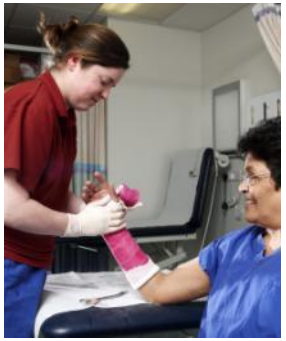
Improving Patient Safety in Primary Care Medical Services

A Themed Report by the Nursing Directorate, Quality and

Safety Team for Berks East CCG

NHS England South
(South Central)

May/June 2016



Objectives- to provide an overview…..

- What the Quality and Safety Team have been doing and how we have been working with the CCG's to help drive improvements in quality and patient safety

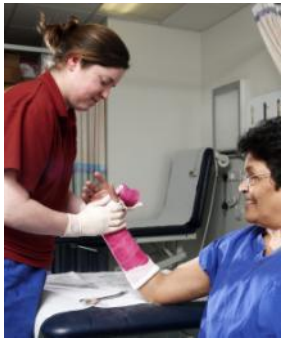
What have we been doing?

- Reflecting on **patient safety culture** within General Practice
- **PPG focus groups** on patient safety
- Working with HETV to deliver **human factors** and quality improvement training for **admin and support** staff
- Provided eight **significant event audit (SEA)** masterclasses across South Central
- Pilot practices with the **NRLS GP e-form**

Working with CCG Colleagues to:

- increase **national** and **local** **incident** **reporting**
- respond to **CQC inspections** and **support** practices with an inadequate rating
- **share** the **learning** from CQC and SEA's across South Central
- implement the **vulnerable practice** support programme

Patient safety culture



Patient Safety Culture

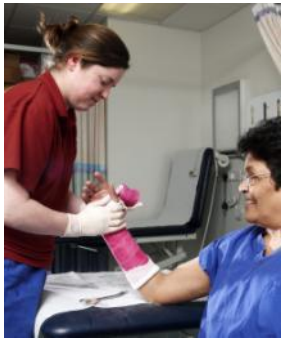
- Five practices in Thames Valley participated in MAPSAF workshops 2014-2015:
    - Main areas of improvement identified were how SEA meetings were held and who was involved, reviewing for trends and themes, communicating and sharing learning. (These areas are mirrored in the CQC inspections)
    - Admin and support staff didn't always understand their role in patient safety
    - NHS England South Central have simplified the framework tool for use within practices

What is a JUST Culture?

- If you make an **error**, you are cared for and supported
- If you behave in a **risky** manner by not adhering to policies, you are asked why first before being judged
- If you **recklessly** and intentionally put your patients or yourself at risk, you are accountable for your actions

- **Find out more www.signuptosafety.nhs.uk**

PPG Focus Group

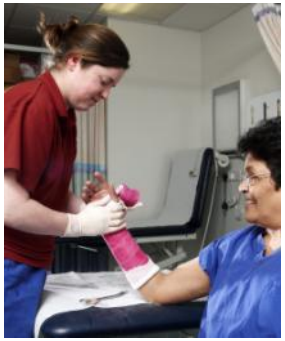


Patient Focus Groups- what does a ‘safe’ practice look and feel like……

You said, we did....

- Training for admin and support staff
- Improving standards of SEA to enable learning, and sharing
- Encouraging responses to patient feedback and FFT
- Encouraging patient involvement in investigations and awareness of Duty of Candour
- Encourage practices to keep patients up to date with their improvements by posting on their website
- Attention to infection control audits, risk assessments, cleaning schedules

Identifying and delivering training



Human Factors Training Sept 2016

- As a result of the work in General Practice a training need has been identified for admin and support staff to understand and enhance their role in patient safety

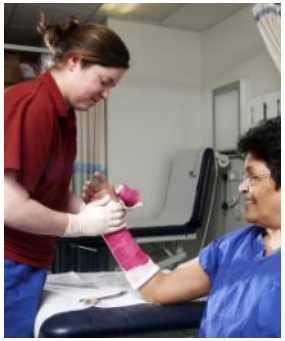
- NHS England South Central is working with the Academic Health Science Network's Oxford Patient Safety Academy and HETV to deliver free training in September 2016

- Human factors is a broad discipline which studies the relationship between human behaviour, system design and safety

Significant Event Masterclass

- 8 Significant event analysis masterclasses held across South Central 2015/16
- 150 staff including admin, practice managers and clinical staff attended 1 day training
- 40 accreditation qualifications available
- Feedback has been very positive
- ‘Sharing SEA’ masterclass due November 2016

A promise to learn- Donald Berwick



Safe in the NHS?
A promise to learn……

NHS England

Avoidable harm in primary care?

