trying to improve?

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

What will success look like?

Success will be a vacancy rate of less than 5%, some staff will leave due to retirement or for reasons which we will not be able to retain them. The introduction of new starters is always welcomed and with this they bring fresh ideas and challenge which is very healthy.
For our International Nurses success will be measured by the attainment of their OSCE, completion of preceptorship and being achieving competence to work independently within their first year of employment.

How will we monitor progress?

We will review agency spend across the site, continue to review vacancies especially if they have been advertised for over 3 months without applicant and we will endeavour to retain our staff.

Priority 3

What are we trying to improve?

Knowing Net Zero is very topical at this time; Shepton Mallet Hospital is already planning and working towards what we can do to help with the emissions of greenhouse gases.

Healthcare alone as a global industry is contributing to 5% of the emissions, so it is imperative we work as an organisation to improve this. The NHS has been very ambitious by setting an objective of reducing emissions by 80% between 2028 and 2032.

Practice Plus Group are already working with partners to see what we can do. One of these partners are Trees for Travel whereby we offset travel and mileage into a plantation of trees in Haiti. We have also agreed to backdate this from the last three years to realise the seriousness of this issue. Planting will start early this year.

Over the course of the next year, we will move our electricity supply to renewable sources. We had planned to do this for the start of this financial year but volatility in the energy market has led to us postponing this for a few months. We will return to this in the New Year when the time is right.

We will be rolling out recycled A4 paper and envelopes over the coming year. This single change will save 1,000s of Tonne's of CO2 and millions of litres of water that are used in the production of new paper.

Locally, we are aiming to change non-clinical processes to reduce our use of paper. We are managing to do this with the introduction of our new PAS which will allow us to import and share documents with the appropriate persons without the need to waste paper and time. This in turn will also adhere to GDPR as there is less risk that paper documents are found in the wrong place or not secure.

We have already met as an Operational Team to discuss how our processes need to be tweaked to use the full functionality of the system. Stakeholders across the board are involved to make sure any changes remain safe and in line with Information Governance protocols.

What will success look like?

The first part of success will be new referrals can be registered and booked electronically without the need to print. We would like to see that all teams involved embrace the new process and feel things are better and not causing extra workload.

Of course, this priority is multi-faceted, so success will be seen month after month as we deliver this project.

Other new systems coming on board to help with a sustainable future are Medisight and SOLOS, which will reduce our reliance on printing information and being able to access images and patient record details online rather than in paper format.

On the road map for our Business Systems colleagues, they are currently developing a patient portal, which will give our patients the functionality to make a booking and track progress. The great thing about this is ceasing the need to post appointment letters, as this can all be done on the portal.

How will we monitor progress?

Every 12 months we look at our services, processes and procedures and use the Remind, Review and Renew methodology. This helps us track progress and make changes if needed. As this is a new project, this review cycle will be done every three months until changes are fully embedded to ultimately achieve a high level of excellence.

Southampton Hospital

Performance against the priorities set for 2021/22

Priority 1 - Fall prevention

We said we would:
Investigate the reason for all falls or near miss falls in our hospital.

What we have achieved:

We reviewed all the falls in the hospital in 2019 and 2020, to see what actions could be taken with the aim to reduce the number of falls reported, and improve near miss reporting. A MDT meeting was held to review falls and discuss the best way forward. Whilst evidence as to the best way to prevent inpatient falls is not yet conclusive, current best practice in the NICE clinical guideline' Falls in older people: assessing risk and prevention (CG161)' calls for a multifactorial falls risk assessment (MFRA) for all inpatients aged over 65 (and in those aged 50–64 who are clinically judged to be at risk) leading to interventions tailored to address identified risk factors. The falls assessment was reviewed, including weekly meetings to review patients at high risk of falls. Bi-monthly Falls Meetings were commenced. The patient education leaflets were reviewed, and an SOP written for patients at high risk of falls who stay overnight on the Inpatient Ward, which is where the falls occurred.

