



**Practice Plus
Integrated Urgent Care**



Providing NHS services

Quality Account

Integrated Urgent Care services
2025–2026



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Why publish a quality report?

The purpose of a quality report is to inform the public about the quality of services delivered by Practice Plus Group's Integrated Urgent Care (IUC) services. It is not a mandated requirement, as it is for many NHS providers, but we want to demonstrate our commitment to continuous, evidence-based quality improvement and to explain our progress.

It improves patient care

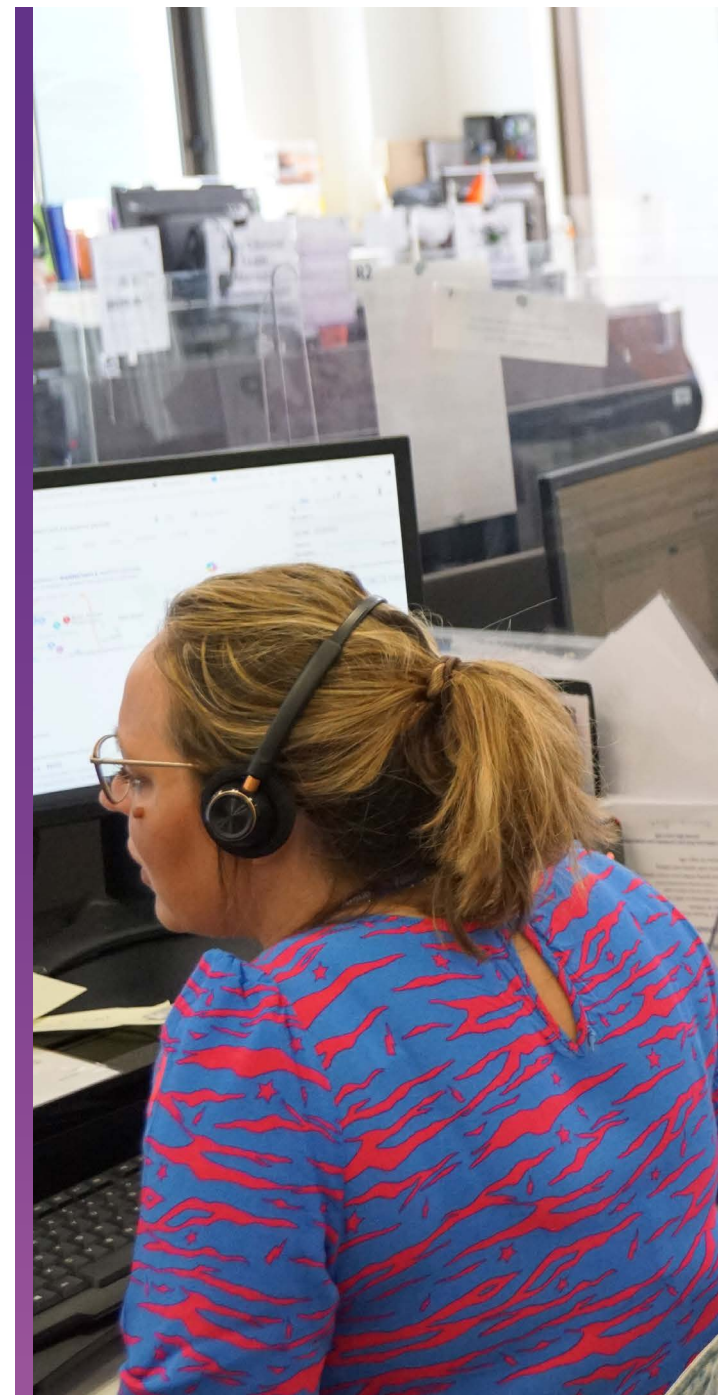
- A quality report helps identify strengths and areas for improvement in patient care.
- It ensures care is safe, effective, patient-centred and consistent with NHS standards.

Accountability and transparency

- It shows how our services are performing to patients, staff, regulators and the public.
- It builds trust and highlights best practice and lessons learned.

Demonstrates outcome and impact

- It shows how services have made a difference in patient health and wellbeing.
- It communicates progress against key NHS priorities: safety, clinical effectiveness, patient experience.



Introduction

Practice Plus Group provides NHS 111 services, out-of-hours urgent care services, clinical assessment services and health centres across England.

This Quality Account is our annual report to our stakeholders and the public on the quality of services we provide. It sets out not only the challenges which these services face, but also the achievements and the innovations that underpin our work. It also sets out our priorities for quality improvement over the coming year. In developing this Quality Account we have both drawn on and shared information and first-hand experience across the organisation as part of a sustained focus on improvement and inclusion. The purpose of the Quality Account is to demonstrate accountability, support continuous improvement and enable stakeholders to understand how we are performing in relation to local and national priorities.

Our approach to quality

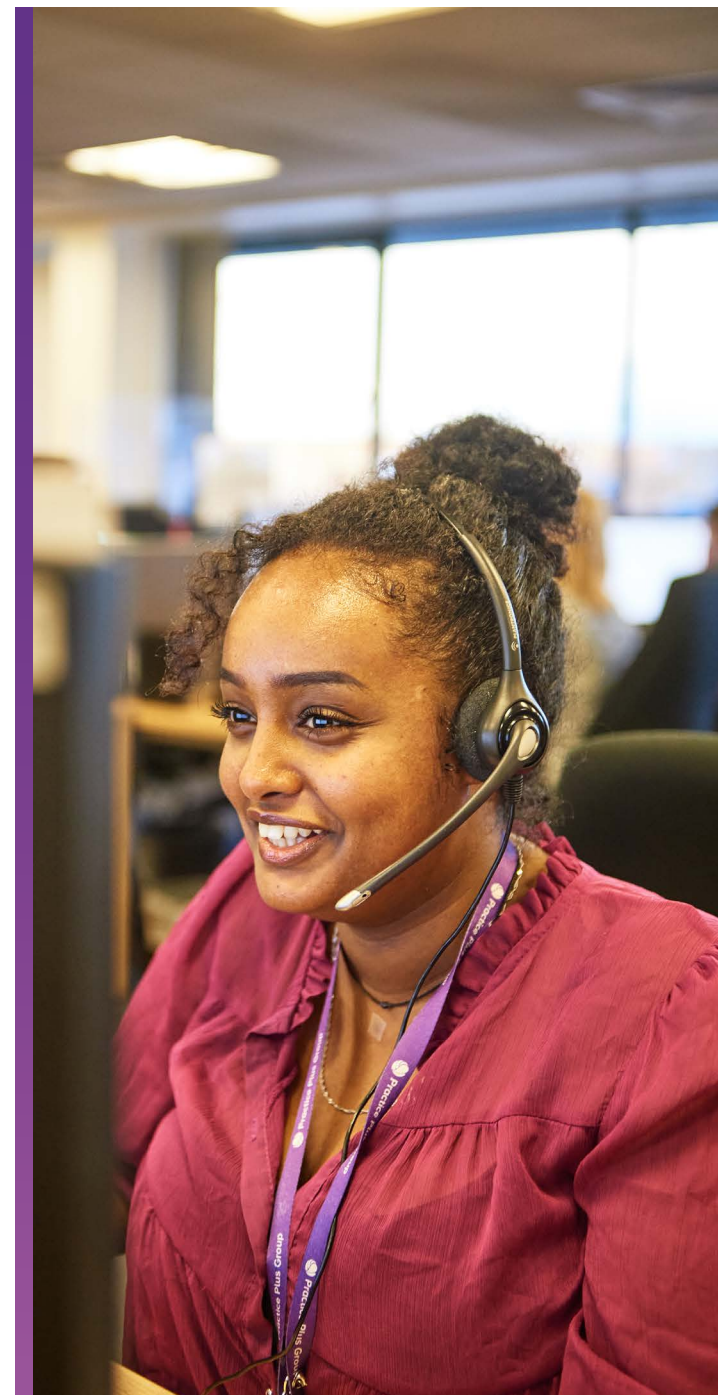
Our values

Across our services we share core values which are at the heart of every service we deliver and which inform the way in which we run every service. We undertook an organisation-wide consultation to review and refine our values, making sure they are not just relevant but have also been shaped by all of the team providing and supporting patient care.

- We treat patients and each other as they would like to be treated.
- We act with integrity.
- We embrace diversity.
- We strive to do things better together.

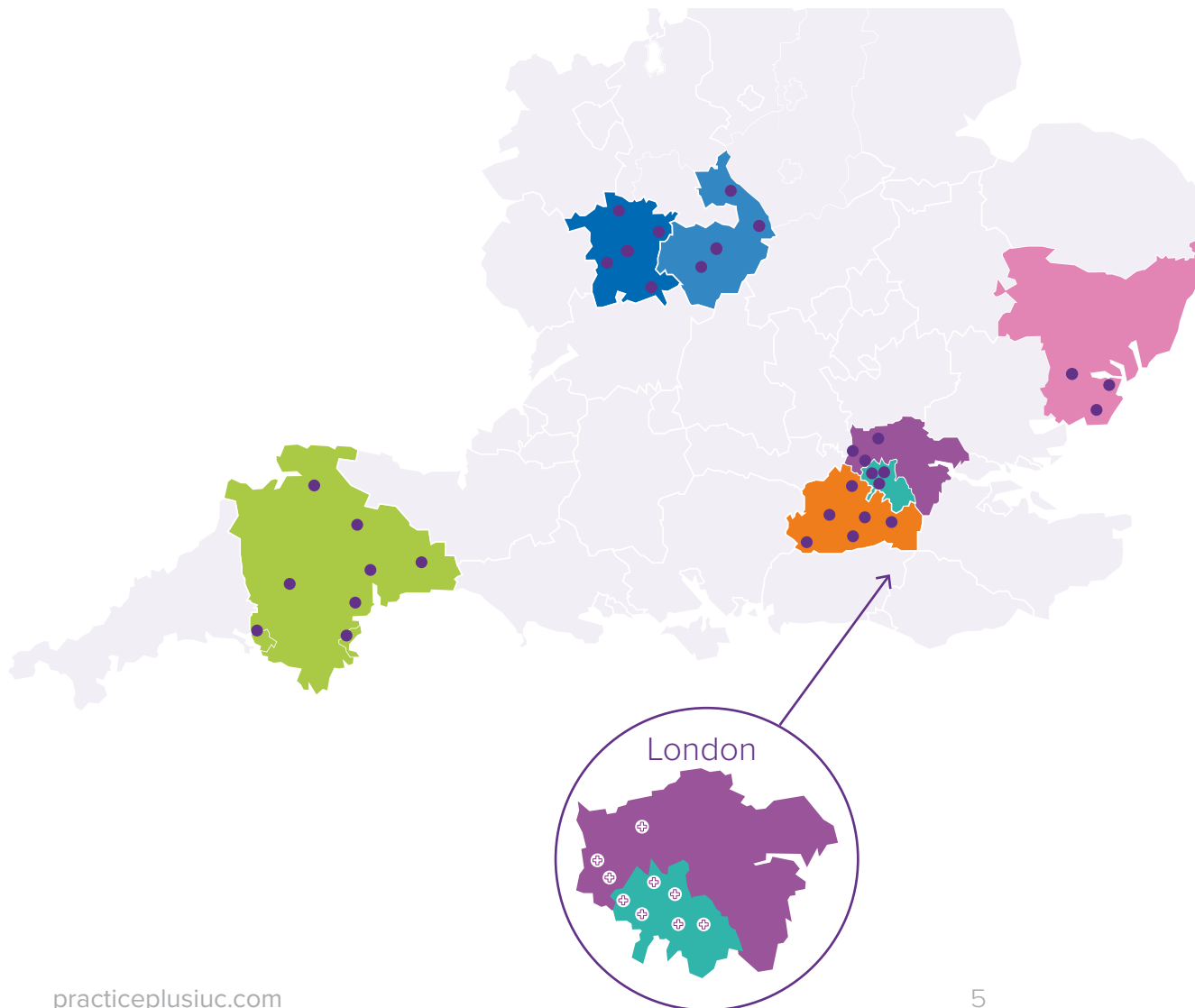
Our vision

We are a healthcare provider with a clear purpose: to deliver exceptional care and expand our reach responsibly so more people benefit. Our services are trusted by patients and NHS commissioners alike, offering high quality, accessible healthcare for all. Powered by innovation and delivered by expert colleagues, we are proud to set the standard for modern, compassionate healthcare.



