Nursing & Quality	Primary Care Quality Report	January 2022
Authors: Jacci Yuill, Sandra Muffet, Zoe Moloney **Sponsors: Michael Richardson, Rosi Shepherd**	**Report for : PCOG/PCCC/Quality Committee** This report aims to provide an overview of the current issues and the work being undertaken regarding quality and patient safety.	

Key Lines of Enquiry (principles)

- Support to GP Practices with acknowledged quality issues identified via the dashboard
- Specific areas of focus in these practices include patient access, complaints, safeguarding and the management of pathology results/prescriptions/letters.
- Themed work includes specific domains related to Patient Safety, Clinical Effectiveness, Responsiveness and Leadership

Risks

- A number of practices require focussed support to improve identified quality issues which could potentially impact on patient health outcomes resulting in patient harm.

Assurance

- Quality Dashboard Spotlight provides evidence of focussed support to practices and is shared at PCOG/PCCC(closed).
- Quality Standard Operating Procedure, Quality Stocktake and Escalation Plan will be used to identify issues and enable a process for quality improvement.
- Quality, Development (Resilience) and Contracting meet CQC monthly to discuss issues with practices in BNSSG.

Next Steps:

To work with Primary Care to deliver the vision for quality and patient safety to shape the future vision with aims to:

- Monitor quality and support the delivery of quality improvement.
- Drive up improvements in population health, reduce health inequalities and develop the personalised approach to help people achieve their health goals.
- Ensure services are safe and effective, making the best of combined resources
- Promote and champion a learning culture within primary care

Care Quality Commission Update

Practices which have undergone a CQC inspection:

Current position

- **3** Practices have an ***Overall*** '**Outstanding'** Rating
- **68** Practices have a **'Good'** rating
- 5 practices have **'Requires Improvement'** overall
- There are no practices which have an Inadequate rating
- The details of recent CQC published reports can be found on Slide 3

Actions and Projects

- Monthly relationship meetings with CCG and CQC to discuss high risk practices, forthcoming inspections and process updates
- CQC have postponed inspections due to new covid variant surge and GP Practices need to support acceleration of the booster programme.
- CQC will be looking at the Good and Outstanding practices who are at the 5 year position to undertake a 'dip sample' involving a clinical search and monitoring call. Depending on the outcome further investigation may include a site visit with full inspection.
- It is likely that most of the CQC activity in Q3 will be outside BNSSG however they will continue to undertake a risk based approach intervening as required.
- Next steps will involve addressing those amber rated practices to ensure that improvements are taking place and they don't tip towards red.

	Coniston Medical
Published Date	**26.11.2021**
Overall	**Good**
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well Led	Good
People with LTC	Good
Families, Children and Young People	Good
Older people	Good
Working Age People	Good
People experiencing with Mental Health	Good
People who are vulnerable	Good

Primary Care Incidents Update Quarter 2 2021/22	Primary Care Leads (Quality and Medicines Optimisation)	https://bnssg-datix.scwcsu.nhs.uk/index.php

Current situation in Primary Care:

- Incidents reported onto the CCG Datix system are reviewed by the Quality and Medicines Optimisation Teams.
- All providers are asked to investigate further/share learning within the practice/PCN.

Key Lines of Enquiry

- Work is required to establish which BNSSG GP Practices require training to enable them to report incidents onto the Datix system
- The numbers of incidents being reported onto Datix is constant. In quarter 2 of 2021/22 there were a total of 226 incidents submitted onto Datix compared to 227 for the same period in 2020/21.
- The reported Datix incidents are reviewed and broken down into themes; this allows learning to be identified and is provided in the slides below. The learning is also shared quarterly in a newsletter to Primary Care.