Encourage incident reporting

Incident Reporting Survey Autumn 2015 (total respondents 83)

Barriers for reporting

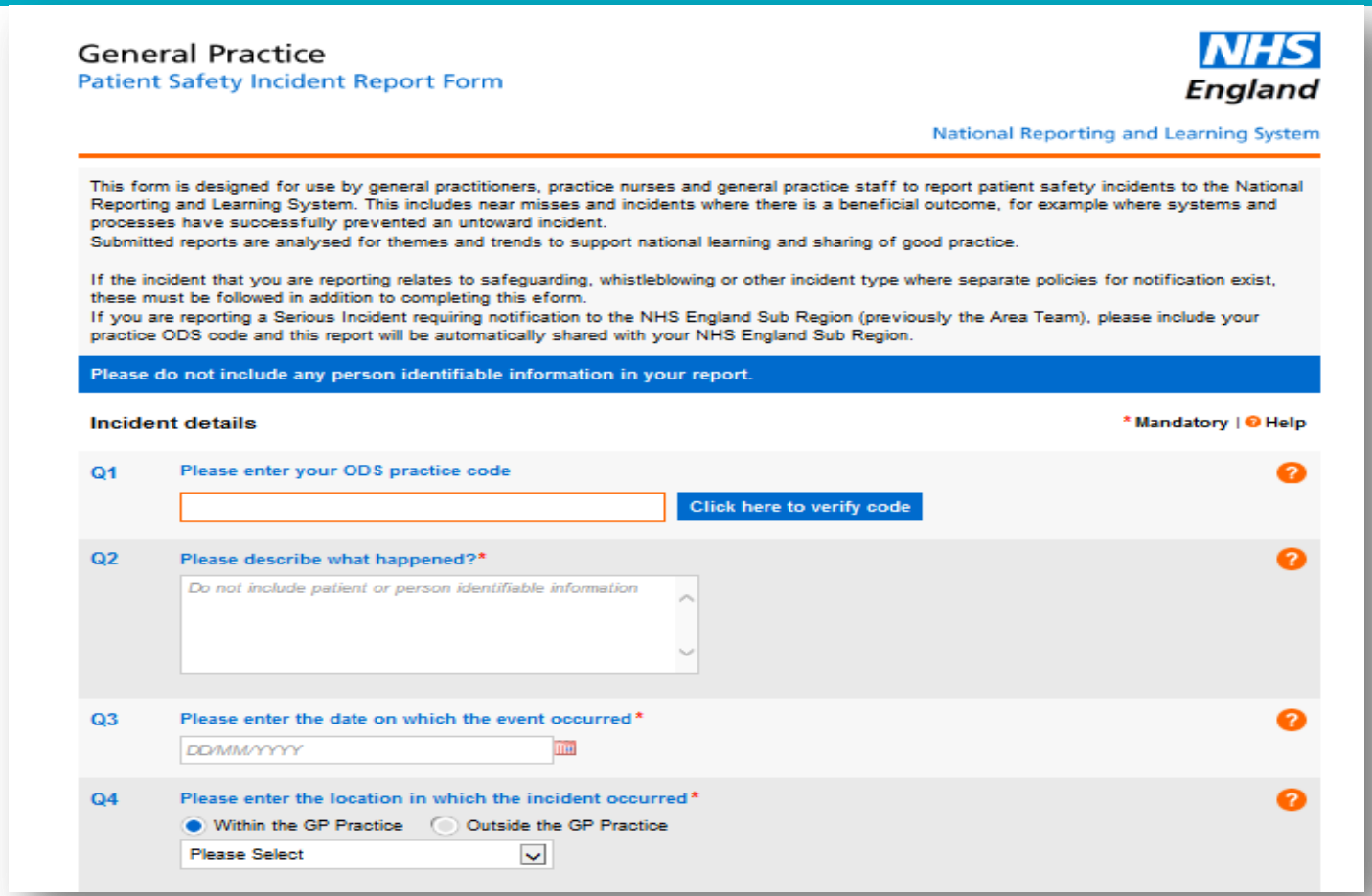
- Nearly 20% feared blame
- 61% said that they lacked time to report
- 6% suggesting it was a waste of time
- 28% felt the process was too complicated.