Compared with 2019 the number of falls reported in 2021 reduced by 84% and the number of near miss reporting increased by 100%.

Priority 2 - Staff support

We said we would:
Provide staff access to mental health first aiders.

What we have achieved:
We commenced 2021 with no Mental Health First Aiders and by the end of 2021 12 members of staff had undertaken, and passed the Mental Health First Aiders course. The MHFAs are helping to support the mental wellbeing of the staff at PPGHS by talking/listening and sign posting staff at work. They have their own support group.

Local outcomes

Southampton	#	%	Comments
NJR submission	141	98.5%	Revision and mortality rates within expected range. NJR Quality Data Provider Award Received December 2020.
PROMS response rate	48/123	39%	2020- 2021 data
PROMS improvement rate in Oxford hip/knee score hips		100%	
knees		94.7%	
VTE risk assessment	9710/9799	99%	
VTE incidents	2/1,164	0.17%	
Complaints received	40/12,856	0.31%	
Complaints upheld/partially upheld	32/40	80%	4 not upheld; 4 outcome not recorded
Incidents relating to patient harm	42/153	27.5%	33 patient safety incidents that resulted in low patient harm and 9 resulted in moderate harm.
Serious patient safety incidents	0		
Serious patient safety incidents	2/34	5.9%	1 Never Event

Priorities for 2022/23

Priority 1

What are we trying to improve?
Information given to patients and their relatives/carers on discharge home from the Inpatient Ward regarding wound care and medication, with an emphasis on analgesics.

What will success look like?
Improved information for patients and their relatives/carers.

How will we monitor progress?
Review calls to the 24 hour helpline for wound care and medication advice.

Priority 2

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

What will success look like?
Aiming for the average length of stay to be reduced to 44 hours.

How will we monitor progress?
Reporting on and feeding back/discussing length of stay monthly to the Senior Management Team, orthopaedic, and anaesthetic meetings and local Governance Meetings.

St. Mary's Surgical Centre

Performance against the priorities set for 2021/22

Priority 1 - Ophthalmology pathway review

We said we would:
Identify increased efficiency in Ophthalmology to support increased demand from the local community.

What we have achieved:
Enhanced clinic capacity with the introduction of "Super Clinics" resulting in 12-14 patients per theatre list for the majority of the Ophthalmology Clinicians. Two Optometrists have been employed to support the new pathway and to support waiting times.

Priority 2 - Virtual clinics

We said we would:
Introduce virtual clinics for our Dermatology service.

What we have achieved:
This service was no longer commissioned from June 2021.

Priority 3 - Patient satisfaction

We said we would:
Increase patient satisfaction response rate.

What we have achieved:
We currently have a good patient satisfaction response rates but due to the current Covid pandemic we stopped elective surgery to firstly become a step down unit and secondly so both our clinical and administrative staff could assist at our local Trust, this therefore affected the numbers of surveys completed during this time. Feedback is good with an average score of 99% of patients would recommend our services.

Priority 4 - Staff training

We said we would:
Increase staff mandatory training completion rate.

What we have achieved:
At the start of the pandemic the Centre was 100% compliant with mandatory training, unfortunately due to staff shortages/vacancies and sickness our compliance levels have fallen to below our target of 85%.

Priority 5 - Incident reporting

We said we would:
Improve quality of incident reporting.

What we have achieved:
Due to incident reporting training taking place for all staff on induction days the understanding of how to complete a Datix appropriately has improved considerably, incident reporting rates have increased with the content of the incident being clear and concise.

Priority 6 - Dementia care

We said we would:
Take part in NHS England's Always Event with a working action plan to ensure patients with dementia are treated with respect and dignity and as an individual.