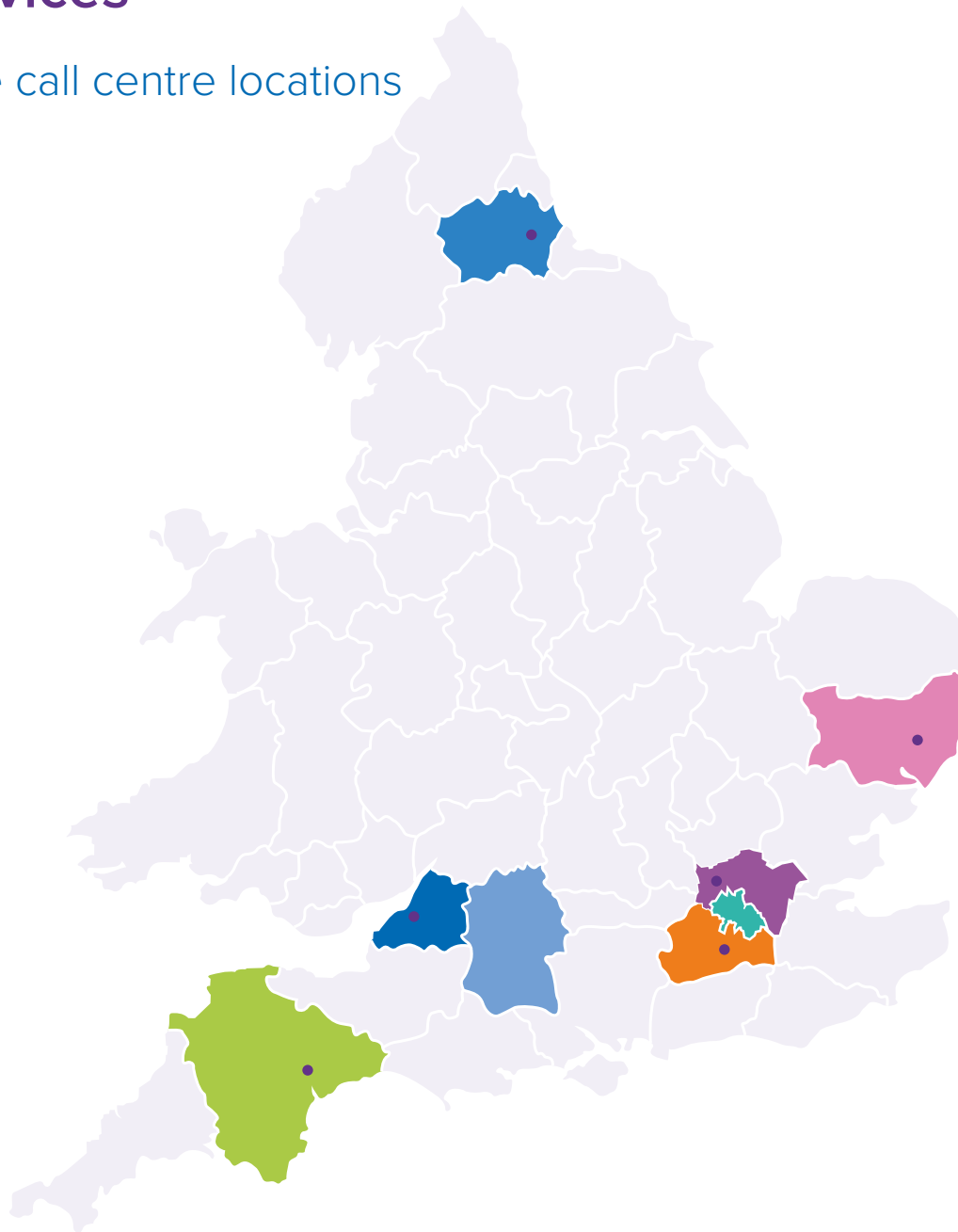
Map of services

Out-of-hours and clinical assessment service locations



Map of services

NHS 111 service call centre locations



Stockton-on-Tees contact centre

Resilience

Ipswich contact centre

East of England

Southall contact centre

North West London

South West London

Dorking call centre

Surrey Heartlands

Bristol contact centre

Bristol North Somerset and
South Gloucestershire

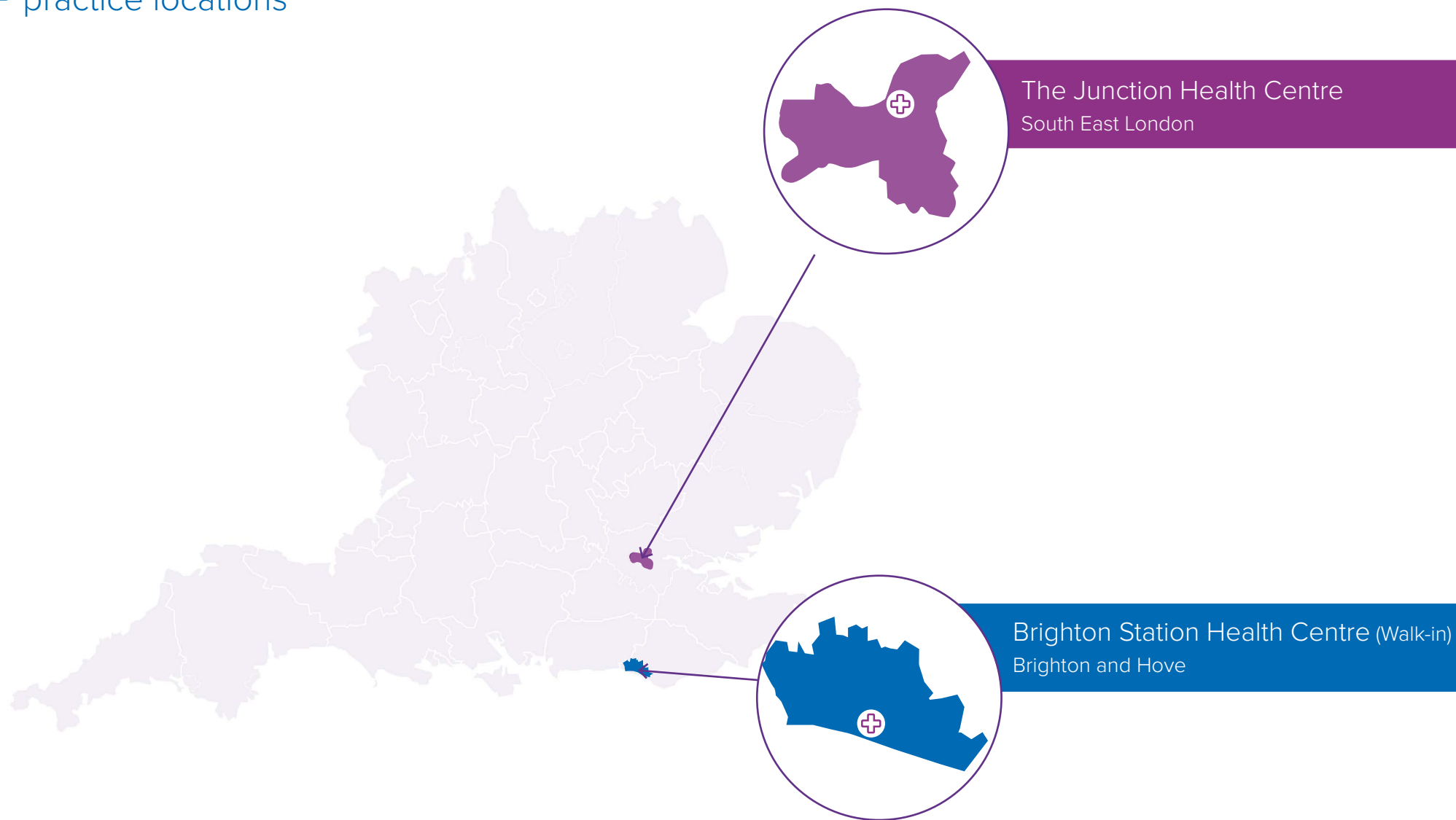
Bristol North East Somerset and
Swindon, Wiltshire

Devon contact centre

Exeter

Map of services

GP practice locations



Statement on quality from the Chief Executive



I am pleased to present Practice Plus Integrated Urgent Care (IUC) Quality Account for 2025–26. This report reflects our continued commitment to delivering high quality NHS services with integrity, supported by robust governance, and a culture in which every colleague is valued. It also provides an opportunity to review our progress, acknowledge the pressures facing the wider health and care system, and set out our priorities for further improvement.

Our purpose remains clear: to design and deliver safe, responsive, and consistently high quality local healthcare, strengthened by the scale and expertise of a national organisation and by long standing partnerships across the NHS. This foundation enables us to provide reliable, person centred care while adapting to the distinct needs of each community we serve. We are equally proud of our inclusive people strategy, which ensures colleagues feel respected, supported, and empowered to perform at their best.

Over the past year, our IUC services have continued to play a vital role within the NHS urgent care pathway. Our NHS 111 contact centres, out of hours services, Clinical Assessment Service, Health Centres, and Practice Assist have all made significant contributions. In 2025–26, our NHS 111 teams have answered over 2.3 million calls from people seeking urgent advice, while our OOH and CAS teams have managed in excess of 719,000 patient episodes.

We have also built on the major investments made in recent years. Our colleagues working at our Stockton on Tees contact centre have matured into a confident, high performing team supporting health advisors nationwide. Meanwhile, our London hub at Stockley Park is now firmly established, bringing NHS 111, CAS, and OOH services together in a modern, collaborative environment that enhances staff wellbeing and strengthens patient care.

Our Brighton Station and Junction Health Centres continue to provide essential access to NHS GP services, supporting both registered patients. Our Brighton Station service was successfully retained, delivering approximately 5,000 walk-in appointments, home visits and surgery appointments in year. These centres exemplify our commitment to accessible, community based care. We have successfully retained the Worcestershire Out of Hours (OOH) service following the recent commissioning review. In addition to confirming their confidence in our continued delivery of a safe and reliable urgent care service, commissioners have also asked us to expand our remit to include the Community Outbreak Service for the local population. This development reflects the strength of our existing service model, the quality of our clinical and operational performance, and the trust placed in us to support wider system priorities across the county.

This year has also brought well deserved recognition for our teams. Our IUC colleagues were once again celebrated at the Practice Plus Excellence Awards, reflecting the consistent quality of their work. Externally, we were named finalists at the HSJ Partnership Awards for Best Contribution to the Improvement of Urgent and Emergency Care for our IUC Unscheduled Care Coordination Hub (UCCH), and we received a Highly Recommended award for our Patient Engagement and Experience Initiative. Additional achievements included a Silver award for New Employee Experience at the UK National Call Centre Awards and a Bronze award for Best Approach to Diversity, Equity, Inclusion and Belonging; important markers of the progress we are making.

We have continued to explore the role of emerging technologies in supporting clinical quality and efficiency. This year, we piloted use of automated note-taking software; the tool listens to the consultation and automatically generates a structured medical summary for the clinician to review and approve, enabling clinicians to focus fully on the patient rather than on documentation.

Alongside this, we are working with NHS England on an NLP pilot, with 'intent capture' (the reason for your call) now live and demographic capture currently in testing. We are also trialling applications within our face to face services; such as a system that produces a draft clinical record based on the consultation, which the clinician can then refine and finalise. These innovations are helping us reduce the administrative burden, improve record accuracy and enhance the overall patient experience.

We recognise that the sustainability of urgent care depends on the wellbeing and development of our people. During this year we have invested in leadership development, clinical education and wellbeing initiatives that support colleagues working in a demanding environment. Our Springboard programme, part of Female Futures, successfully expanded to include a women's mentoring pilot. Our extensive e learning portfolio continues to provide staff with accessible, high quality training that underpins clinical excellence, operational effectiveness and ongoing professional development across all areas of the service. In addition, we rolled out Health Advisor and Team Manager apprenticeships, creating structured development routes that enable staff to gain nationally recognised qualifications while building the skills and confidence needed for progression. By creating opportunities for growth, supporting flexible working, and strengthening multidisciplinary collaboration, we aim to build a workforce that feels confident, supported, and equipped to deliver excellent care.

Finally, we know that urgent care does not operate in isolation. Our ability to deliver safe, timely support relies on strong partnerships across primary care, ambulance services, community teams, and acute hospitals. In the year ahead, we will continue to strengthen these relationships, contributing to integrated care pathways that reduce pressure on emergency departments and ensure patients receive the right care in the right place. By working together, we can support a more resilient and responsive urgent care system for the communities we serve.

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

Jim Easton
CEO

Note: From 1st September 2026, Practice Plus IUC were delighted to welcome a new Chief Executive Officer, David Beresford, whilst retaining Jim Easton's expertise in his new role of Non-Executive Director.

Our improvement priorities

Safe: Strengthening Our Systems to Prevent Avoidable Harm and Improve Patient Safety

What are we improving?

- We aim to enhance patient safety by ensuring that all deaths occurring in proximity to contact with our services are examined through a systems based learning approach, in line with PSIRF principles.
- Our focus is on understanding how our systems function in practice, identifying opportunities for improvement, and embedding learning to reduce the risk of future harm.

What will success look like?

- A reduction in patient safety events where the care we provided contributed to avoidable harm.
- Increased completion of proportionate patient safety incident learning responses within expected timeframes.
- Evidence that patients consistently receive appropriate assessment, advice and escalation, aligned with clinical standards and safe care pathways.

How will we monitor progress?

- All relevant patient safety incidents are recorded, reviewed and subject to appropriate learning responses in line with PSIRF.
- Thematic learning is identified through analysis of patient safety events and shared across teams and service lines to drive system improvement.
- Monitoring of improvement actions to ensure learning is embedded, sustained and demonstrably improving patient safety.

Caring: Ensuring Patients Receive Compassionate, Timely Support Throughout Their Care Journey

What are we improving?

- We aim to strengthen the continuity and quality of patient care by improving how we monitor, track and follow up on patient contacts across our services.
- By enhancing communication, ensuring timely responses and supporting seamless transitions between teams, we seek to reduce delays, improve patient experience and maintain a consistently caring approach.

What will success look like?

- A reduction in patient safety incidents linked to delays in follow up, advice or onward referral.
- Increased confidence among clinical and non-mndscinical teams that patients are receiving timely, compassionate and appropriate support.
- Clear evidence that learning from patient feedback and safety events is being embedded into everyday practice to improve care continuity and reduce risk.

How will we monitor progress?

- Review of incidents, concerns and complaints recorded on the central Datix system to identify themes and areas for improvement.
- Use of enhanced data intelligence to understand patterns in call volumes, response times and service availability across the system.
- Regular review through governance forums to ensure improvements are sustained and that patient experience remains central to service delivery.

Our improvement priorities

Responsive: Strengthening Internal Communication and Organisational Transparency

What are we improving?

- We aim to enhance the clarity, consistency and accessibility of internal communication across the organisation. By ensuring that staff receive timely, relevant and transparent information, we intend to build greater trust, alignment and understanding of organisational priorities, decisions and developments

What will success look like?

- Staff feel supported, valued and listened to with clear improvements in morale, engagement and overall wellbeing.
- Wellbeing initiatives are embed in everyday practice.
- A culture of continuous improvement and psychological safety, where staff are empowered to speak up, share ideas and help shape positive change.

How will we monitor progress?

- Staff survey results showing positive trends in perceptions of communication quality, transparency and organisational understanding.
- Analytics from communication platforms (e.g., intranet engagement, attendance at briefings, open rates for key updates) demonstrating increased reach and effectiveness.
- Qualitative feedback from staff networks, team meetings and engagement forums highlighting improved clarity, accessibility and trust in organisational communication.

Effective: Enhancing Clinical Triage Accuracy to Improve Patient Outcomes in OOH Services

What are we improving?

- We aim to strengthen the accuracy, consistency and reliability of clinical consult and triage within the Out of Hours service to ensure patients receive the most appropriate level of care at the earliest opportunity. By refining triage processes, improving access to clinical decision support tools and enhancing staff training, we seek to reduce unwarranted variation and improve the safety and effectiveness of patient assessment.

What will success look like?

- Clinical triage decisions are accurate, timely and aligned with evidence based guidance, ensuring patients are directed to the right care pathway.
- Improved alignment between NHS 111 dispositions, OOH clinical assessment and onward referral outcomes, resulting in more efficient patient journeys.
- Staff report increased confidence in triage processes, supported by robust training, clear protocols and reliable digital tools.

How will we monitor progress?

- Audit of triage outcomes to assess accuracy, consistency and adherence to clinical standards.
- Review of incident reports, near misses and quality metrics to identify reductions in triage related risks or inappropriate dispositions.
- Feedback from clinicians, clinical leads and partner services to evaluate the effectiveness of triage improvements and identify further opportunities for refinement.

Our improvement priorities

Safe: Strengthening Our Systems to Prevent Avoidable Harm and Improve Patient Safety

What are we improving?

- We aim to enhance patient safety by ensuring that all deaths occurring in proximity to contact with our services are examined through a systems based learning approach, in line with PSIRF principles.
- Our focus is on understanding how our systems function in practice, identifying opportunities for improvement, and embedding learning to reduce the risk of future harm.

What will success look like?

- A reduction in patient safety events where the care we provided contributed to avoidable harm.
- Increased completion of proportionate patient safety incident learning responses within expected timeframes.
- Evidence that patients consistently receive appropriate assessment, advice and escalation, aligned with clinical standards and safe care pathways.

How will we monitor progress?

- All relevant patient safety incidents are recorded, reviewed and subject to appropriate learning responses in line with PSIRF.
- Thematic learning is identified through analysis of patient safety events and shared across teams and service lines to drive system improvement.
- Monitoring of improvement actions to ensure learning is embedded, sustained and demonstrably improving patient safety.

Caring: Ensuring Patients Receive Compassionate, Timely Support Throughout Their Care Journey

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- We aim to strengthen the continuity and quality of patient care by improving how we monitor, track and follow up on patient contacts across our services.
- By enhancing communication, ensuring timely responses and supporting seamless transitions between teams, we seek to reduce delays, improve patient experience and maintain a consistently caring approach.

What will success look like?

- A reduction in patient safety incidents linked to delays in follow up, advice or onward referral.
- Increased confidence among clinical and non clinical teams that patients are receiving timely, compassionate and appropriate support.
- Clear evidence that learning from patient feedback and safety events is being embedded into everyday practice to improve care continuity and reduce risk.

How will we monitor progress?

- Review of incidents, concerns and complaints recorded on the central Datix system to identify themes and areas for improvement.
- Use of enhanced data intelligence to understand patterns in call volumes, response times and service availability across the system.
- Regular review through governance forums to ensure improvements are sustained and that patient experience remains central to service delivery.

Our improvement priorities

Safe: Strengthening Our Systems to Prevent Avoidable Harm and Improve Patient Safety

What are we improving?