Incident Reporting Survey Autumn 2015

- Reporters want ‘feedback’ to engage with reporting externally
- Very few practices had reported nationally
- Still fears about what happens with the information
- Need clarity on what types of incidents to report
- Don’t want to duplicate reporting
- System needs to be quick and simple

New GP eform – a reporting tool specifically designed for general practice

https://report.nrls.nhs.uk/GP_eForm



General Practice
Patient Safety Incident Report Form

NHS England
National Reporting and Learning System

This form is designed for use by general practitioners, practice nurses and general practice staff to report patient safety incidents to the National Reporting and Learning System. This includes near misses and incidents where there is a beneficial outcome, for example where systems and processes have successfully prevented an untoward incident.
Submitted reports are analysed for themes and trends to support national learning and sharing of good practice.

If the incident that you are reporting relates to safeguarding, whistleblowing or other incident type where separate policies for notification exist, these must be followed in addition to completing this eform.
If you are reporting a Serious Incident requiring notification to the NHS England Sub Region (previously the Area Team), please include your practice ODS code and this report will be automatically shared with your NHS England Sub Region.

Please do not include any person identifiable information in your report.

Incident details

* Mandatory | Help

Q1 Please enter your ODS practice code

Click here to verify code

Q2 Please describe what happened?*

Do not include patient or person identifiable information

Q3 Please enter the date on which the event occurred*

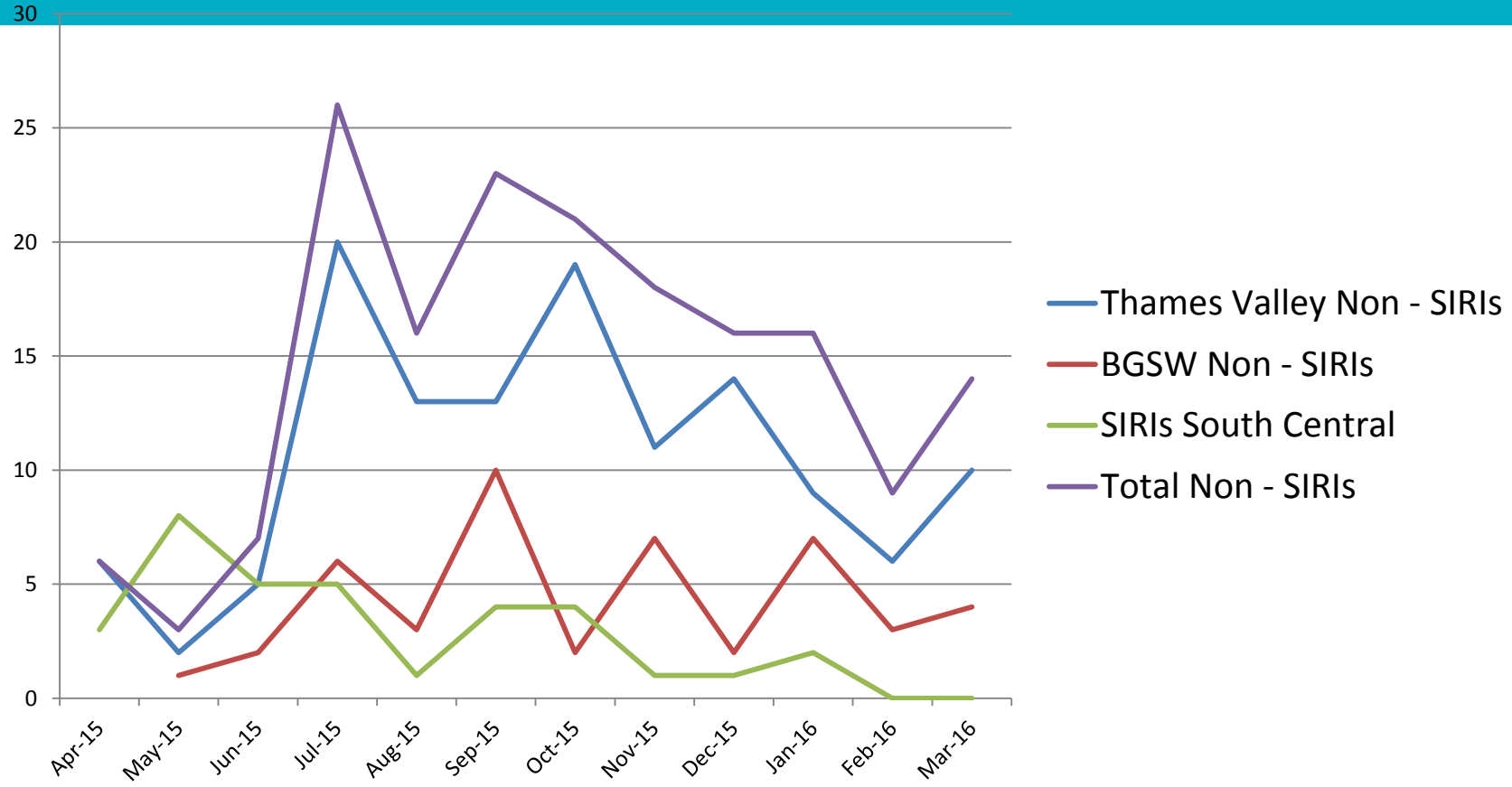
DD/MM/YYYY

Q4 Please enter the location in which the incident occurred*

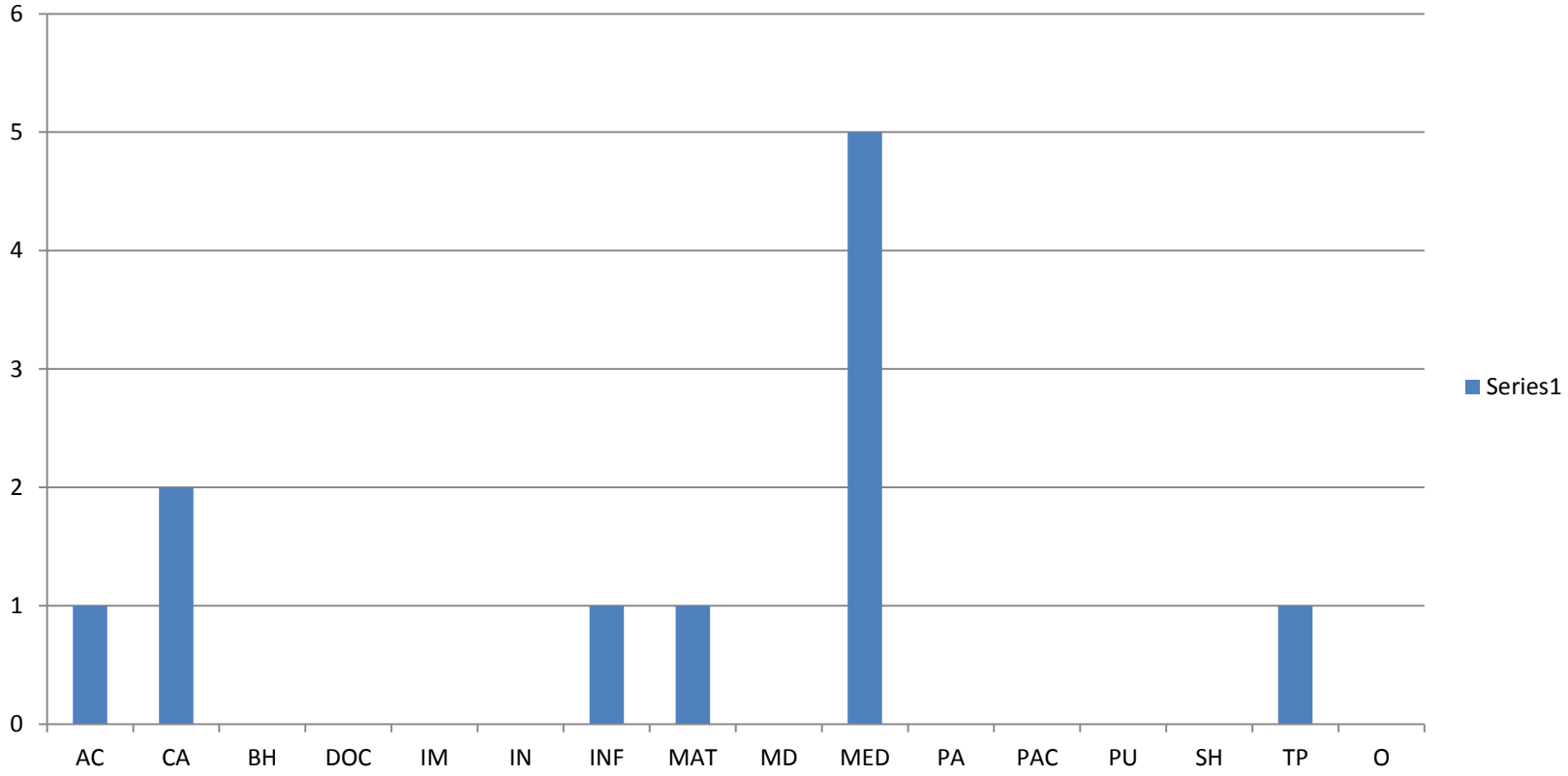
Within the GP Practice Outside the GP Practice