What we have achieved:
60% of staff have become Dementia friends and attended the Dementia Bus virtual training. All signage, clocks, toilet seats and taps have be changed to become Dementia friendly. One time use Dolls and Teddy bears have been bought for Dementia patients attending the day unit for comfort. For Ophthalmology patients the set up for theatre has changed to allow a family member or carer to attend with the patient. 100% compliance received in the PLACE assessment for Dementia care.

Local outcomes

St Mary's	#	%	Comments
NJR submission			N/A
PROMS submission hips			N/A
knees			N/A
PROMS health gain hips			N/A
knees			N/A
VTE risk assessment		94%	Quarterly audits undertaken
VTE incidents	0	0%	
Complaints received	28/9,455	0.3%	
Complaints upheld/partially upheld	15/28	53.6%	1 complaint is outstanding; 5 not upheld; 7 outcome not recorded
Incidents relating to patient harm	12/189	6.3%	9 low harm; 2 moderate harm; 1 severe harm
Serious patient safety incidents	2/12	16.7%	

Priorities for 2022/23

Priority 1

What are we trying to improve?
Increase patient satisfaction response rate.

What will success look like?
Uptake of 10% on current figures.

How will we monitor progress?
Monthly review..

Priority 2

What are we trying to improve?
Understanding our current position for mandatory training at St Mary's Portsmouth (currently the system is not fit for purpose and training lead is currently reviewing the systems and processes). To ensure staff are attending mandatory face to face training and completion of on-line training.

What will success look like?
Easy access to on-line mandatory training with % compliance reports easily available for all line managers and staff to access to ensure we have oversight in real-time which will ensure staff are safe to practice and are compliant in all mandatory training – current KPI 85%.

How will we monitor progress?
Double checking that we have the correct information being pulled through monthly from our training database (LMS) and cross checked by line managers. Escalation to the corporate team by Hospital Director and Clinical Services Manager if relevant information is not made accessible.

Priority 3

What are we trying to improve?
Number of Patient Participation Group members.

What will success look like?
Increase in numbers from four to eight members.

How will we monitor progress?
Increased consistent membership.

Priority 4

What are we trying to improve?
Civility amongst all staff

What will success look like?
Civility saves lives campaign to include:-

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

Gillingham Surgical Centre

Performance against the priorities set for 2020/21

Priority 1 - Complaints

We said we would:
Reduce the number of stage 1 and 2 complaints

What we have achieved:
We have managed to reduce both the number of stage 1 and 2 complaints. We have received no further stage 2 complaints in 2020/21.

Priority 2 - Cancellations

We said we would:
Reduce the number of clinical cancellations on the day.

What we have achieved:
We continue to work hard to reduce the number of clinical cancellations. This has been difficult when there have been spikes in COVID cases which have contributed to the reason for this. Despite patients attending COVID swabbing clinic and given their pre-operative instructions and asked vital questions some patients do not inform us of new medical conditions / changes of medication until the day of admission.

Priority 3 - Histology processes

We said we would:
Create a local SOP to ensure that histology results are received and relayed to the patient in a timely manner.

What we have achieved:
Histology results are now reaching patients in a more timely manner.

Local outcomes

Gillingham	#	%	Comments
NJR submission			N/A
PROMS submission hips			N/A
knees			N/A
PROMS health gain hips			N/A
knees			N/A
VTE risk assessment		100%	
VTE incidents	0	0%	
Complaints received	13/7,457	0.17%	
Complaints upheld/partially upheld	1/13	7.7%	Twelve complaints with outcome not recorded
Incidents relating to patient harm	5/30	16.7%	Two low harm, two moderate harm and one patient death
Serious patient safety incidents	2/5	40%	

Priorities for 2022/23

Priority 1

What are we trying to improve?
Reduce the number of surgical site infections.

What will success look like?
There will be less patients returning with surgical site infections.

How will we monitor progress?
Monthly audits.

Priority 2

What are we trying to improve?
Reduce the number of avoidable clinical cancellations of the day of surgery

What will success look like?
There will be less avoidable clinical cancellations on the day. There will be improved pre-assessment processes to ensure pre-existing medical conditions are identified prior to admission.