- We aim to enhance the clarity, consistency and accessibility of internal communication across the organisation. By ensuring that staff receive timely, relevant and transparent information, we intend to build greater trust, alignment and understanding of organisational priorities, decisions and developments.

What will success look like?

- Staff report improved clarity and confidence in organisational messaging, with a stronger understanding of strategic priorities and operational changes.
- Communication channels are streamlined, reliable and widely used, reducing duplication and ensuring information reaches the right people at the right time.
- A culture of open communication and transparency is evident, where staff feel informed, connected and able to contribute to organisational dialogue.

How will we monitor progress?

- Staff survey results showing positive trends in perceptions of communication quality, transparency and organisational understanding.
- Analytics from communication platforms (e.g., intranet engagement, attendance at briefings, open rates for key updates) demonstrating increased reach and effectiveness.
- Qualitative feedback from staff networks, team meetings and engagement forums highlighting improved clarity, accessibility and trust in organisational communication.

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- Clinical triage decisions are accurate, timely and aligned with evidence based guidance, ensuring patients are directed to the right care pathway.
- Improved alignment between NHS 111 dispositions, OOH clinical assessment and onward referral outcomes, resulting in more efficient patient journeys.
- Staff report increased confidence in triage processes, supported by robust training, clear protocols and reliable digital tools.

How will we monitor progress?

- Audit of triage outcomes to assess accuracy, consistency and adherence to clinical standards.
- Review of incident reports, near misses and quality metrics to identify reductions in triage related risks or inappropriate dispositions.
- Feedback from clinicians, clinical leads and partner services to evaluate the effectiveness of triage improvements and identify further opportunities for refinement.

Our improvement priorities

Well led: Strengthening Governance, Assurance and Accountability Across Urgent Care Services

What are we improving?

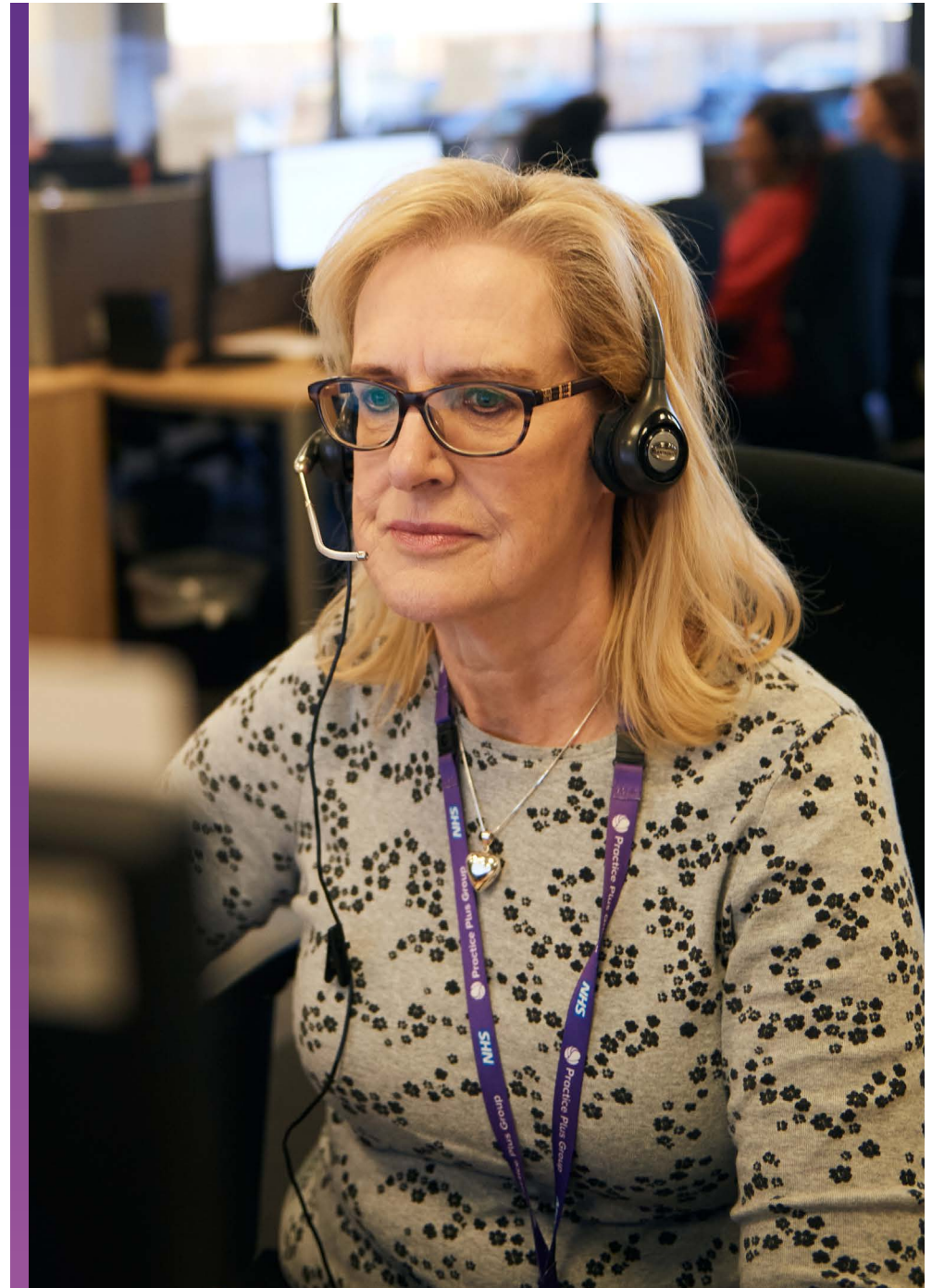
- We aim to enhance organisational governance by ensuring clear accountability, robust oversight and consistent leadership standards across all urgent care services. By refining our governance structures and strengthening decision making processes, we seek to improve service reliability, regulatory compliance and overall organisational performance.

What will success look like?

- Clear and transparent governance arrangements that support timely, evidence based decision making.
- Leaders at all levels demonstrate strong accountability, with clear ownership of quality, safety and performance outcomes.
- Improved organisational alignment, with teams working cohesively towards shared priorities and consistently delivering high quality, patient centred care.

How will we monitor progress?

- Regular review of governance frameworks, risk registers and assurance reports to ensure compliance with regulatory and organisational standards.
- Performance dashboards and quality indicators demonstrating strengthened oversight and improved service outcomes.
- Structured feedback from leadership forums, clinical governance meetings and external partners to evaluate the effectiveness of governance.



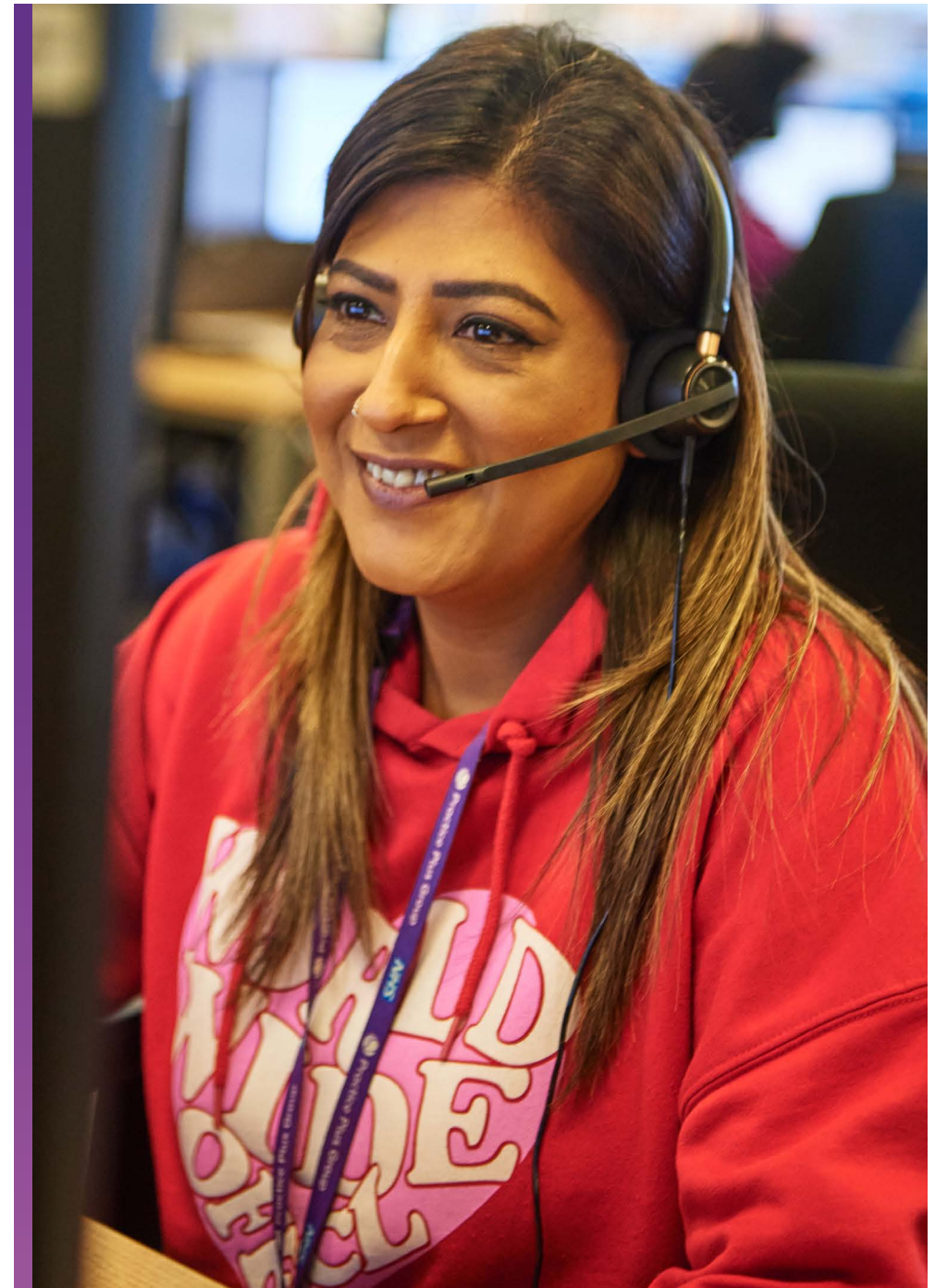
NHS 111 services

Building quality through growth

Last year we expanded our NHS 111 network with the opening of our Stockton on Tees contact centre at Cavendish House. Since then, the site has grown into a well established and high performing part of our national service. It now plays a central role in supporting call demand across the country, providing a stable and skilled workforce that strengthens our overall resilience. The centre has become a key contributor to the local community, offering long term employment opportunities and supporting the continued regeneration of the Tees Valley. Today, it stands as a mature and confident part of our NHS 111 infrastructure, helping ensure that callers receive timely, safe and appropriate advice whether that involves self care guidance, urgent treatment, clinical call backs, or access to specialist services.

The workplace itself has also evolved. The modern environment created through our partnership with specialist designers has proven to be an important asset, supporting both staff wellbeing and operational performance. The combination of dedicated workstations, flexible training areas and high quality facilities has helped us attract and retain skilled health advisors and clinical advisors. Our comprehensive induction and development programmes continue to equip colleagues with the knowledge and confidence they need to deliver excellent care.

Our London NHS 111 contact centre at Stockley Park has also developed into a fully integrated hub for urgent care services. Bringing together NHS 111, the Clinical Assessment Service and out of hours teams has created a more connected and collaborative working environment, improving communication and enabling smoother patient journeys. The centre's design with its open, bright spaces, wellbeing rooms and flexible collaboration areas has had a lasting positive impact on staff morale and team culture. What began as a major relocation project has now become a thriving operational base that supports some of the busiest parts of the capital.



NHS 111 case volumes by contact centre

Our NHS 111 services are staffed by teams of fully trained advisers, supported by experienced nurses and paramedics. They assess symptoms, then either provide healthcare advice or direct to a local service that can help. That could be a late-opening pharmacy, community nurse, out-of-hours doctor, walk-in centre, urgent care centre, Minor Injury Unit (MIU) or the emergency department.

We provide;

- Medical help that is not a 999 life-threatening emergency.
- Advice to patients who think they need to go to the emergency department or need another NHS urgent care service but are unsure.
- Advice to patients who don't know who to call or don't have a registered GP.
- Health information or reassurance about what to do.

Case volumes April 2025 to March 2026

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec2025	Jan 2026	Feb 2026	Mar 2026	Total
Devon NHS 111	34348	36437	33394	33759	36555	32892	35406	35667	41530	39578	34073	36599	430238
London NHS 111	54960	54105	49222	48627	47649	46536	49730	52076	58623	54768	47527	53022	616845
South West NHS 111	52885	52487	49259	50608	51204	49760	53457	54134	62510	59918	51321	55299	642842
Suffolk and NE Essex NHS 111	29307	30250	27593	27718	29554	26723	27492	28709	34511	32449	28554	29227	352087
Surrey Heartlands NHS 111	23176	23018	21734	21666	22639	21493	22796	23777	27267	25450	22283	23936	279235
Total	194676	196297	181202	182378	187601	177404	188881	194363	224441	212163	183758	198083	2321247

111 service audit programme

As part of the requirement for services to maintain the pathways licence, all health advisors and clinical advisors have a number of their calls independently audited each month. Each advisor has three calls audited each month. If an audit highlights improvements to be made, the advisor receives feedback and audits increase to five calls each month until the advisor and their manager are happy that the required standard can be maintained. Additional audits are undertaken at the request of incident and complaint investigators, hence why monthly completion rates below, are in excess of 100%.