Please Select

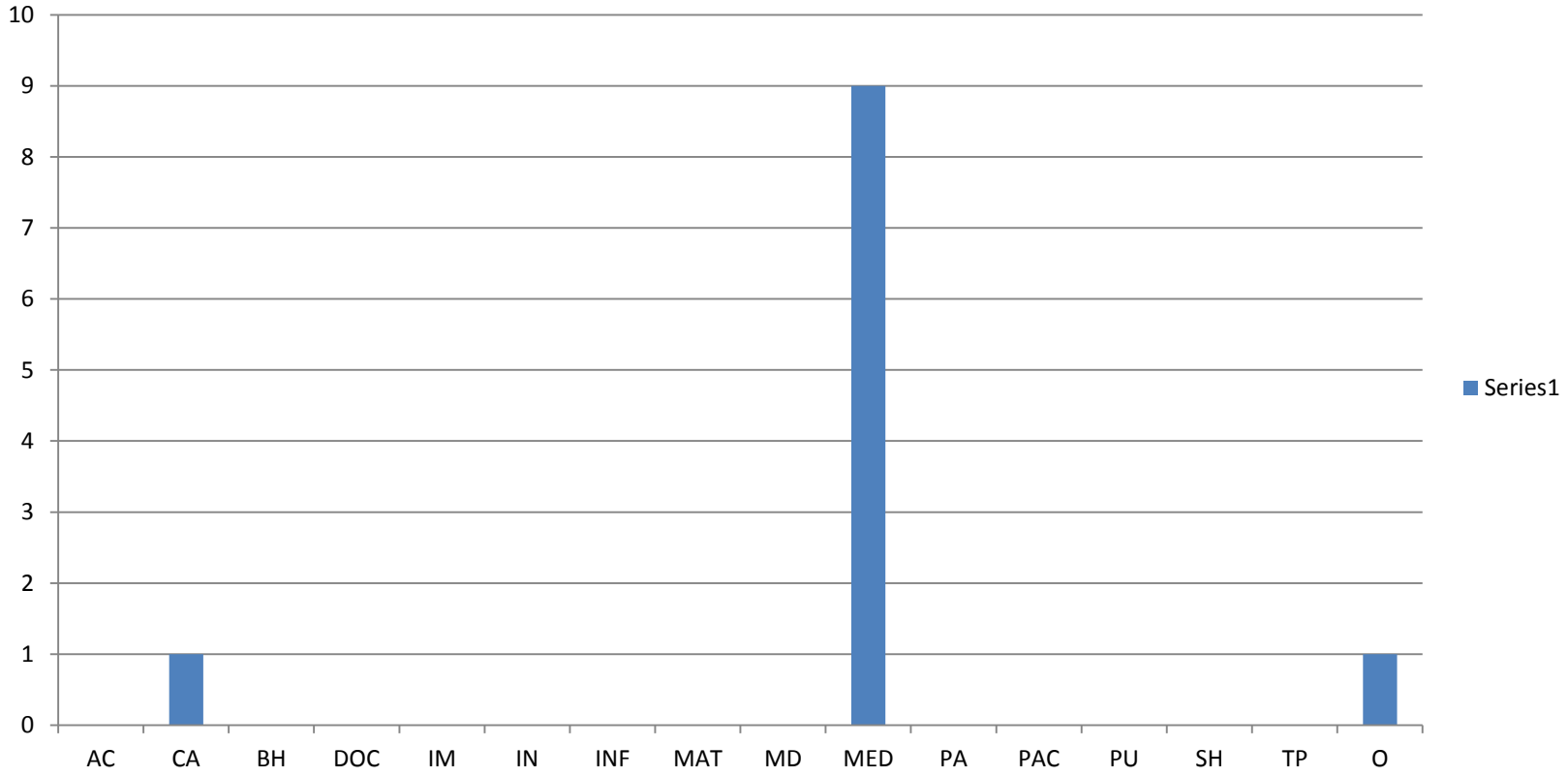
Reported Patient Safety Incidents South Central