How will we monitor progress?
By monthly KPI reports and at the monthly business review.

Priority 3

What are we trying to improve?
Improve the WET AMD service.

What will success look like?
This will ensure patients are not waiting excessive times for their injections by training and introducing nurse injectors.

How will we monitor progress?
This will be monitored using the waiting list data and satisfaction with the service and outcome through the patient experience feedback devices.

Diagnostics and Urgent Hospitals

Performance against the priorities set for 2021/22

Priority 1 - Radiographers

We said we would:
Increase the numbers of reporting radiographers on site.

What we have achieved:
There has been an increase from one to three reporting radiographers on site.

Priority 2 - Nurse Practitioners

We said we would:
Redefine the Nurse Practitioners' role to support progression.

What we have achieved:
The role has been defined into 3 categories and rewarded as such to attract new candidates to the Urgent Treatment Centre.

Priority 3 - GP Leadership

We said we would:
Develop GP Leadership in both UTCs to support quality and audit.

What we have achieved:
GP Governance lead has been put into place, but due to constraints on the service has not been able to fully engage in all aspects of shared Governance. Currently meetings are being set up between GP Lead/Clinical lead and Clinical Services Manager.

Priority 4 - Incident reporting

We said we would:
Improve quality of incident reporting to ensure that lessons are learned and information is disseminated appropriately.

What we have achieved:
We have invested in stand-alone Friends and Family stations to collect patient feedback in both UTCs and currently implementing for Diagnostics.

There has been an increase in numbers of feedback records received but not at a level we were hoping for due to the current Covid pandemic some patients do not want to complete a survey due to infection concerns.

Priority 5 - Dementia care

We said we would:
Take part in NHS England's Always Event with a working action plan to ensure patients with dementia are treated with respect and dignity and as an individual.

What we have achieved:
60% of staff have become Dementia friends and attended the Dementia Bus virtual training. All signage, clocks, toilet seats and taps have be changed to become Dementia friendly. One-time use Dolls and Teddy bears have been bought for Dementia patients attending the day unit for comfort. For Ophthalmology patients the set up for theatre has changed to allow a family member or carer to attend with the patient. 100% compliance received in the PLACE assessment for Dementia care.

Priority 6 - Over to You survey

We said we would:
Improve results from last year's survey with actions implemented from report findings.

What we have achieved:
Improvements have been made by all staff working together identifying the required changes needed from the results of the staff survey, compiling an action plan and working jointly to incorporate these changes.

Local outcomes

St. Mary's UTC	#	%	Comments
Complaints upheld/partially upheld	15	0.02%	
Incidents relating to patient harm	3/20	2.04%	2 low harm; 1 moderate harm
Serious patient safety incidents	3	0%	
Southampton UTC			Comments
Complaints upheld/partially upheld	5	0.002%	
Incidents relating to patient harm	13/25	11%	12 low harm; 1 moderate harm
Serious patient safety incidents	0	0%	
St. Mary's & Havant Diagnostics			Comments
Complaints upheld/partially upheld	2	0.008%	
Incidents relating to patient harm	0	0%	
Serious patient safety incidents	1	5%	From 20 reported incidents

Priorities for 2022/23

Priority 1

What are we trying to improve?
Staff retention and recruitment

What will success look like?
Full complement of qualified staff with the appropriate skill mix.

How will we monitor progress?
Weekly resourcing/recruitment calls and rota management in both departments.

Priority 2

What are we trying to improve?
UTC Governance Structure.

What will success look like?
Embedding a shared governance approach which will provide staff with the ability to learn from incidents and complaints and ensure changes are made and learnings are disseminated to the team through the team huddle daily and team meetings.

How will we monitor progress?
Minutes of daily huddle and minutes of the governance meetings.