Health advisors	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Active advisors	678	689	674	633	602	575	574	566	603	615	601	678
Audits required	2,714	2,75	2,649	2,405	2,194	2,041	2,050	2,059	2,285	2,459	2447	2,780
Completed (for month)	3,109	3,040	2,838	2,522	2,397	2,196	2,284	2,344	2,624	2,700	2,676	1,578
Completed %	115%	111%	107%	105%	110%	108%	111%	114%	115%	110%	109%	57%
Passed	2,597	2,595	2,486	2,249	2,094	1,972	1,984	1,961	2,156	2,003	2,136	1,202
Passed %	83.53%	85.36%	87.60%	89.18%	87.36%	89.80%	86.87%	83.66%	82.16%	74.19%	79.82%	76.17%
Feedback completed	2529	2,492	2,316	2,201	2178	2,068	2,086	2,029	2,271	2166	2,033	1,085
Feedback completed %	81%	82%	82%	87%	91%	94%	91%	87%	87%	80%	76%	69%

Clinical advisors	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Active advisors	254	244	239	228	214	217	216	226	238	226	216	226
Audits required	832	794	771	724	658	667	664	688	726	704	698	750
Completed (for month)	943	862	831	796	705	717	716	732	768	742	755	693
Completed %	113%	109%	108%	110%	107%	108%	108%	106%	106%	105%	108%	92%
Passed	922	836	799	772	694	703	709	723	754	683	724	673
Passed %	97.77%	96.98%	96.15%	96.98%	98.44%	98.05%	99.02%	98.77%	98.18%	92.05%	95.89%	97.11%
Feedback completed	809	728	737	743	661	708	690	711	748	700	687	561
Feedback completed %	86%	84%	89%	93%	94%	99%	96%	97%	97%	94%	91%	81%

NHS 111 service HA and CA compliance audit schedule

A schedule of compliance audits support the listening and clinical audits undertaken within the service

Audit schedule April 2025 to March 2026 - NHS 111

Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Audit topic												
HA audit - completed %												
HA audit - passed (≥ 86) %												
CA audit - completed %												
CA audit - passed (≥ 86) %												
PC - CAS alert monthly audit												
Safeguarding compliance audit												
Risk assessments review audit												
HR records, PCRs and 121s												
Emergency scenario audit												
PC - Workplace health and safety checklist									Start		Finish	
Information governance and security												

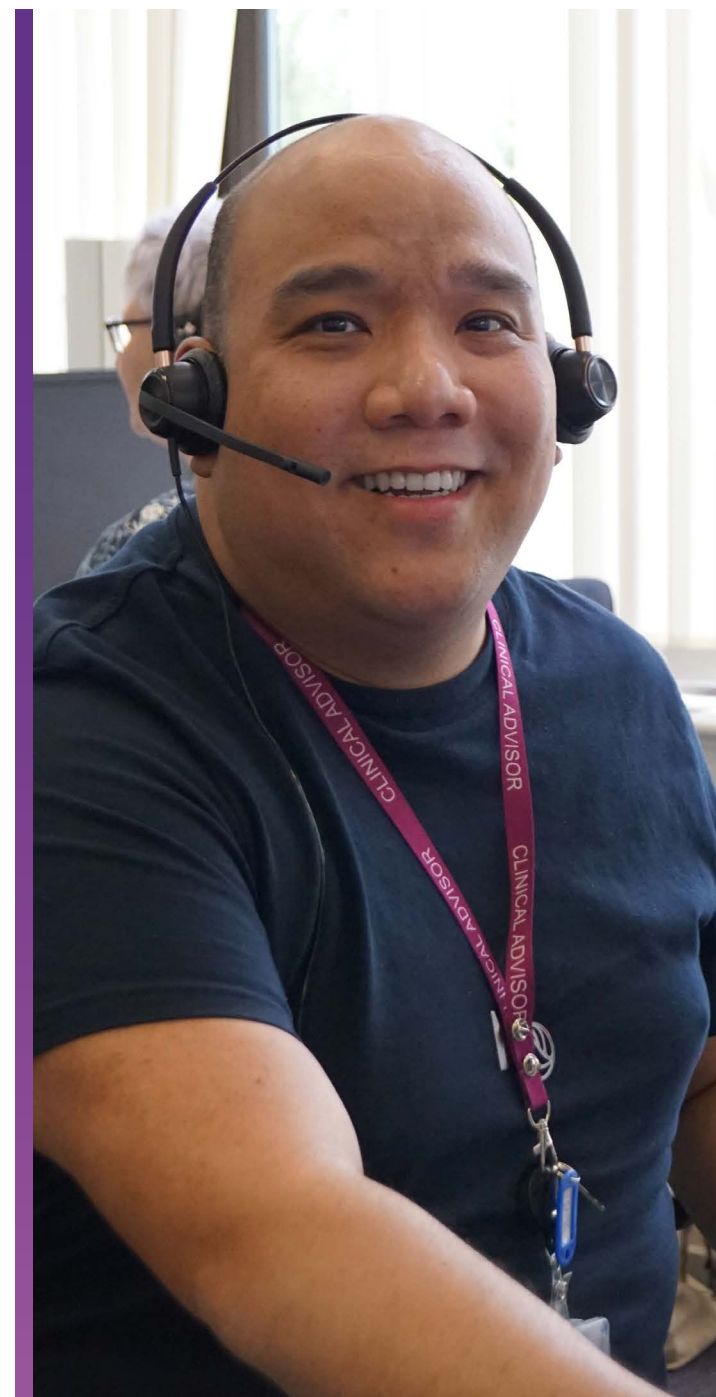
Regulation and compliance

Our NHS 111 services are registered with and inspected by the Care Quality Commission (CQC)

Following each inspection visit the service receives a rating: Outstanding, Good, Requires Improvement, or Inadequate. Inspection reports are published on the CQC website.

Service ratings are published on the Practice Plus Group website and displayed at each of our services.

Service	Dates of inspection	CQC rating
Devon NHS 111	02 December 2025	Not yet rated under PPG management
London NHS 111	12-13 March 2024	Good
South West NHS 111	9-10 December 2021	Outstanding
East of England NHS 111	28 February 2017	Good. Outstanding in Well-Led category
Surrey Heartlands NHS 111	17-18 May 2017	Good. Outstanding in the Well-Led category



Recognition from CQC's most recent NHS 111 inspection reports

Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Leaders at all levels were visible and approachable.

South West NHS 111

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. For example, in a case where a delay in access to translation services, caused by the provider of interpreter services not being able to find a Somali interpreter quickly enough, action had been taken and a service level agreement put in place to help ensure speedy access to interpreter services.

East of England NHS 111

People were positive about the quality of their care and treatment. Feedback from surveys, compliments, and case studies demonstrated that individuals felt listened to, respected, and involved in decisions about their care.

Devon NHS 111

Patients received coordinated and person-centred care. This continued when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services.

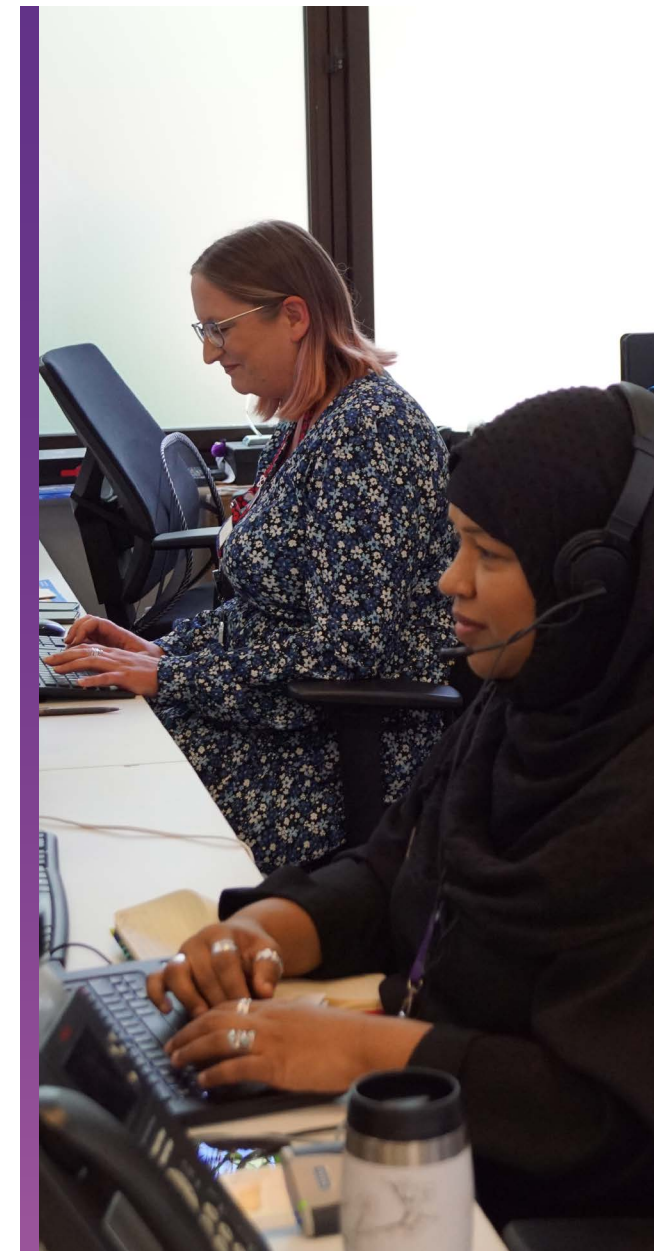
South West NHS 111

The service used every opportunity to learn from internal and external incidents to support improvement. Learning was based on a thorough analysis and investigation.

East of England NHS 111

The vision and strategy was based on three 'Ps': Patients, People and Performance. This encompassed ensuring there were the right staff with the appropriate skills to manage calls from patients, with safety and effectiveness at the heart of the service. To provide a high quality patient focused service, which drives improvement and exceeds key performance indicators. The vision and strategy were developed and owned by all staff, with the involvement of patient focus groups.

Surrey Heartlands NHS 111

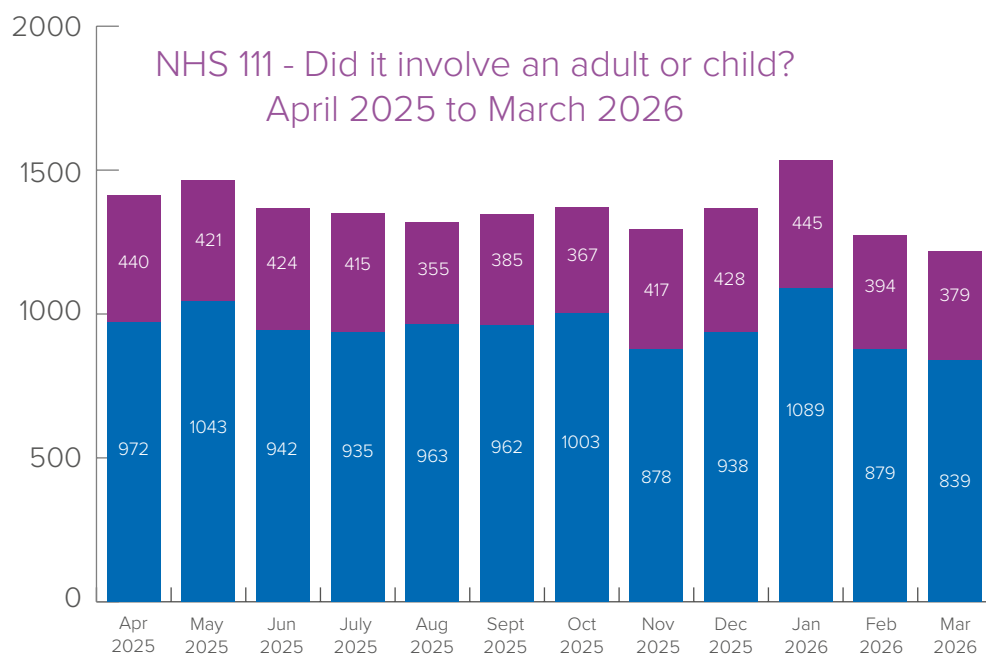


The Safeguarding Hub

Our NHS 111 services are frequently the first contact a patient or their family have with NHS healthcare and are the first service to identify a potential safeguarding issue.

Practice Plus IUC operates a unique 'safeguarding hub' that collates all safeguarding concerns raised by our clinicians and operational staff across Practice Plus IUC services and makes the onward referral to the relevant social services. This ensures a speedy referral to the right agency to undertake an assessment and allows NHS 111 colleagues to return to patient calls.

Safeguarding referral received into the Hub



Call PHILL – Integration with the IUC Safeguarding Hub

In addition, the Hub now manages Call PHILL (Prisoner Health Information and Liaison Line). This is an innovative patient safety and advocacy service developed in partnership with NHS England. It serves as a bridge between the secure estate and the community, functioning as a specialised addition to the Safeguarding Hub.

The Call PHILL team manages high-risk information to protect vulnerable individuals in custody.

- Call handlers process reports of imminent risks; self-harm concerns, mental health crises, recent substance misuse.
- Families can relay essential details about ongoing treatments or specific medication needs to prevent delays in care.
- The hub facilitates communication between prison healthcare teams and external professional services.
- While protecting patient privacy, the service allows clinicians to contact “trusted persons” or family members when appropriate to discuss care plans.

Integrating Call PHILL into the Safeguarding Hub strengthens the “holistic wellbeing model” used across Practice Plus’s secure sites.

Patient and family feedback

We have a responsibility to ensure that anyone who makes a complaint, comment or gives a compliment about our NHS 111 services receives the appropriate response

Anyone who raises a concern or complaint is treated with compassion, dignity and respect.

All anonymous complaints are investigated, providing that there is sufficient detail to do so. Where ever it is possible to verify the complaint, the appropriate remedial actions are taken. Of the 2,025,530 contacts made to our services between April 2025 to March 2026, 0.02% resulted in a complaint.

NHS 111 services % of complaints received against case volume

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Devon NHS 111	0.003%	0.01%	0.01%	0.03%	0.01%	0.03%	0.02%	0.01%	0.02%	0.01%	0.02%	0.03%	0.02%
London NHS 111	0.01%	0.02%	0.02%	0.01%	0.02%	0.02%	0.03%	0.03%	0.03%	0.01%	0.02%	0.01%	0.02%
South West NHS 111	0.01%	0.01%	0.02%	0.02%	0.02%	0.02%	0.03%	0.01%	0.02%	0.01%	0.02%	0.03%	0.02%
Suffolk and NE Essex NHS 111	0.003%	0.02%	0.01%	0.02%	0.01%	0.02%	0.03%	0.01%	0.03%	0.02%	0.02%	0.02%	0.02%
Surrey Heartlands NHS 111	0.02%	0.02%	0.01%	0.01%	0.02%	0.00%	0.00%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%
Total	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.04%	0.03%	0.04%	0.02%	0.03%	0.03%	0.03%

NHS 111 Compliments

Patient's husband, a doctor, wanted to say that 111 is the most amazing service that the UK has - and we do an amazing job and thank you!

London NHS 111

I just wanted to say, your team has been bl**** marvellous. I want to compliment on two things:

1. The level of knowledge from your service to help and the advice.
2. The person I was speaking to was so patient with me when I was feeling unwell and stressed is so impressive.

Please pass this onto your whole team, I am so pleased with the service and thank you.

Devon NHS 111

I would just like to thank the call handler for his professional patience and calmness when I was just rambling on obviously in a state of shock, I just remember his calm voice explaining what I needed to do and on reflection I am very grateful.

East of England NHS 111

Patient wanted to log some positive feedback for the health advisor that they spoke to. Patient advised about the health advisor "she was fantastic. I don't think she realises how much she calmed me down and made me feel like they cared. They stopped me from spiraling today with regards to my mental health".

East of England NHS 111

Just had a wonderful elderly gentleman MS on the phone who has never called 111 before, He spoke to a HA and a CA from our service and said it was such a wonderful experience and so grateful for all the work we are doing and help we provide.

South West NHS 111

This patient wanted to thank the service at the end of our call, she said we are 'amazing, kind, efficient, and wonderful'.

Surrey Heartlands NHS 111

The patient called in to say they were grateful for the help they received. The HA was very helpful and arranged a GP telephone call and the GP called back within the timeframe given and they are already feeling better.

The patient wanted it documented that they were really grateful and would be using our service again.

London NHS 111

Patient wanted to express thanks to the call handler and CA. It's the first time he has ever called 111 and he is really appreciative of the help and guidance he has received today. He is very impressed with the service.

South West NHS 111

I

don't usually do feedback, but this lady really made a bad situation into a good one. She assured my mother you were there to help and she assured me that she would be ok. Great work from the 111 service. Thank you so much.

Surrey Heartlands NHS 111

A very prompt answer from 111. Advisor was friendly, caring, reassuring and decisive. Very impressive indeed and very helpful!

