Paper 6

Ayrshire and Arran NHS Board

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Scottish Patient Safety Programme: Primary Care

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Recommendation

The Board is asked to note the programme of implementation for Scottish Patient Safety Programme – Primary Care and the progress made to date.

Summary

Out of 55 GP practices in Ayrshire, 52 are currently taking part in the local enhanced service for patient safety, an increase of two practices since the last review. This paper sets out the current position in relation to progress in the fourth year of implementation of the SPSP-PC.

The aim of the SPSP-PC is to reduce the number of events which could cause avoidable harm from healthcare delivered in any primary care setting.

Key Messages:

Significant progress has been made in each of the three work streams:

- **Safety culture**: all practices have completed the trigger tool review method and safety climate surveys.
- **Safer medicines**: Compliance with care bundle audits in relation to medicines reconciliation, warfarin management and disease modifying anti–rheumatoid drugs (DMARDs) has improved and the improvement has been maintained.
- **Safety at the interface**: consistent high rates of compliance with care bundle audits for test results handling in practices.

Glossary of Terms

DMARDs	Disease-modifying anti-rheumatic drugs
LES	Local Enhanced Service
NES	NHS Education for Scotland
SEAs	Significant Event Analysis
SPSP	Scottish Patient Safety Programme
SPSP-PC	Scottish Patient Safety Programme – Primary Care

1. Background

The aim of the SPSP-PC is to reduce the number of events which could cause avoidable harm from healthcare delivered in any primary care setting. The Scottish Patient Safety Programme in General Practice is progressed through a SPSP–PC Local Enhanced Service. During 2017/18 out of 55 GP practices in Ayrshire, 52 are currently taking part in the local enhanced service for patient safety, an increase of two practices since the last review. In late 2017/18 one of the practices spilt in two and both component practices are continuing with SPSP work. This paper sets out the current position in relation to progress in the fourth year of implementation of the SPSP-PC.

2. Progress in 2017/18

Significant progress has been made in the three Patient Safety work streams:

- **Safety culture**: all practices have completed the trigger tool review method and safety climate surveys.
- **Safer medicines**: Compliance with care bundle audits in relation to medicines reconciliation, warfarin management and disease modifying anti–rheumatoid drugs has improved and the improvement has been maintained.
- **Safety at the interface**: consistent high rates of compliance with care bundle audits for test results handling in practices.

3. SPSP–PC Local Enhanced Service Specification 2017 - 2018

The SPSP–PC Local Enhanced Services Specification 2017-18 sets out the following requirements for practices:

1) **Develop the patient safety and improvement skills of staff and be part of an improvement collaborative**

   Each practice will nominate a named GP, Senior Administrator/Practice Manager and another member of staff to lead on this project. This work is intended to build on pre-existing work and the training provided in improvement methodology.

   The practice will take part in two learning sets, which will be held locally and will form part of the work of the GP clusters. This will be facilitated by the GP cluster quality leads. The practices should discuss Significant Event Analysis, audit results, and share learning.

2) **Undertake one patient safety SEA**

   Primary Care engagement in incident reporting worldwide is very low. The General Medical Council guidance on duty of candour is explicit and there is a need to be open about patient safety incidents.

Each practice carries out one Enhanced SEA relating to patient safety. This would:

- Be sent to NHS Education for Scotland for peer review
- Brought to the locality meeting for discussion and sharing.
- Copied to the SPSP lead for the locality for collation of themes and the establishment of any organisational learning needs or actions.
- Shared with the patient where appropriate, thereby demonstrating the duty of candour.

3) Undertake a bundle audit with respect to DMARDS, Warfarin, Medicines Reconciliation and Results Handling

Practices will undertake a bundle audit in these four areas once in the 2017- 2018 year.

Month	Topic
August 2017	Warfarin
October 2017	DMARDS
December 2017	Medicines Reconciliation
March 2018	Results handling

4) Complete a Practice Safety Checklist

This has been developed by NES in conjunction with the Centre of Excellence group in Ayrshire and Arran.

This work would be undertaken by the Practice Manager and allow practices to demonstrate an ongoing review of the safety systems within the practice.

The Patient Safety Checklist covers the following areas:

- Medication Safety (controlled drugs, emergency drugs and equipment, vaccinations)
- Housekeeping (infection control, stocking of clinical rooms, clinical equipment maintenance, confidential waste)
- Information Governance (data protection, record keeping)
- Practice Team (registration checks, cardiopulmonary resuscitation and anaphylaxis training)
- Patient Access and Identification
- Health and Safety (premises and staff health and wellbeing)

Again, practices would be expected to share learning from this as part of the Quality agenda within clusters.

4. Recommendation

The Board is asked to note the programme of implementation for SPSP – PC and the progress made to date.

Monitoring Form

Policy/Strategy Implications	Supports NHS Ayrshire & Arran's Core Purpose on quality of care and corporate objective "the people using our services having a positive experience of care to get the outcome they expect".
Workforce Implications	No additional workforce. Practices have identified patient safety / Practice Quality Leads.
Financial Implications	Local enhanced service – funding is in place.
Consultation (including Professional Committees)	Ongoing Patient Safety Programme. Oversight provided through Clinical Governance arrangements.
Risk Assessment	No risk from Programme. Purpose of the programme is to reduce patient safety risk.
Best Value - **Vision and leadership** - **Effective partnerships** - **Governance and accountability** - **Use of resources** - **Performance management**	Provides more effective use of resources, learning to ensure the right care is provided first time.
Compliance with Corporate Objectives	Working together to create compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and result in the people using our services having a positive experience of care to get the outcome they expect
Single Outcome Agreement (SOA)	Not applicable
Impact Assessment Impact assessment not required as this is an internal document reporting on a national programme.	