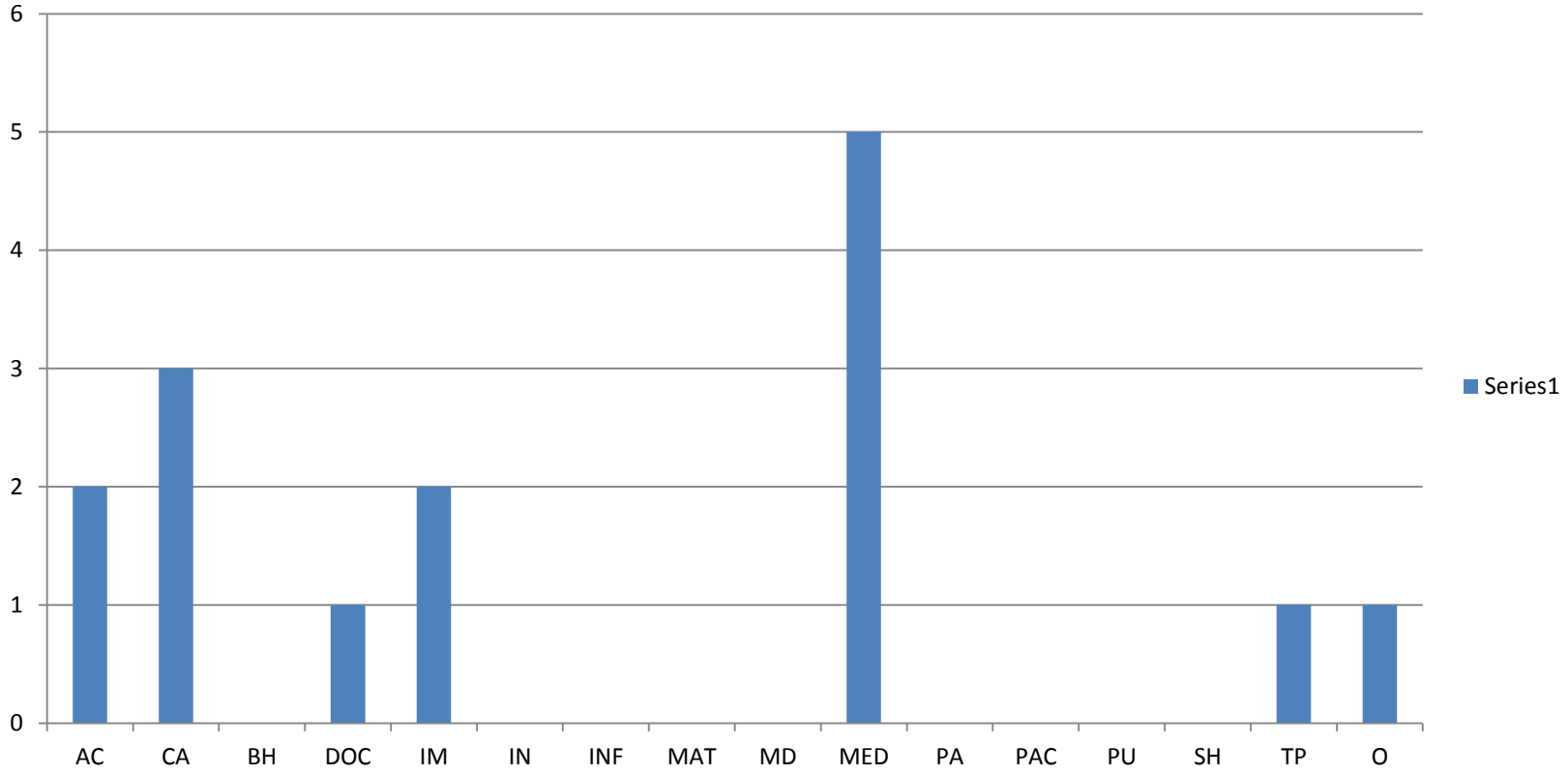
Patient Safety Incidents Slough April 15- April 16