Surrey NHS 111



‘Hot topics’

Circulated April 2025 to March 2026

Staff receive regular ‘hot topics’ for revision of those topics that have been identified for additional learning. Subjects may be prompted by recorded incidents, complaints, changes in NHS pathways algorithms or epidemiological patterns of disease (e.g. outbreaks). A programme of refresher topics focusses on a particular area of learning each month. Subjects included:

Month	Focus for the Month	Hot Topic
Apr-25	Symptom Specific	Button Battery Ingestion, Cold and Flu, Ectopic Pregnancies, Burns, Diabetes Insipidus, Sickle Cell Disease, Immune System Problems
May-25	Module 0 Symptoms	Anaphylaxis, Diabetic Emergencies, Stroke, Stroke in Children, Seizures
June 25	Blood Loss, Major Falls & Adrenal Crisis	Major Blood Loss, Major Trauma Falls, Clinical Shock, Addison's Disease (Case Study)
Jul-25	Assessing Breathing and Consciousness	Agonal Breathing, Breathing problems, Checking Breathing and Consciousness during Assessment, Levels of Consciousness, Choking, Oxygen Saturation Levels
Aug-25	Suicide and Self-Harm	Suicide, Assessing Self Harm, Illness or Injury
Sep-25	Cardiac	Anticoagulant Medicines, Aortic Aneurysm, Aspirin
Oct-25	Septicemia & Meningitis	Sepsis, Meningitis, Severe Illness and Pain, Unwell Child (Case Study)
Nov-25	Pathways Usage	Responding to Changes in Triage, Environment Potentially Poses Threat to Life, Pre-Determined Management Plan, Early Exit, Discovery of a dead body
Dec-25	DOS & Public Health	Pharmacy Services, DoS Returns
Jan-26	Call Control	Complex calls, Controlling Calls, Questioning Skills
Feb-26	Multiple Symptoms, Timeframes and Declared Screen	Declared Screens and Pathways, Managing Multiple symptoms, Symptom Time Frames
Mar-26	Pathway Selection	Medication Enquiry or Accidental Poisoning Pathway Selection Abdo pain, Vomiting, Bringing up Blood Pathway Selection Wound Problems, Penetrating Injuries, Scratches, Grazes

GP Out-of-Ours (OOH) services and Clinical Assessment Services (CAS) supporting the healthcare system

During 2025/2026 our services provided a number of initiatives designed to support the broader healthcare system, delivered by highly trained clinicians to meet the needs of the local population

The Acute Respiratory Infection (ARI) hub

In 2025 we launched an Acute Respiratory Infection (ARI) hub pilot for patients living within a defined catchment area in the East of England. An ARI hub is a healthcare service designed to manage respiratory infections, easing pressure on A&E, urgent care centres, and GP practices. These hubs offer same-day, face-to-face and telephone appointments with clinicians for individuals experiencing symptoms like coughing, wheezing, or shortness of breath. The Hub provided advice, prescriptions, face to face appointment and telephone consultations to an average of 500 patients a month, who would otherwise have sought care through other pressured areas of the healthcare system. During this year the service has gone from strength to strength. When surveyed 100% of patients using the service felt they were treated with respect during their consultation, that the doctor or nurse listened carefully to what they had to say and rated their overall experience of the service as 'very good' or 'good'.

The Conveyance Avoidance Helpline (CAH)

Our Conveyance Avoidance Helpline (CAH) continues to provide a valuable resource to ambulance crews on scene. The service provides real-time clinical advice and decision support, enabling more effective patient assessment and streamlined care pathways. By offering expert guidance, it helps crews determine the most appropriate destination - whether hospital or alternative care - thereby improving patient outcomes and reducing unnecessary delays.

Care coordination hubs

Our services have continued to play a vital part in supporting system flow and reducing avoidable pressure on urgent and emergency care. Through strengthened collaboration with regional ambulance services, NHS 111 and community providers, the Care Coordination Hubs have ensured that patients receive timely clinical advice, safe assessment and appropriate onward referral without defaulting to 999 or A&E.

Our East of England urgent care coordination hub moved to new premises this year the relocation of the Care Coordination Hub to new premises has had a significant positive impact on both staff experience and operational effectiveness. The improved environment has enabled the hub to function more efficiently, support staff wellbeing and enhance the overall quality of service delivery. With teams now co located in a more open and accessible space, communication has become more fluid and efficient. This has reduced delays, improved escalation processes and supported a more cohesive approach to managing patient referrals and system pressures.

The East of England Ambulance Service recognises the continued development of the hub and the strong collaborative approach demonstrated across the service. Their feedback highlighted the hub's clinical leadership; the responsiveness, constructive engagement and commitment to improving the support provided to patients. It also noted the strength of the working relationships that have developed between our teams and EEA clinicians, which has contributed to more effective day to day coordination. Overall, the feedback reflects the collective efforts of the entire team and the progress made in strengthening the effectiveness, reliability and quality of the UCCH as it continues to evolve.

GP out-of-hours (OOH) services

GP out-of-ours services provide urgent primary care for patients who have health concerns that cannot wait until their own GP surgery reopens

The aim is to reduce pressure on A&E departments and ensure patients receive timely care in the most appropriate setting. Patients access these service via NHS 111, which triages the patient's needs and refers them to the appropriate level of care. OOH services include;

- Telephone consultations with a doctor, clinician or pharmacist.
- Face-to-face appointments at one of our designated primary care centres.
- Home visiting, where clinically appropriate.
- Prescribing and issuing medication.
- Referral to hospital or emergency services when more urgent care is needed.

Case volumes within the OOH service: April 2025 to March 2026

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Devon OOH	7911	8392	6691	6512	7736	6272	6591	7639	9502	8534	6750	7184	89714
Coventry & Warwickshire	7902	8260	6505	6521	7477	6409	6924	7811	9475	8373	7076	7560	90293
North East Essex OOH	2495	2616	2127	2135	2362	2054	2064	2243	2853	2802	2301	2332	28384
South West London OOH	5692	5963	5114	4758	5385	4736	4916	6166	7019	6371	5404	6142	67666
Surrey Heartlands OOH	4955	5123	4249	4093	4658	3981	4057	4841	5917	5414	4217	4603	56108
North West London OOH	5237	5322	4399	4302	4676	4131	4737	5588	6119	5818	4868	5419	60616
Worcester OOH	5816	6091	4560	4658	5425	4604	4826	5527	6719	6052	4879	5254	64411
Total	28955	30354	24686	24019	27618	23452	24552	28700	34766	31494	25748	27821	332165

Clinical Assessment Service (CAS)

Clinical Assessment Services (CAS) provide enhanced clinical input to support triage and care decisions

Our CAS are staffed by multidisciplinary healthcare teams including GPs, advanced nurse practitioners, pharmacists and paramedics. Our CAS improves patient outcomes by ensuring clinical oversight and directing patients to the right care. The CAS forms a key part of our Integrated Urgent Care (IUC) model. We work closely with 999, urgent treatment centres and other providers. The services we provide include:

- Clinical validation of NHS triage outcomes.
- Clinical advice to other healthcare providers such as ambulance services and district nursing.
- Telephone and video consultations.
- Advice, treatment and onward referral.
- Prevention of unnecessary A&E attendance by managing cases that can be treated safely in the community.

Case volumes within the CAS: April 2025 to March 2026

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Devon CAS	6225	6462	5277	5037	6002	5138	5472	5776	7035	6620	5150	5414	69608
North West London CAS	6875	6931	6333	6469	5743	5983	6261	11310	10330	8942	8166	9145	92488
South West London CAS	8732	8556	7620	5728	7380	7405	8557	9099	9902	9089	7700	8355	98123
Suffolk and NE Essex CAS	6777	6669	5603	5728	6277	5793	6111	6374	6903	6854	5576	5187	73852
Surrey Heartlands CAS	4828	4710	3918	3907	4270	4086	4150	4564	5263	4955	4258	4198	53107
Total	33437	33328	28751	26869	29672	28405	30551	37123	39433	36460	30850	32299	387178

OOH/CAS compliance auditing

In addition to our national standard clinical audit schedules, our services undertake audits across the breadth of governance domains to provide assurance that our non-clinical systems and processes are working in accordance with our policy standards.

Audit schedule April 2025 to March 2026 - OOH

Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Audit topic												
PC - OOH's Coordinator Audit												
PC - OOH's Receptionist Audit												
PC - OOH's Drivers Audit												
PC - OO's Driving Standards Audit - New Drivers Completed month after new driver starts												
PC - OOH's Driving Standards Audit - All Drivers (policy adherence)												
PC - OOH's Driving Standards Audit - Oversight												
1% Clinical Notes Audit (F2F clinicians)												
1% Clinical Calls Audit (triaging clinicians)												
TAS Audit (if using TAS clinicians in service)												
PC - CAS Alert Monthly Audit												
PC - Safeguarding Compliance Audit												
PC - Risk Assessments Review Audit												
PC - Operations Supervisor Spot Checks - PCC's sites Audit												
PC - Medicine Management - Responsibilities & Prescribing												
PC - Meds Management - Controlled Drugs												
PC - Medicines Management - Stock Control												
PC - Medicine Management - Admin, Error and Incidents												
PC - PCR's 121 & HR records audit												
PC - Emergency Scenario Audit												
PC - IPC Observation Audit												
PC - Out of Hours - IPC Service Cars												
PC - Workplace Health and Safety Checklist (PPG-HC-HSE-25-F3)												
PC - Information Governance and Security (One Trust)												

Clinical audit

Clinical audit is central to our governance framework, supporting service improvement and providing clinicians with valuable insights into their practice

All our clinicians have their practice scrutinised throughout the year through a programme that looks at written notes and telephone/video calls undertaken with patients. Audits that identify room for improvement are fed back by the respective discipline lead and plans put in place to provide assurance that standards are met and maintained.

Audit schedule April 2025 to March 2026 - CAS

Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
1% Clinical Calls Audit (triaging clinicians)												
1% TAS Audit												
Dental audit												
Mental Health Nurses audit												
Pharmacist audit												
PC - CAS Alert Monthly Audit												
PC - Workplace Health & Safety Checklist									Start			Finish

Clinical audit

Each clinician has one percent of their cases audited each month

Audits are undertaken by the medical lead for the service or a senior clinician within the service. Results are fed back at 121 meetings or sooner if the case warrants. The table below shows the number of audits undertaken each month. Clinical notes are reviewed and the telephone calls audited. Results are used to improve consultations to improve quality, patient satisfaction and safety.

1% clinical notes audit

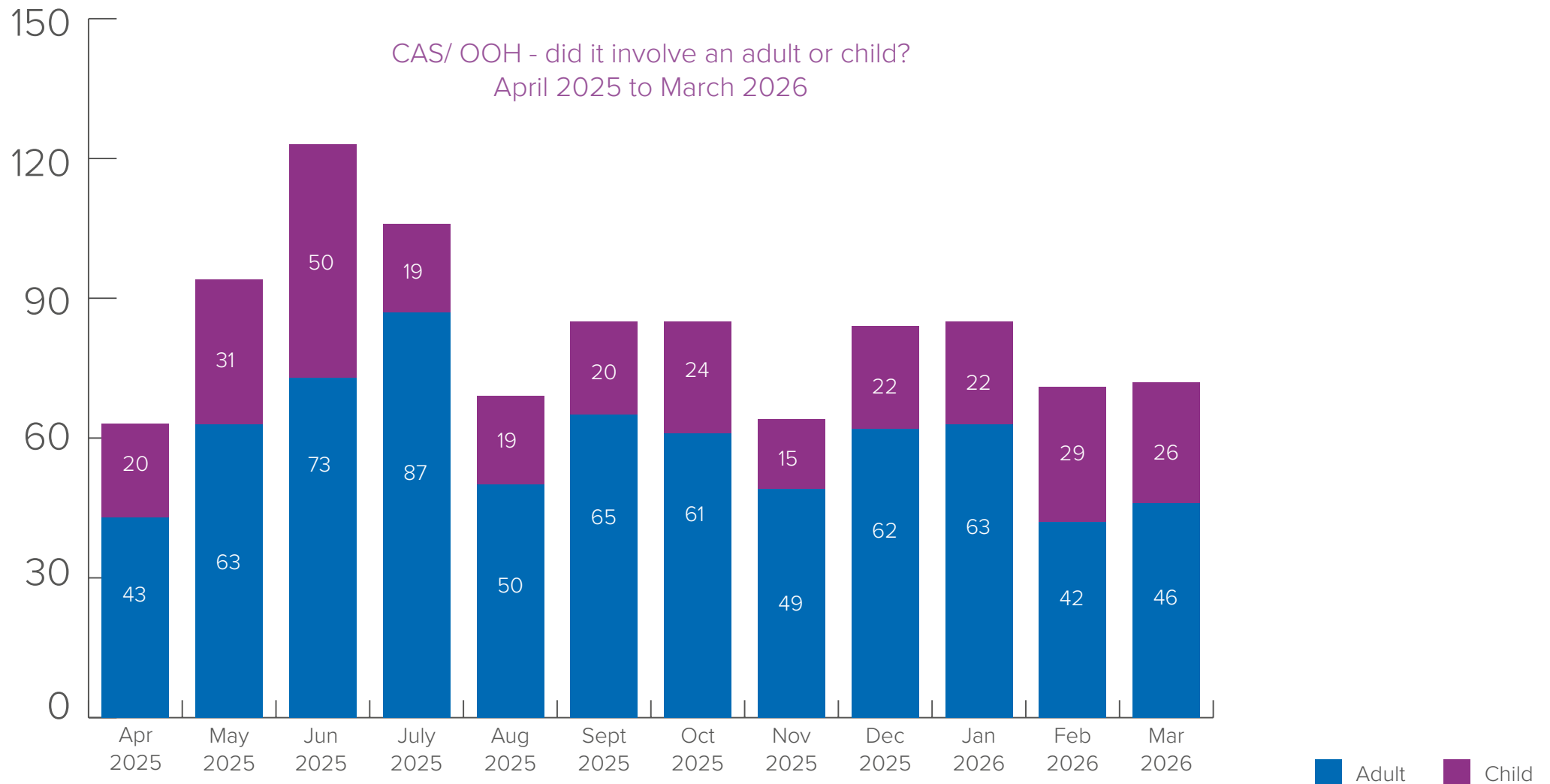
Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Devon OOH	100%	91%	92%	92%	91%	NS	91%	91%	91%	90%	90%	90%
Coventry & Warwickshire OOH	88%	90%	9%	89%	91%	91%	90%	87%	90%	88%	91%	89%
North East Essex OOH	NS	NS	95%	91%	94%	95%	96%	95%	96%	95%	93%	92%
South West London OOH	95%	94%	96%	89%	89%	NS	90%	89%	90%	92%	92%	90%
Surrey OOH	95%	94%	96%	89%	89%	NS	NS	91%	87%	91%	90%	93%
North West London OOH	95%	94%	96%	89%	89%	NS	90%	89%	90%	92%	92%	90%
Worcester OOH	92%	82%	95%	96%	94%	98%	95%	93%	94%	92%	93%	94%

1% clinical calls (triage) audit

Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Devon OOH	86%	94%	94%	92%	93%	NS	95%	95%	91%	93%	94%	93%
Coventry & Warwickshire OOH	94%	94%	91%	89%	86%	97%	94%	91%	92%	96%	92%	99%
North East Essex OOH	NS	NS	86%	83%	89%	89%	92%	NS	97%	NS	92%	86%
South West London OOH	91%	94%	96%	89%	93%	NS	90%	85%	92%	88%	92%	96%
Surrey OOH	86%	86%	86%	92%	91%	85%	NS	88%	78%	78%	86%	89%
North West London OOH	91%	94%	89%	96%	93%	NS	90%	85%	92%	88%	92%	96%
Worcester OOH	95%	87%	89%	89%	86%	90%	92%	89%	89%	90%	88%	89%

Safeguarding referrals

Our OOH/CAS services use our safeguarding hub to raise concerns so that they may be referred on to the appropriate agency. Calls to the service flow through from the NHS 111 service, hence, the number of referrals needing to be made is far less than the NHS 111 service



Regulation and compliance

Our OOH and CAS services are registered with and inspected by the Care Quality Commission (CQC)

Following each inspection visit the service receives a rating: Outstanding, Good, Requires Improvement, or Inadequate. Inspection reports are published on the CQC website. Service ratings are published on the Practice Plus Group website and displayed at each of our services.