Priority 3

What are we trying to improve?
Reviewing and improving work rotas to ensure they are meeting the patient's needs.

What will success look like?
The correct skill mix and staffing numbers to meet the demands of the patient's needs with decreased wait time.

How will we monitor progress?
Clinical lead will sign off weekly rotas, identifying staffing numbers and any gaps with staffing which would increase wait times and patient experience. Meetings with GP and Clinical lead and staff to identify improvements in patient care.

Appendix 2
Local clinical audit schedule

Audit	Purpose	Frequency
VTE Full	Assess compliance with NICE guidance to reduce the risk of venous thromboembolism	Quarterly
VTE Patient Pathway	A shorter audit covering key components of the full VTE audit	2-monthly
WHO Surgical Safety Checklist	Assess compliance with the World Health Organisation checklist, designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of perioperative care	Bi-monthly
WHO Observational	Assess compliance with WHO checklist sign in, time in and sign out procedures	Bi-monthly
NEWS – Real time Audit	Compliance with the use of National Early Warning Score to identify and act on early signs of deterioration in patients	Daily
Perioperative Hypothermia	To assess compliance with NICE CG65, designed to reduce the risk of perioperative hypothermia	Quarterly
Fluid Balance	To assess management of fluid balance in patients	6-monthly
Pain	To assess management of pain in patients	6-monthly
Blood Transfusion	Compliance with blood administration safety and national transfusion guidance	Annually
Anaesthetic Observation	Assessing quality of anaesthetic practice	6-monthly
Ward Round (MDT)	Assessment of ward round practices and the involvement of key team members	6-monthly
Emergency Response /Scenario	To ensure that all staff are fully prepared and aware of their responsibilities in an emergency scenario	Monthly
Falls	Patient safety and compliance assessment tool	Monthly
Documentation	Supports best practice in clinical documentation and guidance from professional bodies	6-monthly
Information Governance / Security	To monitor compliance with IG Toolkit and ISO 27001 accreditation requirements	6-monthly
Agency/locum/ temporary staff	To ensure that the appropriate checks and local inductions are undertaken for all agency, locum and temporary staff	Quarterly
Safeguarding Assurance Framework	To ensure that safeguarding concerns are referred and logged, providing assurance that safeguarding responsibilities are discharged	Quarterly

Audit	Purpose	Frequency
Accessible Information Policy	Information to be accessible to all care users, including those with a disability	Annually
Site compliance (non-FM)	To assess compliance with the statutory Health and Safety Executive regulations	Annually
Endo Decontamination QMS Assurance Audits	To assess compliance with standards for decontamination of endoscopes	6-monthly
TSSU Decontamination QMS Assurance Audits	To assess compliance with standards for decontamination of reusable sterile equipment	6-monthly
CD Documentation	Compliance with the documentation element of Controlled Drugs	Quarterly
Medication Reconciliation	To ensure compliance with NICE guidance, focusing on reconciliation of medicines	Quarterly
Omission of Medications	To ensure compliance with NICE guidance, focusing on medicine omissions	Quarterly
Inpatient Medication Documentation	To ensure compliance with NICE guidance, focusing on the documentation of medicines for inpatient services	Quarterly
Antibiotic Stewardship	To reduce the risk of inappropriate antibiotic usage in line with Practice Plus Group policy and national Antibiotic Stewardship guidelines.	6-monthly
Medication Deep Dive	To ensure medication management processes and arrangements are robust and controls are comprehensive	Annually
X-Ray Interpretation	To monitor the accuracy of x-ray interpretation	Monthly
Rejection Analysis (data capture)	To determine the rate and rationale for rejecting imaging	Quarterly
DVT Ultrasound	Assessment of compliance with standards for DVT ultrasound	6-monthly
Diagnostics Clinical Practice and Documentation	Assessment of compliance with the diagnostics standards for documentation	6-monthly
Dose Referral Level Audit	To ensure that local dose levels of radiation for common imaging examinations are in line with National Regulatory Dose reference levels.	Annually