Patient Safety Incidents WAM April 15- April 16



Patient Safety Incidents Bracknell & Ascot April 15- April 16



Key

KEY	
Access, admission, transfer, discharge (including missing patient)	AC
Clinical assessment (including diagnosis, scans tests, assessments)	CA
Disruptive, aggressive behaviour (includes patient to patient)	BH
Documentation (including electronic & paper records, identification and charts)	DOC
Implementation of care and ongoing monitoring / review	IM
Infection control incident	IN
Infrastructure (including staffing, facilities, environment)	INF
Maternal fetal neonatal incidents CNST triggers	MAT
Medical device / equipment	MD
Medication	MED
Patient abuse (by staff / third party)	PA
Patient accident	PAC
Pressure ulcer	PU
Self-harming behaviour	SH
Treatment, procedure	TP
Other	O

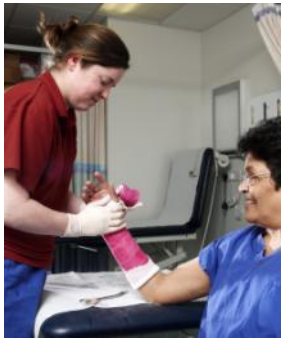
Sharing the learning from reported NRLS incidents

- NHS England feedback and review the SEA with a view to help support the practice reduce the risk of the incident happening again
- Trends and themes are triangulated with complaints, safeguarding and patient feed back.
- Themed action learning bulletins
- National safety alerts
- Identify learning needs and further work required at local, regional and national level

Challenges and next steps

- Improving safety cultures
- Challenges facing primary care workforce
- Encouraging local and national reporting
- Incident management systems
- Feedback to practices- resource to do so
- Ensuring that learning has taken place and sustainable actions in place to help reduce the risk of it happening again
- Effectively sharing lessons learnt- reaching those that need it most
- Trends/themes and alerts, identifying further work

Responding to CQC inspections



CQC- Safe and Well Led- Key Themes

- Vision and values, developed and shared with staff and patients- how are they demonstrated?
- Identifying, managing and monitoring risks
- Medicines management, safeguarding, infection control, cold chain, prescription security
- Leading through Learning from incidents, complaints, patient feedback, QOF and audit
- Following up on actions and reviewing changes
- Practice management, policies, HR, recruitment, staff appraisals and training

CQC- our response

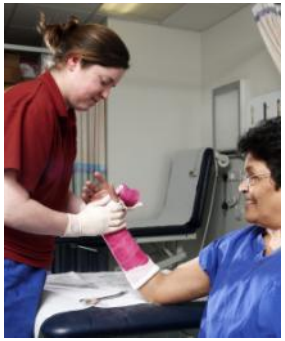
- Supporting robust action plans to lead to sustainable improvements
- several practices now rerated as ‘good’

- Action learning bulletins and top 10 tips

- PLT learning sessions to prepare for CQC- using CCG, NHS England and practices’ experiences to share learning to other practices.

- Encourage ‘buddying’ and exemplars
- RCGP support- match funding

Vulnerable practice support programme



Vulnerable Practice Support

- Practices identified for support
- Sustainable and quality pathways