Our current CQC ratings by service

Service	Dates of inspection	CQC rating
Devon OOH /CAS	02 December 2025	Recently inspected – Awaiting feedback
SW London OOH/CAS	26 & 29 March 2026	Good
NW London OOH/CAS	7 December 2023	Good
Coventry and Warwickshire OOH	27 & 30 January 2020	Good
Worcestershire OOH	28-29 March 2018	Good
Surrey Heartlands OOH/CAS	5 October 2017	Good
North East Essex OOH	28 February 2017	Good Outstanding in Well-led

Recognition from CQC's most recent inspection reports

The service understood the needs of its population and tailored services in response to those needs. For example, the service engaged and worked closely with local community-based rapid response teams to optimise care and use resources effectively.

Coventry and Rugby (now merged with Warwickshire)

There were comprehensive systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service. The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Worcestershire OOH

People were involved in decisions about their care. People received fair and equal care and treatment. People were involved in planning their care and understood options around choosing to withdraw or not receive care

SW London OOH

The provider had a comprehensive business continuity plan in place for major incidents such as power failure or building damage, as well as those that may impact on staff such as a flu pandemic. The plan included emergency contact numbers for staff. The plan also addressed fluctuations in demand for the service and staff shortages.

Surrey Heartlands OOH

There was good collaborative working between the provider and health and social care agencies to help ensure patients' needs were met by the most appropriate agency. This meant that patients were given the best opportunity to experience 'joined up' health and social care. During our inspection we observed the prompt and smooth transfer of a patient to hospital.

North East Essex OOH

There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. The provider informed us they had plans in place to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as a Bank Holiday weekend.

NW London OOH

People were treated with kindness and compassion. Staff protected their privacy and dignity. They treated them as individuals and supported their preferences.

SW London OOH/CAS

The service was actively involved in quality improvement activity and made improvements through the use of completed audits. Audits were regularly carried out in a number of areas, for example infection prevention control (IPC), medicines management, safeguarding and clinical safety. In addition, a monthly audit was completed on 1% of all clinical contacts. This had achieved a positive impact on quality of care and outcomes for patients.

Worcestershire OOH

Patient and family feedback

We have a responsibility to ensure that anyone who makes a complaint, comment or gives a compliment receives the appropriate response

OOH and CAS services % of complaints received against case volume

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Devon OOH	0.09%	0.12%	0.07%	0.05%	0.06%	0.02%	0.05%	0.08%	0.04%	0.04%	0.06%	0.04%	0.07%
Coventry & Warwickshire OOH	0.01%	0.04%	0.11%	0.02%	0.00%	0.05%	0.07%	0.01%	0.03%	0.04%	0.03%	0.01%	0.02%
North East Essex OOH	0.04%	0.04%	0.09%	0.00%	0.13%	0.15%	0.05%	0.00%	0.07%	0.04%	0.04%	0.00%	0.03%
South West London OOH	0.00%	0.03%	0.00%	0.04%	0.00%	0.06%	0.02%	0.00%	0.06%	0.03%	0.04%	0.05%	0.01%
Surrey Heartlands OOH	0.04%	0.12%	0.00%	0.02%	0.02%	0.03%	0.05%	0.02%	0.03%	0.06%	0.00%	0.02%	0.02%
North West London OOH	0.04%	0.02%	0.00%	0.02%	0.04%	0.00%	0.00%	0.02%	0.05%	0.05%	0.00%	0.02%	0.01%
Worcester OOH	0.00%	0.02%	0.00%	0.09%	0.02%	0.00%	0.06%	0.05%	0.06%	0.02%	0.04%	0.00%	0.03%
Total	0.04%	0.08%	0.06%	0.05%	0.04%	0.05%	0.06%	0.04%	0.06%	0.05%	0.04%	0.03%	0.19%

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Devon CAS	0.03%	0.03%	0.02%	0.02%	0.02%	0.04%	0.02%	0.02%	0.01%	0.00%	0.02%	0.06%	0.02%
North West London CAS	0.00%	0.01%	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%
South West London CAS	0.03%	0.04%	0.01%	0.02%	0.03%	0.00%	0.05%	0.02%	0.01%	0.03%	0.01%	0.02%	0.02%
Suffolk and NE Essex CAS	0.03%	0.00%	0.02%	0.00%	0.10%	0.10%	0.07%	0.03%	0.12%	0.00%	0.04%	0.02%	0.04%
Surrey Heartlands CAS	0.00%	0.02%	0.03%	0.00%	0.00%	0.00%	0.00%	0.02%	0.06%	0.04%	0.00%	0.00%	0.02%
Total	0.02%	0.02%	0.02%	0.01%	0.03%	0.03%	0.03%	0.02%	0.04%	0.01%	0.01%	0.02%	0.02%

OOH service compliments

Patient wanted to compliment our clinician on how good he is at his job, made her feel very comfortable and at ease whilst going through the assessment, and would like this to be acknowledged/shared with the clinician.

Surrey Heartlands OOH

I found Dr Z very welcoming. His consultation was in depth and extremely empathetic and understanding, A very professional approach. I left doubting if (the pharmacy) would have notification of my medication submitted for my collection early Monday morning, I should have not worried it was there ready for collection. I would be grateful if you could pass this feedback onto Dr Z and thank him.

Surrey Heartlands OOH

I wanted to take a moment to provide feedback regarding the out-of-hours doctor who saw me over the weekend. Although I unfortunately didn't catch his name, I recall that he was from Jordan.

He was extremely kind, attentive, and professional throughout my visit. He went above and beyond to ensure I received the care I needed, taking extra time to explain my condition and thoroughly addressing all my concerns. His compassionate approach made a significant difference, and I truly appreciate the care he provided during what was a stressful time for me.

Devon OOH

My overall experience was very good. Amazing. I rang and immediately rung back by Dr. and offered an apt at the hospital within the hour! Incredible.

Worcestershire OOH

The patient's mother said she was very impressed in the whole experience that she received from our service. She was more than happy with the way the doctor conducted his examination, diagnosis and how he interacted to make the patient feel comfortable and informed at every stage.

North East Essex OOH

Patient was triaged and then had a home visit - every one I spoke to was very well mannered and everyone knew their job and was very caring, I would like to thank everyone for their help please say a big thanks to everyone who helped me that day. Everyone I spoke to the experience was great.

Coventry and Warwickshire OOH

Excellent experience with the GP. Created a rapport, listened to my information, asked questions to confirm her thoughts, then proposed the appropriate treatment, which has worked. To be honest, better experience than what I'd had at most recent appointment with my own GP two weeks previously.

Worcestershire OOH



Health centres and Practice Assist

Health centres

Brighton Station Health Centre and The Junction Health Centre provide comprehensive NHS GP services from locations intended to be easily accessible for registered populations (The Junction) and walk-in consultations (Brighton Station).

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a tool utilised to monitor the quality of care and disease prevalence in primary care. The NHS QOF indicators assess the achievement rates against 76 indicators for the 2025–2026 year. These indicators are vital in tracking the quality of care and disease prevalence.

The QOF contains three domains:

- Clinical
- Public health
- Public health - Additional services
- Public health - Vaccination and immunisation
- Quality improvement

Brighton has approximately 9,000 registered patients within the health centre. In addition, the walk-in centre has the provision to undertake 37,000 walk-in consultations per year, approximately 15% of these are for sexual health services. The practice has a patient demographic where approximately 85% of patients are aged between 20 and 49 years. Less than 8.5% are aged between 50 and 89 years of age. Approximately 6.5% of the patient population is under 18.

The Junction service delivers Alternative Provider Medical Services (APMS) to a patient population of about 8,300 and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice has greater number of working age patients compared to local and national averages and lower numbers of children and older people compared to local and national averages.

Both practices serve a younger demographic than a traditional GP practice. This is reflected in the public health domain: vaccination and immunisation, where there are fewer children registered and so fewer opportunities to undertake vaccinations. This is especially true of the Brighton service that has historically provided walk-in appointments in a greater number than appointments for a registered population. Similarly, there are high prevalence's of asthma and diabetes, conditions that tend to be conditions initially identified in a younger population.

QOF achievements 2025–2026

Quality and Outcomes Framework (QOF) Performance

This year's QOF results demonstrate strong performance across our primary care sites, with Brighton Station achieving 93% and The Junction achieving 88%. These outcomes are highly commendable, particularly given the markedly different populations each practice serves and the distinct operational challenges associated with their respective demographics.

The Junction's performance reflects sustained delivery of high quality, evidence based care within a population that presents with a broad range of clinical needs. The practice has continued to maintain robust systems for long term condition management, proactive patient recall and effective use of digital tools to support monitoring and follow up. Brighton Station's achievement is equally noteworthy. Serving a population with higher levels of deprivation, increased complexity and greater barriers to accessing healthcare, the practice has demonstrated significant commitment to improving health outcomes and reducing inequalities. The 88% QOF score reflects strong clinical leadership, targeted outreach and effective engagement strategies tailored to the needs of its community.

Together, these results highlight the dedication of both teams and their ability to deliver consistent, high quality care across diverse settings. The performance also reinforces the effectiveness of shared learning, collaborative working and continuous improvement across the network.

Clinical domain	Brighton	The Junction	Maximum available
Atrial Fibrillation	24	22.71	24
Asthma	35	35	35
Cholesterol	82	82	82
Secondary prevention of coronary heart disease	53.27	53.53	54
Chronic Obstructive Pulmonary Disease	9	9	9
Dementia (DEM)	14	14	14
Diabetes mellitus	77.37	71.1	78
Heart Failure	25	24.81	25
Hypertension	52	51.92	52
Mental Health	28	28	28
Non-diabetic hyperglycemia	18	18	18
Stroke and transient ischemic	18	18	18
	435.64	428.06	437
PUBLIC HEALTH DOMAIN			
Public health domain: All contracts	51.33	47.95	52
Public health domain: Additional services sub domain	11	10.88	11
Public health domain: Vaccination and Immunisations	29.22	10	64
	91.55	68.83	127
TOTAL	527.19	496.89	564
Total QOF Points	564	564	
% of total QOF points	93%	88%	

Regulation and compliance

Our health centres are registered with and inspected by the Care Quality Commission (CQC)

Following each inspection visit the service receives a rating:

- Outstanding
- Good
- Requires Improvement
- Inadequate

Inspection reports are published on the CQC website.

Service ratings are published on the Practice Plus Group website and displayed at each of our services.

Service	Dates of inspection	CQC rating
Brighton Station	5 and 13 June 2019	Good
The Junction	1 December 2021	Good



Recognition from recent CQC inspection reports

Safeguarding algorithms were built into the symptom checker and direct booking criteria had been built into the system for certain types of patients. These included patients at the end of life, patients with learning disabilities, young children, patients with complex care plans, those requesting a home visit and those with a history of suicide attempt or self-harm.

Brighton Station

The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.

The Junction

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. All patients with a learning disability were offered an annual health check. End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The Junction

The practice had a range of policies and operating protocols in place for patients accessing the online services. This included the use of secure log-ins and appropriate security measures to safeguard information.

Brighton Station

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Brighton Station

The practice provided care in a way that kept patients safe and protected them from avoidable harm. Patients received effective care and treatment that met their needs. Policies and procedures were monitored, reviewed and updated. Staff dealt with patients with kindness and respect and involved them in decisions about their care. The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic. Patients could access care and treatment in a timely way.

The Junction



Brighton Health Centre

Brighton Health Centre provides a comprehensive NHS GP service and uniquely, also a service for walk-in patients not registered with the practice

The services are designed to serve all people within the local community, welcoming all ages and medical conditions.

Brighton Health Centre case volumes April 2025 to March 2026

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Seen By GP	722	724	681	746	586	540	612	604	561	639	504	602
Seen by PCP	811	882	1,020	1,034	903	1,004	1,303	874	921	1,098	1,003	1,099
Home Visits	0	1	0	1	0	1	1	1	1	1	1	3
Telephone Appts	653	794	800	985	795	754	916	867	817	851	903	968
Total Appts	2186	2401	2501	2766	2284	2299	2832	2346	2300	2589	2411	2672
Walk-in clinic	2001	1986	1793	2044	1869	1825	2161	1940	1754	1789	1736	1825
Total WIC	2001	1986	1793	2044	1869	1825	2161	1940	1754	1789	1736	1825
Total	4187	4387	4294	4810	4153	4124	4993	4286	4054	4378	4147	4497

The Junction Health Centre

The Junction delivers Alternative Provider Medical Services (APMS) to a patient population of approximately 8,300

The practice is part of a wider network of GP practices, including the Wandsworth Primary Care Network (PCN) and Battersea GP federation. The practice has greater number of working age patients compared to local and national averages and lower numbers of children and older people compared to local and national averages.

Information published by public health England shows that deprivation within the practice population group is in the sixth highest decile (six of 10). The lower the decile, the more deprived the practice population is relative to others.

The Junction Health Centre case volumes April 2025 to March 2026

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Seen by GP	461	537	551	558	454	547	567	505	478	521	500	566
Seen by PCP	1,047	1,020	971	1,159	902	835	1,293	970	1,008	899	1,457	1,055
Home visits	0	0	0	0	0	0	1	0	1	0	0	1
Telephone appointments	920	1,112	953	1,062	726	906	928	848	825	890	750	860
Total Appts	2428	2669	2475	2779	2082	2288	2789	2323	2312	2310	2707	2482

Health centres audit schedule April 2025 to March 2026

Our health centre audit schedules are essential for ensuring consistent quality of care, enhancing patient safety, supporting clinical accountability and driving continuous service improvement in line with government and regulatory requirements.

Audit schedule April 2025 to March 2026 - practices

Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Audit topic												
Documentation (GP) audit												
Documentation (Nurse) audit												
PC - CAS Alert Monthly Audit												
PC - Safeguarding Compliance Audit												
PC - Risk Assessments Review Audit												
PC - Medicine Management - Responsibilities & Prescribing												
PC - Meds Management - Controlled Drugs												
PC - Medicines Management - Stock Control												
PC - Medicine Management - Admin, Error and Incidents												
PC - Emergency Scenario Audit												
PC - PCR's 121 & HR records audit												
PC - IPC Observation Audit												
PC - Workplace Health & Safety Checklist (PPG-HC-HSE-25-F3)												
Information Governance and Security												

Practice Assist

The Practice Assist service offers community-based GP practices remote telephone and video consultation services for their registered patients

The service provides extra capacity whilst improving patient access, combining Practice Plus Group resources with those of the patient's registered GP to provide accessible and comprehensive healthcare. Registered patients have a same-day consultation, either by telephone or video with a Practice Plus Group GP. Practice Plus Group GPs have full read-and-write access to patient's notes held by the respective GP practice, so they can provide full continuity of care. Provides flexibility and control for the practice.

Practice Assist provides a full consultation with no follow-up required. The Practice Assist GPs are able to provide electronic prescriptions and onward referrals if needed. Where required, the Practice Plus Group GPs are able to turn a booked telephone consultation into a video call. If beneficial to the consultation, they can also receive photographs from the patient.

To ensure quality and safety we must apply the same benchmarks across all services through consistent practice and standardisation. Auditing to the same rigorous standards is key.

Audit Schedule April 2025 to March 2026 - Practice Assist

Audit month	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Audit topic												
Documentation (Clinician) audit												
PC - CAS Alert Monthly Audit												
PC - Safeguarding Compliance Audit												
PC - Risk Assessments Review Audit												
PC - Medicines Management - Responsibilities and Prescribing												
PC - Emergency Scenario Audit												
PC - PCR's 121 & HR records audit												
PC - Workplace Health & Safety Checklist									Start		Finish	
Information Governance and Security												

External recognition and Practice Plus excellence awards

HSJ Partnership Awards

We received recognition for our IUC Unscheduled Care Coordination Hub (UCCH) was shortlisted for its role in improving urgent and emergency care pathways. In addition, our Patient Engagement and Experience Initiative was Highly Recommended, signalling positive progress in how we involve patients and use their feedback to shape services.