Audit	Purpose	Frequency
Health & Safety and Environment Departmental Audit Tool	Routine H&S inspections of departments and offices by individual department H&S Representatives	Monthly
Health & Safety	Audit of wider statutory H&S requirements by H&S Leads	Annually
IPC 01 Strategy and Scope	Assessment of compliance with the IPC Strategy	Annually
IPC 02 Standard Precautions	All standard precautions are observed to reduce the risk of infection	Annually
IPC 03 Hand Hygiene	Hand hygiene is performed by staff at every appropriate opportunity according to the Five Moments of Hand Hygiene	Quarterly
IPC 03a Patient Led Hand Hygiene	Results from patient observations of the hand hygiene employed by the staff treating them	Annually
IPC 04 Environment – Decontamination of Equipment	To ensure that re-usable equipment is managed in accordance with best practice to reduce the risk of infection	6-monthly
IPC 05 Practice – Sharps Handling	To ensure that sharps are managed safely to reduce the risk of inoculation injury	6-monthly
IPC 08 Linen	To ensure that linen is managed in accordance with best practice to reduce the risk of infection	Annually
IPC 09 Practice – Management of Infection Risks	Contaminated waste/specimens are managed safely and in accordance with legislation so as to minimise the risk of infection or injury	6-monthly
IPC 10 Assessment of the Care Environment	To ensure the care environment complies with infection prevention and control best practice	Quarterly
IPC 13 Aseptic Technique	The risk of infection is minimised through implementation of evidence-based practice	6-monthly
IPC 16 Peripheral Vascular Devices	Evidence-based best practice is being consistently applied to prevent peripheral vascular device infections	6-monthly
IPC 23 Urinary Catheter Care	Evidence-based best practice is being consistently applied to prevent urinary catheter infections	Annually
IPC COVID-19 Board Assurance audit	Assess compliance with COVID-19 best practice precautions	Weekly
Mattress Audit	To ensure that all mattresses are in a good state of repair and meet infection prevention and control standards	Annually
One together Assessment (Theatres)	Prevention of surgical site infection	6-monthly
Annual Validation Assessment	Assess compliance with CQC Essential Standards for Quality and Safety	Annually
External Sharps	A site visit and audit of compliance with safe sharps practice undertaken by an external company	Annually

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

Somerset Clinical Commissioning Group

Thanks for sharing PPG's Quality Account 21/22 with us. I have had a read through it and it makes a very positive read in what has been a challenging year due to Covid.

I wanted to take the opportunity to highlight the following points:

- I am very supportive of PPGs Quality Priorities for 22/23. Focusing on timely patient feedback is key to delivery of personalised care for each patient, which we know ultimately improved not only the patients experience but also their outcomes following surgery
- I read with interest on the piloting of a Patient Safety Partner in one of the hospitals. This is something that we are also pursuing here in Somerset and looking at creating system wide Patient Safety Partners (PSPs). If this is a local hospital to Somerset, it would be good to collaborate on this, as we develop a peer group of PSPs
- I also wanted to commend PPG on nearly all of their Patient Reported Outcomes Measures being above the England average, using adjusted data

Thanks again for sharing.
Emma Savage
Deputy Director of Quality and Nursing, BSc Podiatric Medicine, MSc
Somerset Clinical Commissioning Group

NHS Derby and Derbyshire Clinical Commissioning Group

Please find my comments with regards to your Quality account:

Careful consideration has been given to the content and accuracy of the 2021/22 Quality Account to ensure it is in line with the national guidance. The information provided appears to be accurate and representative of the information available to the Commissioners through contract monitoring and quality assurance processes during the year

There continues to be a real focus on staff and their experiences as well as high quality, safe and person-centred care.

Commissioners acknowledge that the last year has presented another challenging year and look forward to continuing to work with you in driving improvements from the lessons learnt.