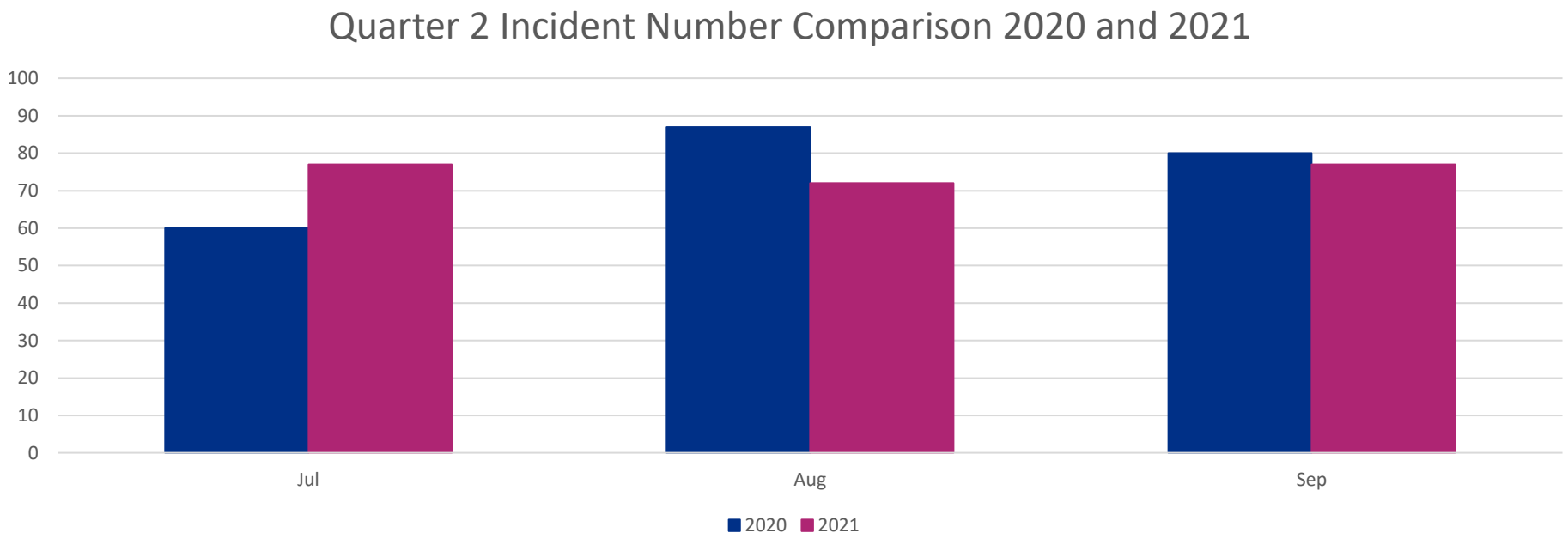
Risks

- With the number of reported incidents increasing, this is impacting on the time taken to review them; this has resulted in a higher number of open incidents being on the Datix system.
- There are a total of 499 incidents open incidents on the Datix system. These incidents have all been seen by a member of the quality team to identify any incidents which require immediate attention.

Assurances

- The Quality team view all incidents that are submitted. All medication incidents are reviewed by the Medicines Optimisation Team.
- Medicines related incident trends are monitored and shared in newsletters and networks. Incident trends inform the medicines safety related work and projects.
- Incidents are shared with relevant parties to investigate, feedback or to share the learning in line with the Standard Operating Procedure agreed.
- The Quality team provides direct support to GP practices and providers to resolve incidents when they are challenging or complex.
- Serious incidents and escalations are discussed with the GP Quality Lead for review and support to take forward concerns and themes into the system.
- A Patient Safety primary care project manager has been employed in the Quality team to implement the patient safety strategy within Primary care.
- Meetings with the Acute providers are held with the Medication Safety Officers to discuss all medication related concerns and the primary care leads to discuss any patient safety concerns to take any incident learning forward. The same approach has been introduced in the Community sector.

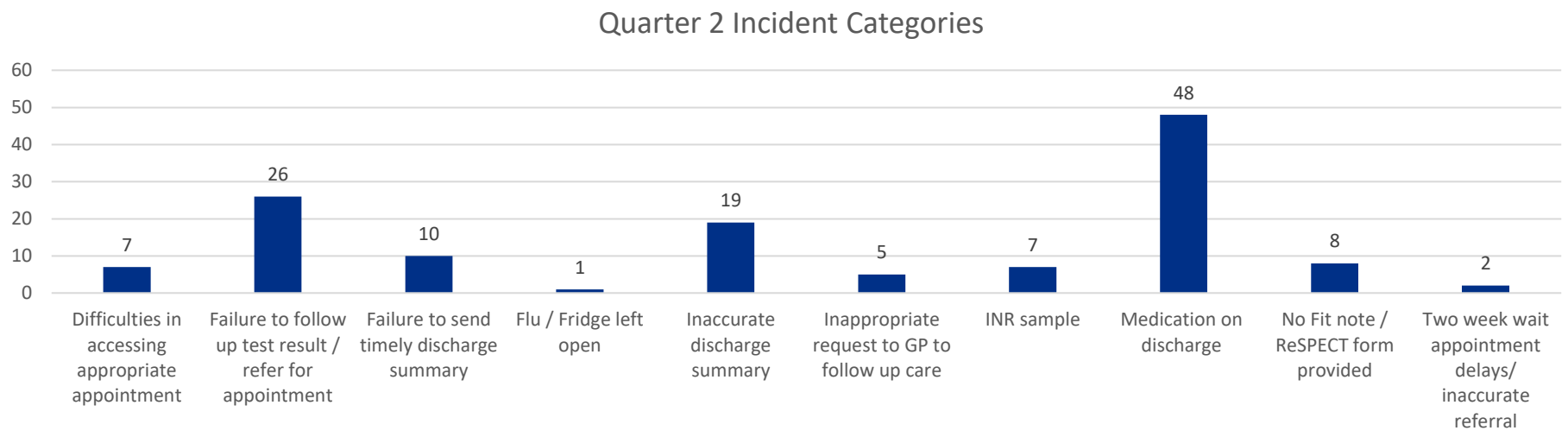
Primary Care Incidents	Quarter 2: July - September 2021