UK National Call centre Awards

Further acknowledgement came when we received a Silver award for New Employee Experience and a Bronze award for our approach to Diversity, Equity, Inclusion and Belonging (DEIB). These awards reflect ongoing work to strengthen the staff experience and build a more inclusive culture, both of which remain central to delivering high quality care.

The Practice Plus Excellence Awards

Serve to honour the dedication, passion, and hard work of individual staff members and teams within the organisation. They foster a culture of appreciation, inspiration and motivation by showcasing exceptional efforts and achievements. Awards are given in categories that reflect excellence in areas such as patient care, leadership, teams work and specific functional contributions.

At a glittering ceremony in November at The Landmark London, our winners of the 2025 excellence awards were crowned. Winners were presented their trophies by members of the Executive Team and guest speaker, Jayde Adams. Colleagues from all corners of the organisation were able to connect and celebrate in true Practice Plus style.

Integrated Urgent Care (IUC) services won awards in the hotly contested categories of;

Healthcare support worker of the year: Surrey Heartlands out-of-hours service. Our colleague won for demonstrating exceptional care by identifying potential sepsis in a patient as well as looking after their baby until a family member arrived, easing their concerns in a stressful situation.

Unsung hero: Coventry and Rugby out-of-hours service. Our colleague won for delivering exceptional quality, mentoring colleagues and recently

supporting a colleague during a tough shift, while donating Disneyland tickets to make a family's dream holiday possible.

Allied health professional of the year: South West NHS 111 service. For developing the REAL forum, to support contact centre clinicians, reflecting on outcomes and ensuring all voices are heard and respected.

Special recognition award: To our service manager for North East Essex out-of-hours service. For being key to designing services such as the conveyance avoidance helpline, care coordination hubs, Covid antiviral services and winter resilience home visiting services.



Patient safety

Our Patient Safety and Incident Response Framework (PSIRF) policy supports the requirements of the framework

The PSIRF sets out Practice Plus Group's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Our policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

Compassionate engagement and involvement of those affected by patient safety incidents;

- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

Patient Safety Incident Response Plan (PSIRP)

Our Plan sets out how Practice Plus Group integrated urgent care services intend to respond to patient safety incidents over a twelve-month period. The plan is not a permanent rule that cannot be changed; it is expected that our patient safety priorities will evolve over time. We remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our investigations

We have introduced an additional category for investigation under the Patient Safety Incident Investigation (PSII) process, focusing on cases where a death has occurred in close proximity to contact with our services. This category has been established to ensure that we thoroughly review and understand any potential links between our interventions (or lack thereof) and the outcome. By investigating deaths that occur shortly after an individual engages with our services, we aim to identify whether there were missed opportunities for care, delays in response, or other contributing factors. This approach reflects our commitment to transparency, learning, and continual improvement in patient safety.

Patient safety

Patient safety priorities 2025-2026

Incidents where sepsis was not considered as part of the assessment / differential diagnosis when partial or all red flags have been missed.

Incidents relating to a delay in clinical call backs which has led to a patient receiving a delayed response resulting in actual harm.

Incidents where incorrect service selection (Via DoS/other) has resulted in actual harm.

Face to face assessment or telephone consultation which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.

Death of a patient with proximity to the service where harm can be attributed to care delivered by Practice Plus IUC.

Information Governance (IG) incidents where actions are contrary to Practice Plus Group policies on data protection and GDPR adherence.

Patient Safety Incident Investigations (PSII) April 2025 to March 2026

Service	IUC PSIRF themes
Suffolk and NE Essex NHS 111	Incidents where sepsis was not considered as part of the assessment/differential diagnosis when partial or all red flags have been missed.
Devon OOH	Death with proximity to the service where harm can be attributed to care delivered by PPG. Incidents relating to a delay in clinical call backs which has led to a patient receiving a delayed response resulting in actual harm. Face to face assessment or telephone consultation, which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.
Coventry & Warwickshire OOH	Death with proximity to the service where harm can be attributed to care delivered by PPG.
Worcester OOH	Death with proximity to the service where harm can be attributed to care delivered by PPG. Face to face assessment or telephone consultation, which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.
Devon OOH	Incidents where sepsis was not considered as part of the assessment/differential diagnosis when partial or all red flags have been missed.
North East Essex OOH	Incidents relating to a delay in clinical call backs which has led to a patient receiving a delayed response resulting in actual harm.
Surrey Heartlands OOH	Incidents where sepsis was not considered as part of the assessment/differential diagnosis when partial or all red flags have been missed.
Suffolk and NE Essex CAS	Incidents relating to a delay in clinical call backs which has led to a patient receiving a delayed response resulting in actual harm.
Surrey Heartlands OOH	Face to face assessment or telephone consultation, which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.
Suffolk and NE Essex NHS 111	Death with proximity to the service where harm can be attributed to care delivered by PPG.
Coventry & Warwickshire OOH	Face to face assessment or telephone consultation, which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.
Suffolk and NE Essex CAS	Incidents relating to a delay in clinical call backs which has led to a patient receiving a delayed response resulting in actual harm.
South West London CAS	Face to face assessment or telephone consultation, which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.
Devon CAS	Face to face assessment or telephone consultation, which resulted in an incorrect decision not to refer patient to A&E or call ambulance resulting in actual harm.
Surrey 111	Incidents where sepsis was not considered as part of the assessment/differential diagnosis when partial or all red flags have been missed.
South West 111 Call Centre	Incidents where sepsis was not considered as part of the assessment/differential diagnosis when partial or all red flags have been missed.

Shared learning

In addition to sharing learning from incidents, complaints and from audits, our bi-monthly publication 'Reflect' examines in detail some of the key cases that have arisen together with what we have learned and how we have adapted practice. Learning from cases managed during the year include:

66-year-old male with intermittent shortness of breath and dizziness

The GP Out of Hours received a case from NHS 111 for a 66-year-old man just before midnight on a mid-week evening. The case was sent through as a 2-hour contact disposition, meaning that the Pathways assessment had identified the need for a face-to-face review within 2 hours.

He had undergone a radical prostatectomy privately 6 weeks earlier for prostate cancer and was awaiting further drainage of a pelvic collection. He had been told by his surgeons to look out for possible signs of this collection becoming infected and he had called to rule this out. He had been well prior to his cancer diagnosis and had no significant medical background other than this. He presented with several days of feeling tired and intermittently short of breath. On the evening in question, he had also felt dizzy. He realised that he was likely dehydrated, having had very little to drink through the day. He had drunk several pints of water and his dizziness had resolved. He was feeling better at the time of the call. He had no fever, chest pain, palpitations, abdominal pain or ankle swelling. He was not audibly short of breath at the time of the call. He had no urinary symptoms. The patient proposed a plausible alternative diagnosis of a viral infection; a family member had been off work with similar symptoms. At the end of the telephone assessment the clinician suggested he speak to his own GP in the morning to arrange a face-to-face review and chest check. He was also advised he contact his surgeon to arrange a review. In the morning the patient called his own GP and was seen in their practice. He was diagnosed with a possible chest infection and started on clarithromycin.

After midnight on the same day, he became acutely short of breath at home and collapsed. His wife called for an ambulance and resuscitation was attempted. Sadly, this was unsuccessful and the patient died at home. Cause of death has been established as pulmonary embolus secondary to a deep vein thrombosis. The cause of death has been established as pulmonary embolus secondary to a deep vein thrombosis.

Reflections on Clinical Learning

There is a need for a high index of suspicion of pulmonary embolus for patients with a cancer diagnosis in the post operative period who present with episodes of shortness of breath, with or without ankle/calf swelling. Although this patient was 6 weeks into his post operative recovery and had been appropriately offered DVT prophylaxis, he had an ongoing pelvic collection which may have increased his clotting risk. It is important to emphasise that symptoms may initially be episodic so clinical vigilance is necessary.

Where pulmonary embolus cannot be ruled out after primary care assessment then patients should be referred urgently to an appropriate secondary care setting for review. In the majority of cases this means swift transfer to their local A&E department, where blood tests and a CTPA can be arranged urgently.

Shared learning

End-of-Life Visit Compassionate Care, Clinical Judgement, and System Learning

The OOH received a home visit request for an end-of-life patient requiring anticipatory medications. The case was dispatched promptly, and the GP arrived within two hours of the call.

The patient required subcutaneous morphine for symptom management. Morphine is not routinely carried in the visiting cars from this particular service, and must be sourced from on-call pharmacies. The GP contacted the coordinator for details on the pharmacy on-call, but the on-call pharmacist declined to provide the service. Further efforts were made to contact a local open pharmacy, but no response was received. The GP then personally travelled to a nearby open pharmacy, only to find that morphine ampoules for subcutaneous use were not stocked.

Recognising the clinical and emotional importance of the situation, the GP contacted the Your Life Line palliative care team. After speaking with the on-call palliative care nurse, it was agreed that the patient was currently stable, and Midazolam could be used as a temporary measure overnight. The nurse confirmed that if symptoms deteriorated, the palliative team could arrange a home visit and, if needed, liaise with paramedics for morphine access.

The GP returned to the family home to explain the plan of care to the patient's wife and son. Midazolam was administered, and the family were reassured. They were provided with an FP10 prescription for morphine, which could be collected from an open pharmacy the following day. Clear advice was given on how to contact Your Life Line 24/7 if the patient's condition worsened.

Clinical Reflection and Outcome

Despite several system challenges, the GP showed exceptional professionalism, persistence, and compassionate communication. The family expressed gratitude for the care and clarity provided. Importantly, the patient remained comfortable, and the family were left with clear guidance and access to support.

Following the incident, the Integrated Care Board (ICB) was contacted regarding the on-call pharmacy rota. As a result, the Pharmacy was removed from the rota to prevent similar issues in the future.

Key Learning Points

System gaps can be mitigated through effective escalation and teamwork. Clear, compassionate communication is vital in end-of-life scenarios. Clinician feedback can drive real-time service improvement.



More than just urgent care

Although our services are not intended for emergency care, our staff are trained and we have training and processes in place to manage the most serious of cases

From April 2025 to March 2026, we undertook Cardiopulmonary Resuscitation (CPR) over the telephone in our 111, OOH, CAS services and during home visits a total of 105 times.

Service	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Total
Devon 111	4	3	2	2	2	2	1	0	1	5	2	0	24
London 111	2	1	4	4	3	2	1	1	3	0	2	0	23
South West 111 Call Centre	1	6	3	4	0	2	4	3	1	2	2	1	29
SNEE 111	1	3	1	0	3	1	4	2	3	2	2	0	22
SWL Out of Hours	1	0	0	0	0	0	0	0	0	0	0	0	1
Surrey 111	0	0	0	3	0	0	1	1	3	2	0	0	10
Stockton 111 (site only)	0	0	0	0	0	0	1	0	0	0	0	0	1
Total	9	13	10	13	8	7	12	7	11	11	8	1	110

Information governance

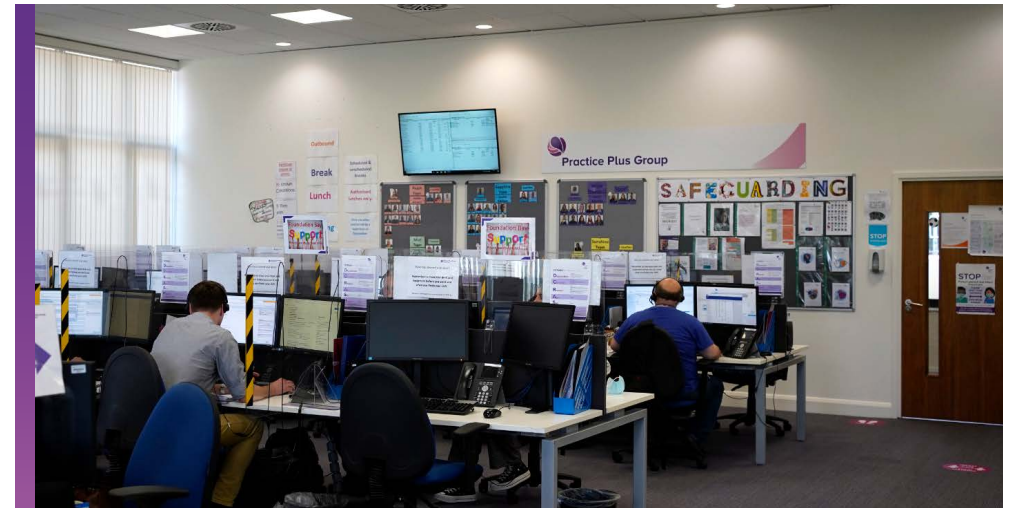
Practice Plus Group recognises the importance of reliable information, both in terms of the clinical management of services and resources

Information governance plays a key part in supporting clinical governance, service planning and performance management. It also gives assurance to Practice Plus Group and to individuals that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

An assessment of compliance with requirements, within the Data Security and Protection Toolkit (DSPT), is undertaken each year. Annual reports and proposed action/ development plans are developed by the information security manager and presented to Practice Plus Group's chief information officer (who is the senior information risk owner) for approval.

Requirements are grouped into the following initiatives:

- NHS code of practice: confidentiality
- General Data Protection Regulations (GDPR)
- Data protection act 2018
- Health records
- Information governance management
- Information quality assurance
- Information security / ISO27001
- Data security and protection toolkit
- Information security and technical audit programme
- Continuous Service Improvement Plan (CSIP log)
- NHS digital



Scrutiny by external auditors and regulators are a key component of the assurance framework. These include:

- Care Quality Commission (CQC) (under the terms of the health and social care act).
- Local authorities (environmental health, food hygiene).
- British standards institute (as part of Practice Plus Group's ISO 27001/20000 certification).
- Cyber essentials plus certification (UK Govt. supplier requirement).
- Health and social care/ legal regulators (DoH, NHS England, ICO).
- Service commissioners (NHS England, clinical commissioning groups, local authorities).

Practice Plus Group's 2025 annual Data Security and Protection (DSP) toolkit submission achieved 100% standards exceeded.

We also obtained our cyber essentials plus certification recertification in July 2025, demonstrating our high standards in cyber security posture.

Practice Plus Group also holds the BSI ISO 27001:2022 certification and completed the migration from ISO 27001:2013 to ISO 27001:2022 standards and are scheduled to undertake the recertification audit to the new standard at the end of August 2025.