Balborough Hospital has worked collaboratively with commissioners and all key stakeholders to ensure patients receive high quality care in the right care setting and as we move towards a Derbyshire Integrated Care Board and System, Commissioners look forward to working with the Balborough Hospital to build system collaborative services .

Kind regards,
Sam Woodward
Senior Clinical Quality Manager
NHS Derby and Derbyshire Clinical Commissioning Group

Hampshire Southampton & Isle of Wight CCG

Hampshire Southampton and Isle of Wight Clinical Commissioning Group and Portsmouth Clinical Commissioning Group (CCGs) are pleased to comment on Practice Plus Group's Quality Account for 2021/22.

The CCGs would like to thank Practice Plus Group for their continued efforts and support to both patients and partners in the local and surrounding areas. We acknowledge that this has been a very challenging year for the organisation, the services provided and staff, due to the continuing COVID-19 Pandemic. Even in the midst of the Pandemic, throughout the Quality Account, it is evident how extensively Practice Plus Group has worked with other organisations and key stakeholders and how staff have remained dedicated, committed and flexible in providing excellent patient care.

Whilst we note the impact the Pandemic has had on achievement of the 2021/22 quality priorities and the need to pause; we welcome the renewed refocus on these priority areas in 2022/23. We particularly look forward to hearing more about the establishment of the Serious Incident Review Panel and the approach to Incident Management, in light of the new Patient Safety Incident Reporting Framework (PSIRF) and the development of the Quality Academy, along with the other local quality improvement projects.

As part of the assurance process and as a mechanism for shared learning, it is encouraging to see information relating to the quality visit schedule within Practice Plus Group and we thank the local teams for also welcoming the CCGs Quality Leads into their internal governance meetings.

The Quality Account outlines the five overall priorities for 2022/23, which includes the carry forward of the Development of the Quality Academy and Wellbeing Champions. Wellbeing and staff resilience remains vitally important at this time and we encourage the continued work on recruitment and retention, with the acknowledgement that clinical staffing has been, and remains, challenging.

In relation to the Portsmouth specific priorities, we are pleased to see the continued drive to involve patients more in service improvement and to increase the patient satisfaction response rate. We commend you on your success in increasing the clinical capacity in Ophthalmology and your work on Dementia Care.

In Southampton, it is positive to see that progress has been made over the last year, including the introduction of Mental Health First Aiders and the reduction in patient falls. It is also encouraging to see the increase in near miss incident reporting. We also welcome the new priorities relating to information provided to patients, relatives and carers on discharge and reducing length of stay following hip and knee replacements.

We note the latest Practice Plus Group Hospital Southampton CQC Inspection rating of 'Good' and hope to work with Practice Plus Group over the coming year as they work to achieve their previous rating of outstanding.

The CCGs would have liked to see the inclusion of patient stories, which had been commended as good practice in previous years' Quality Accounts.

It is positive to note the work undertaken nationally by Practice Plus Group over the last twelve months in relation to safeguarding and are now looking forward to seeing improved outcomes and embedding of related processes within local teams, following a focus locally over the past year in both Southampton and Portsmouth.

As required, Practice Plus Group has reported against the core set of performance data, required for Independent Providers, within this Quality Account.

As with previous years, this is a well written, easy to understand Quality Account which both reflects on the achievements of Practice Plus Group over the last twelve months and acknowledges the challenges, both locally and nationally. It reflects an organisation that has responded well to the Pandemic in supporting the wider system and has set appropriate priorities for the coming year, with good, measurable indicators.

The Quality Account clearly outlines the organisation's continued commitment and approach to quality improvement. The CCGs are satisfied that the Quality Account for 2021/22 meets the national requirements and look forward to working closely with and supporting Practice Plus Group over the coming year in monitoring the quality of care provided and continuing to drive quality improvements within its services.

Julie Dawes, Chief Nursing Officer
Hampshire Southampton & Isle of Wight CCG