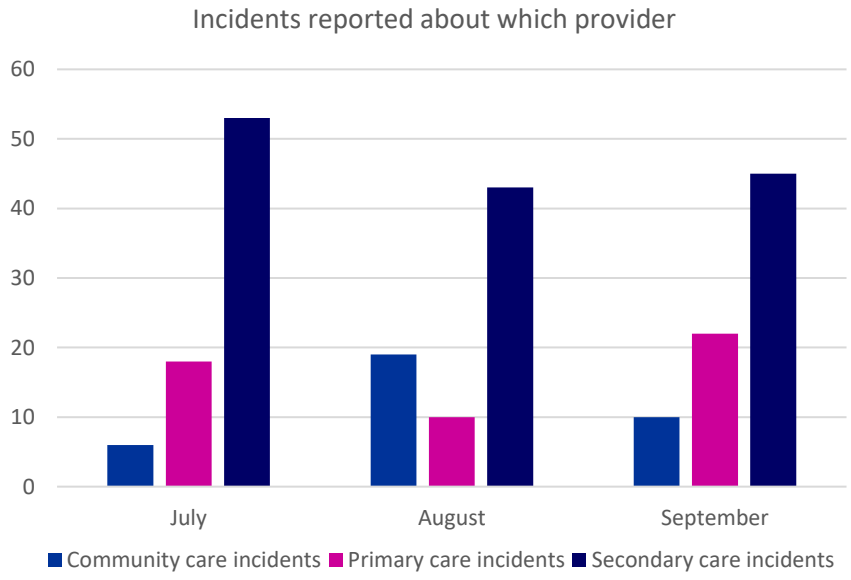


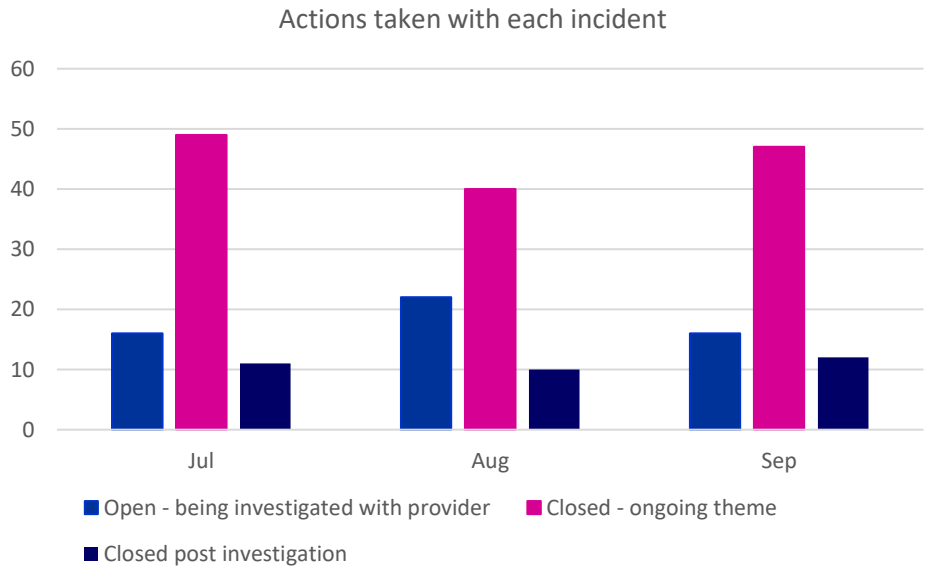
In quarter 2 of 2021/22 there were a total of 226 incidents submitted onto the DATIX system compared to 227 for the same period in 2020/21.