Caldicott guardian

A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly

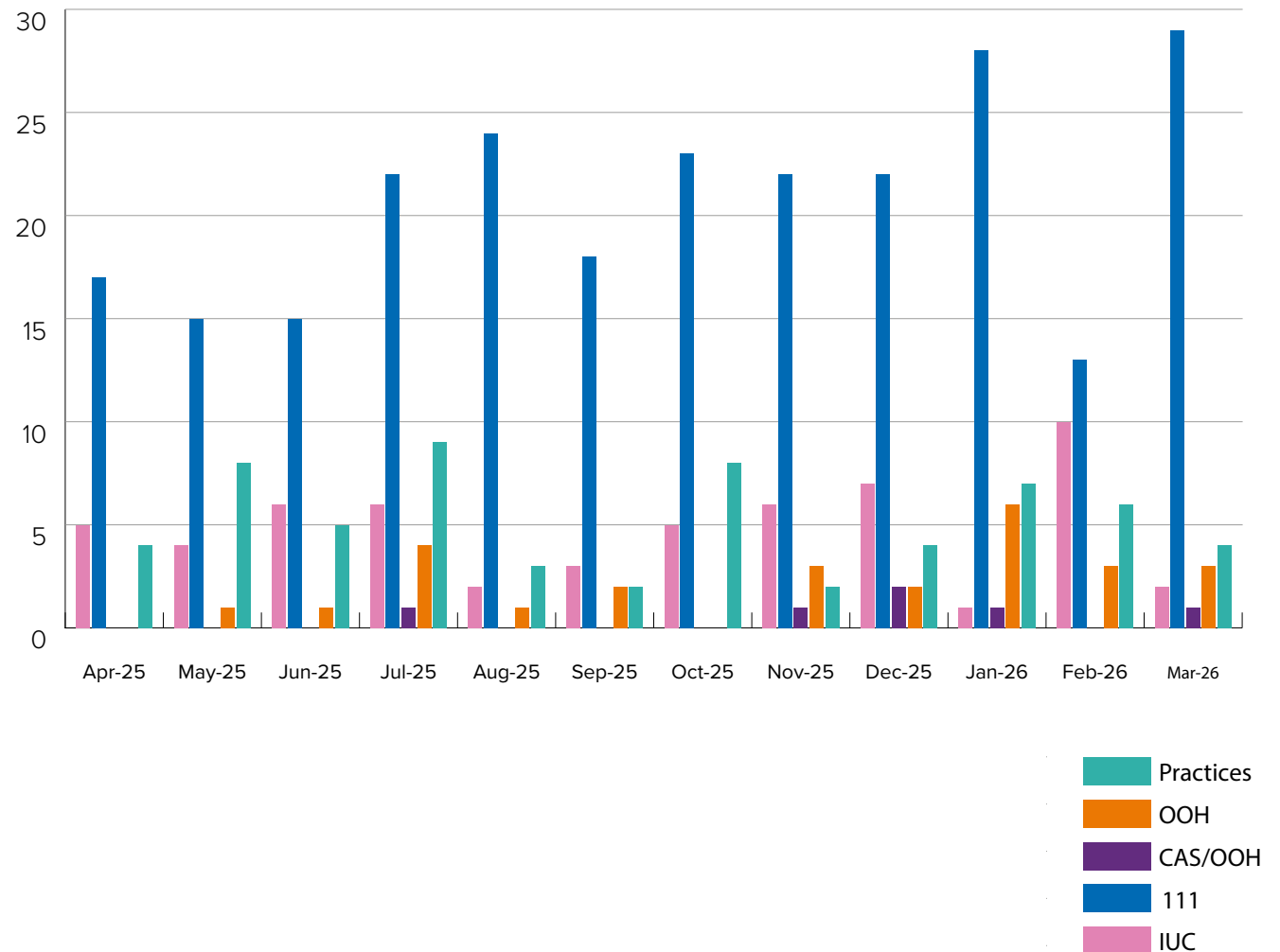
The Caldicott Guardian responsibilities for Integrated Urgent Care (IUC) services are held by the medical director for primary care. Our Caldicott Guardian attends annual refresher training and chairs Practice Plus Group's information governance committee.

Healthcare information requests

We have detailed policies that cover how we process requests for information. This includes requests by (living) individuals under the General Data Protection Regulation (GDPR) for access to the data we hold about them. These are known as Subject Access Requests (SAR).

It also includes the process for managing records requests in relation to deceased individuals, which are covered by the access to health records act 1990, and requests for information made by third parties, including the police, solicitors, coroners, courts and others. The number of requests received during the period is illustrated.

Subject access requests submitted
April 2025 to March 2026



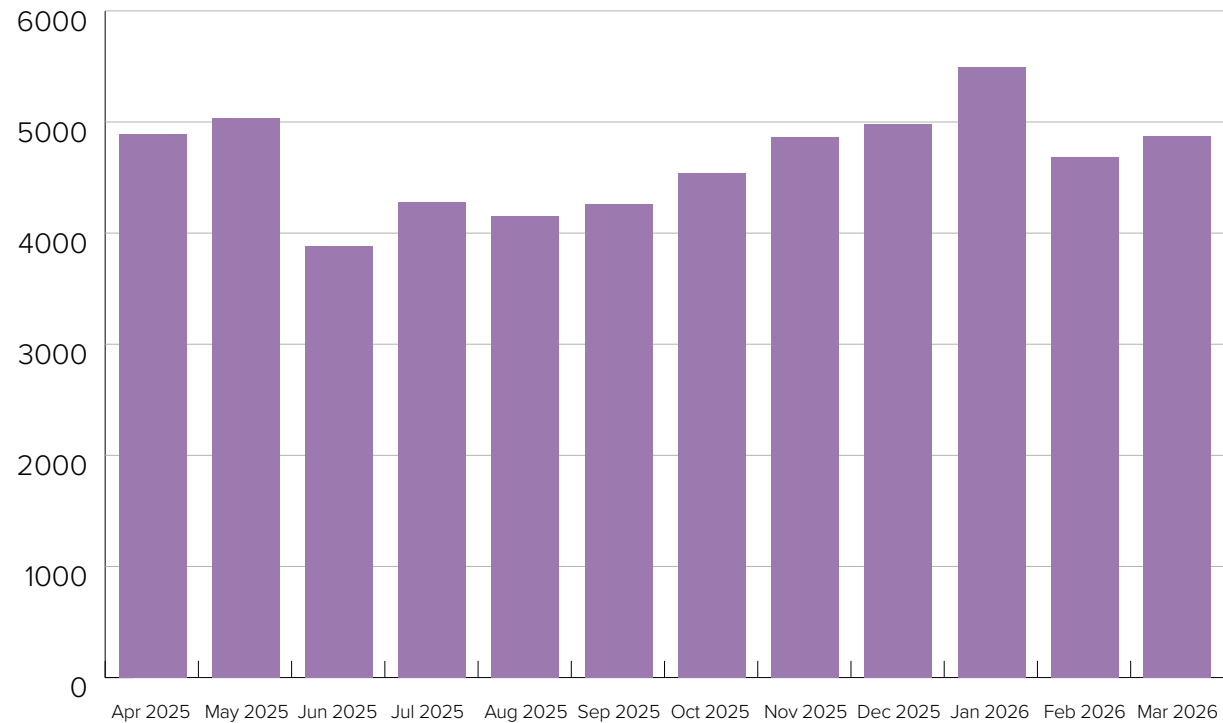
National Homeworking Clinician (NHCW) team

The National Homeworking Clinician (NHCW) team consists of GPs, advanced nurse practitioners, paramedics and pharmacists

They work remotely and provide additional clinical resource across Practice Plus Group's clinical assessment and out-of-hours services.

The initial concept identified a growing appetite for remote working combined with challenges in recruiting to local services. A national team provides opportunity to recruit clinicians from outside local areas. In contrast to our IUC services, the NHCW Team is a majority ANP/ACP workforce.

Hours delivered



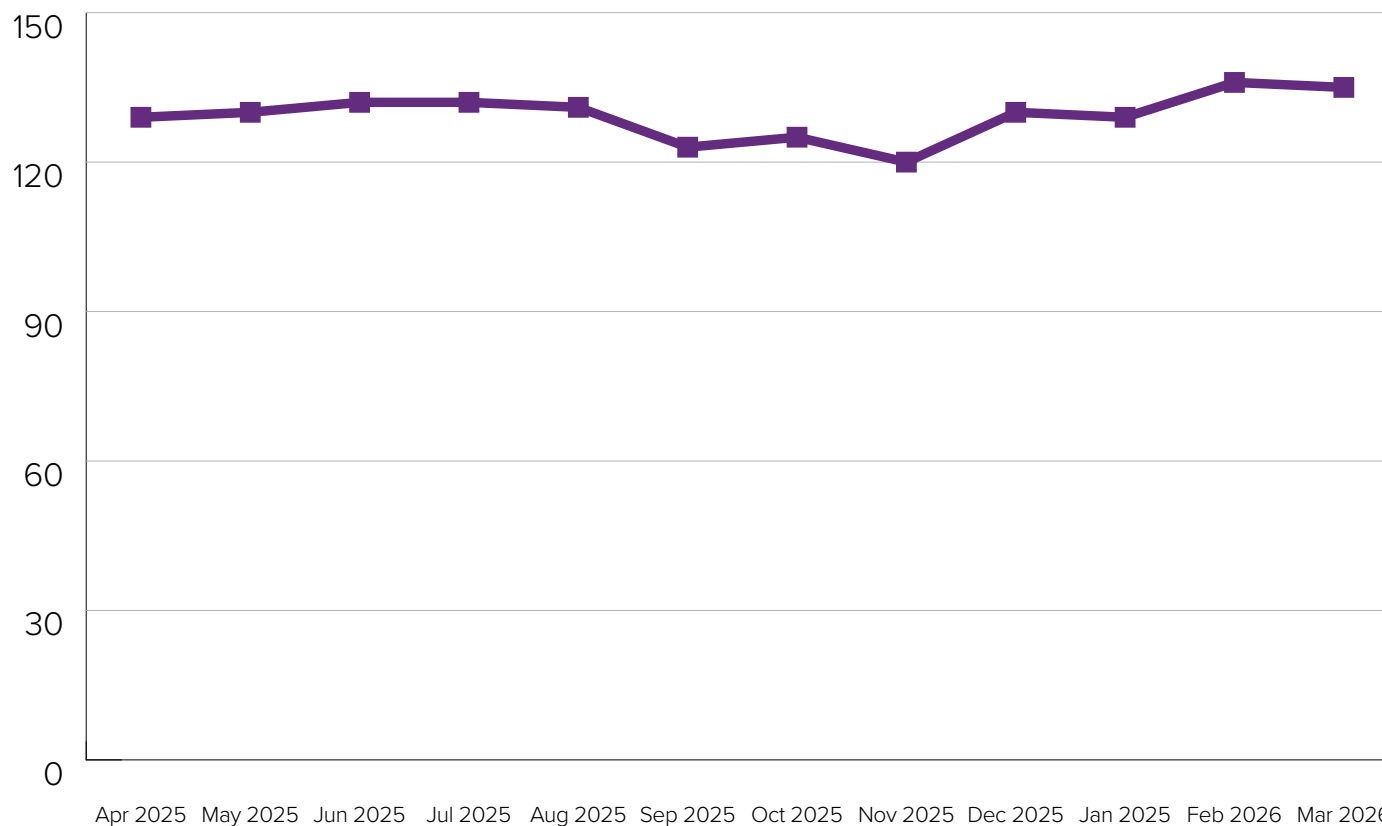
National Homeworking Clinician (NHCW) team

Building a team working alongside call centre and office-based colleagues has made it possible to hire the best candidates, regardless of where they live

However, like many effective recruitment strategies, it is not immune to challenges, especially when it comes to assuring patient safety and clinician competency.

The NHCW team complies with all of our patient safety assurance standards. Clinicians undergo the same rigorous checks upon recruitment and access the same training and support as similarly recruited colleagues working in our location-based services. In order to get the best from the best candidates, we have stabilised our team at between 120 and 140 clinicians, ensuring they work consistently enabling us to appropriately monitor their performance. In common with our other OOH services, each clinician had one percent of their cases audited each month, with an average audit score of 91.8%.

Number of clinicians



Emergency Preparedness, Resilience and response (EPRR)

EPRR is a framework used by the NHS and other government bodies in the UK to plan for, withstand, and recover from emergencies like infectious disease outbreaks or major accidents

It involves a cycle of risk assessment, planning, training, exercising, and responding to incidents, all while ensuring the maintenance and swift restoration of essential services, as mandated by the civil contingencies Act (2004)

This year our assurance programme delivered:

EPRR national rolling power outage exercise.

Scenario focused on the threat of a level three national rolling power outage (ESEC). Strategic and Tactical representatives worked to determine response measures needed to ensure we can continue to provide a service during an NPO event. This exercise will form the basis of a NPO plan going forward.

No-notice communications cascade exercise - to validate the responsiveness and efficiency of our on-call systems. This consists of a cascade from EPRR to operational delivery team, up to tactical and then to strategic, and back down to EPRR. It is a requirement under core standards to have this exercise completed every six months (alternating between in hours and OOH).

Our assurance planning for the next 12 months includes:

- EPRR core standards assurance submission.
- Exercise pegasus - UK government planned exercise to cover a pandemic scenario. Taking place over three months beginning mid-September 2025. All regions within England will be participating, coordinated by EPRR.

Our EPRR work programme includes:

- Review of EPRR plans, procedures and policies to ensure they align with best practice.
- Introduction of new resources for on-call and dedicated teams channels for incident management and response.
- Review of our business continuity management system to align to ISO22301 and business continuity institute good practice guidelines.
 - Rolling out new procedures and templates for business impact analysis and business continuity plans for all IUC services.
 - Introducing new on-call policy and revised governance arrangements.
 - Undertaking a live no-notice exercise undertaken to test cross-service resilience.
 - Co-chairing for NHSE SE region EPRR EDI group to introduce and improve EDI considerations in EPRR planning.
 - Working with ICBs on NPO, infrastructure risk, industrial action and other plans.

Conclusion

This Integrated Urgent Care (IUC) Quality Account reflects our continued commitment to delivering high-quality, safe, and patient-centred urgent care services across our communities

Over the past year, our services have continued to operate within a challenging health and care landscape, marked by sustained increases in demand, workforce pressures and the growing complexity of patient needs. Despite these system wide challenges, our teams have remained committed to delivering timely, safe and effective urgent care. Their dedication has ensured that patients continue to receive high quality advice, assessment and treatment, supported by strong clinical governance and a culture that prioritises learning and improvement.

Collaboration across the urgent care system has been central to our progress. Working closely with NHS 111, GP out of hours providers, ambulance services, urgent treatment centres, mental health partners and community teams, we have contributed to a more integrated and responsive pathway for patients. Enhancements such as the expansion of Clinical Assessment Services (CAS), improvements in digital triage and strengthened workforce support have enabled us to improve clinical outcomes while enhancing the experience of both patients and staff.

This year has also seen notable external recognition of our work. Commissioners, system partners and regulatory bodies have acknowledged the professionalism of our teams, the reliability of our service model and our commitment to continuous improvement. Positive feedback from partners—including ambulance services, primary care colleagues and community

providers—has highlighted the strength of our collaborative approach, the quality of our clinical leadership and the value we bring to the wider urgent care system. The successful retention of key contracts, alongside opportunities to expand our service offer, further reflects the confidence placed in us to deliver high quality, patient centred care.

We continue to recognise the essential role of patient and public feedback in shaping service development. Understanding the experiences of those who use Integrated Urgent Care (IUC) enables us to identify what is working well and where further improvement is needed. Over the past year, we have strengthened our mechanisms for capturing patient voice—through surveys, complaints, compliments and engagement activities—and have used this insight to inform decision making at both operational and strategic levels. Equally, the skill, compassion and professionalism of our multidisciplinary workforce remain fundamental to the delivery of safe and effective care.

We are proud of the collaborative culture that underpins our service, and we remain committed to strengthening it further. Continued investment in training, wellbeing and leadership will support our teams to thrive. By working in close partnership with NHS organisations, local authorities, voluntary sector partners and Integrated Care Systems, we will continue to deliver urgent care that is integrated, responsive and person centred.

Looking ahead, we recognise that quality improvement is an ongoing journey. We will continue to deepen our engagement with patients and communities, advance our digital capabilities and develop our workforce to meet the evolving needs of urgent care. Our priorities will remain aligned with national expectations, ICS objectives and the needs of the populations we serve, ensuring our services remain accessible, equitable and effective.

In closing, we extend our sincere thanks to our staff, partners and patients for their continued contribution to the delivery and improvement of integrated urgent care. Together, we will continue to learn, adapt and strive for excellence in all aspects of our work.