Monthly reports are cascaded to the acute providers; the information is then communicated to the providers internal teams to enable monitoring of any themes identified during that month. Regular feedback has been requested from the providers.

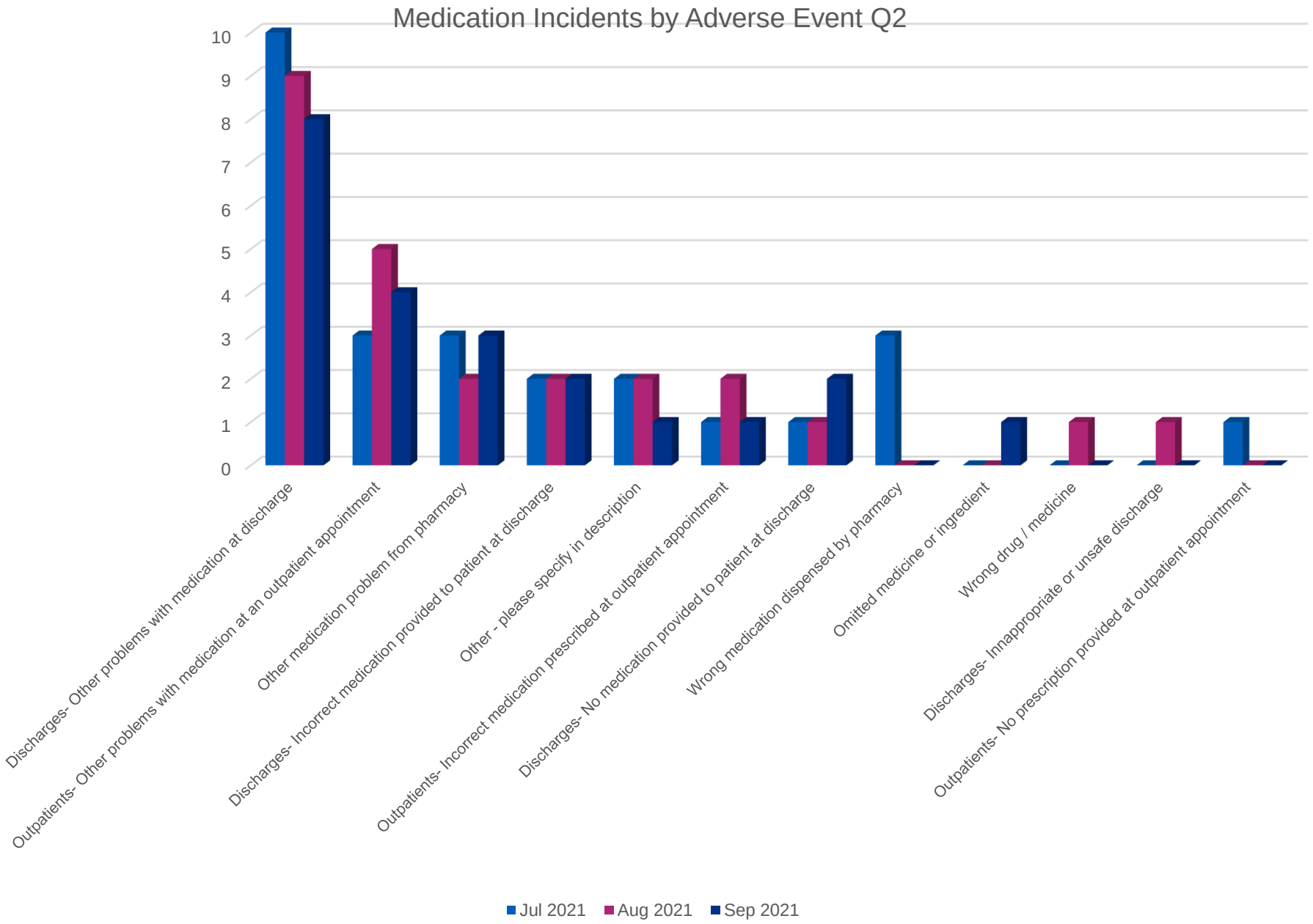
Primary Care Incidents | Quarter 2



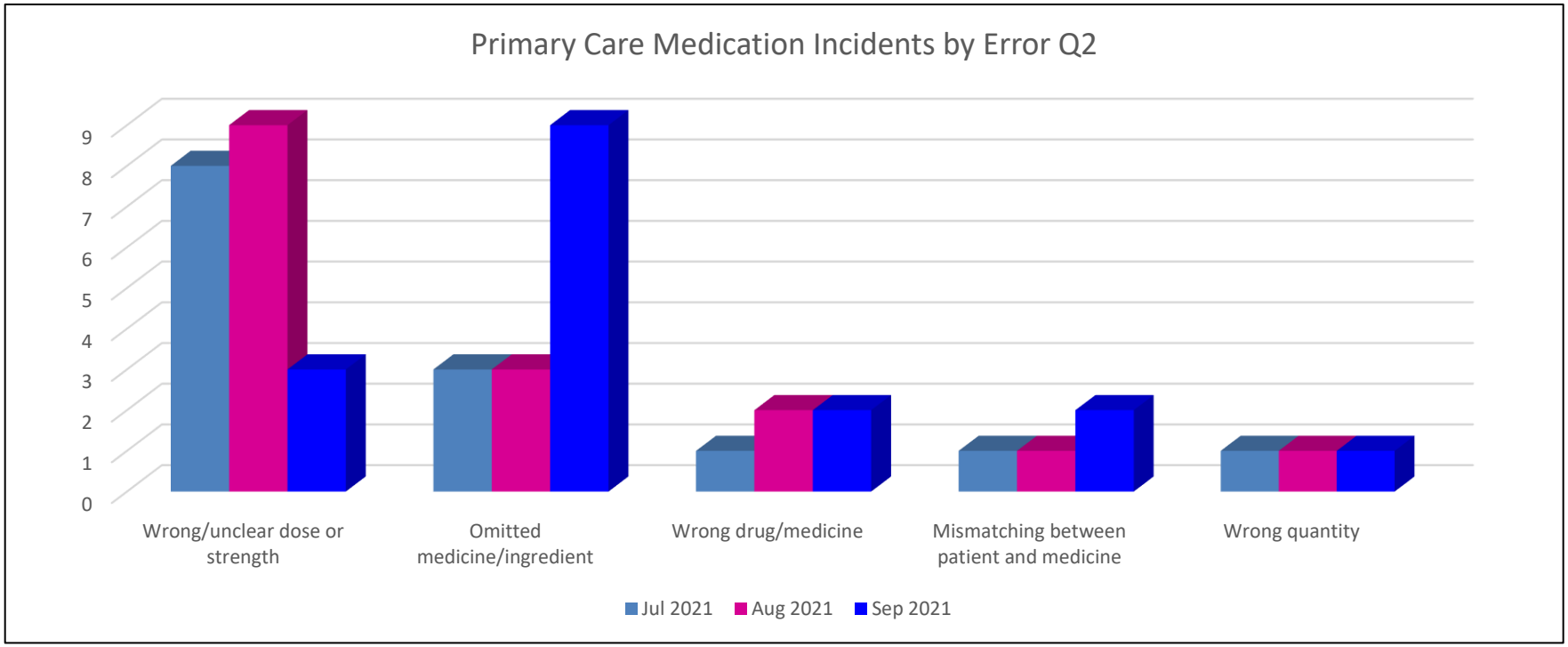




Primary Care Medication Incidents	Quarter 2



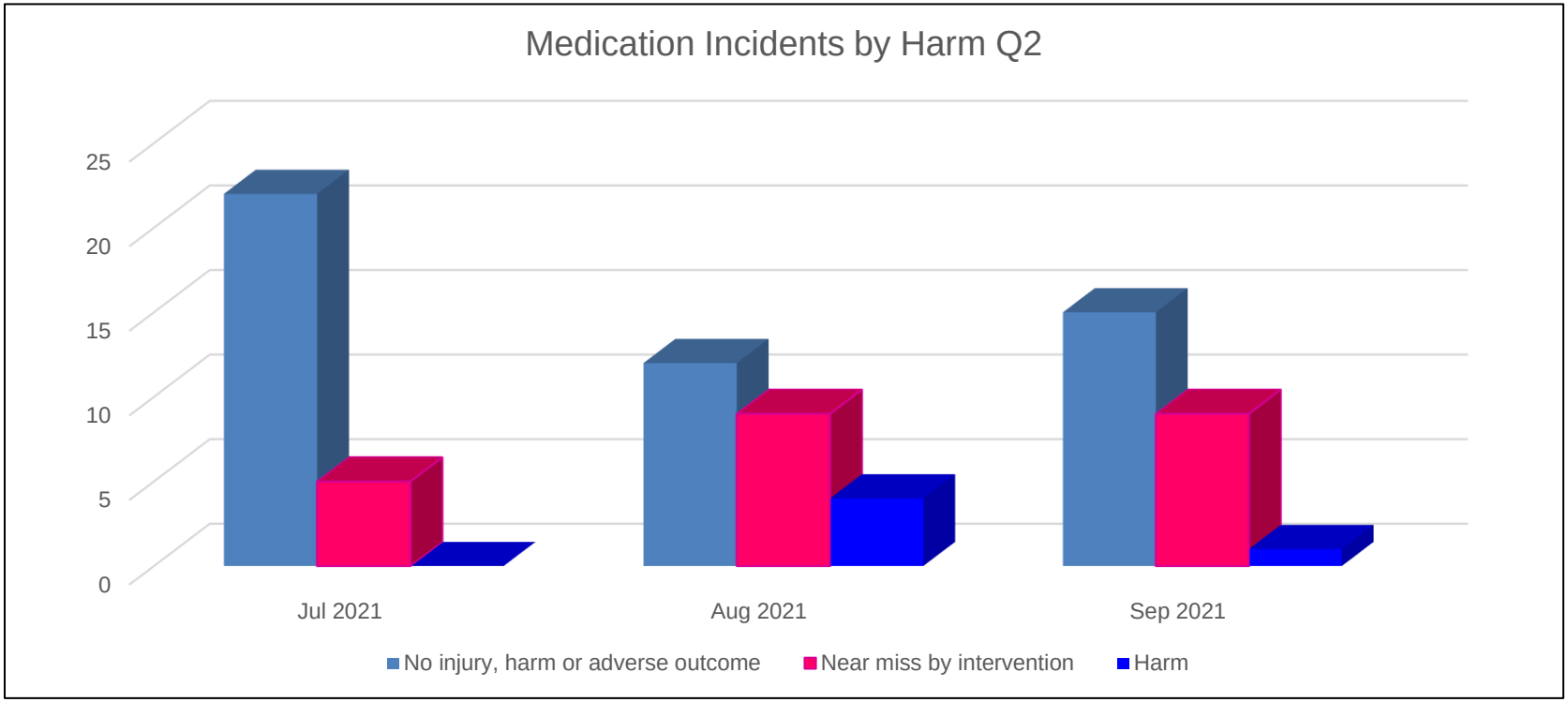
Primary Care Medication Incidents | Quarter 2



*Medication incident by medication error

	Jul 2021	Aug 2021	Sep 2021	Total
Wrong/unclear dose or strength	8	9	3	20
Omitted medicine/ingredient	3	3	9	15
Wrong drug/medicine	1	2	2	5
Mismatching between patient and medicine	1	1	2	4
Wrong quantity	1	1	1	3

Primary Care Medication Incidents | Quarter 2



*Medication incidents by harm

	Jul 2021	Aug 2021	Sep 2021	Total
No injury, harm or adverse outcome	22	12	15	49
Near miss by intervention	5	9	9	23
Harm	0	4	1	5
Total	27	25	25	77

Primary Care Incidents	Quarter 2 2021/22

Themes	Actions/Outcomes/Shared Learning
Discharges and processes	• An acute provider shared that they estimate the number of discharges per quarter is approximately 8000. The number of incidents received during Quarter 2 surrounding discharge issues are relatively low in comparison. However, we know that the actual number of discharge incidents could be much higher but due to the variable reporting in primary care, incidents may not be reported every time there is an issue with a discharge. It is recognised that a third of practices are currently reporting through the Datix system. • Several incidents were submitted regarding taking bloods in the community. These incidents made the provider identify that the process in managing the referrals in the coordination centre was not working effectively. This process has now been amended and we will continue to monitor to see if this process change has been successful.
Medicines	• Actions taken this quarter include: ➢ Sharing learning with relevant groups such as the Medicines, Quality and Safety group and its subgroups (Anticoagulant Safety, Diabetes Safety and Prescribed Dependence Forming working groups) including highlighting incidents relating to harm (3 x negligible, 2 x minor). ➢ In 1 incident where a GP issued a 16 day daily supervised methadone blue script which was then dispensed by a community pharmacist, this prompted an article to be published in the October Medicines Optimisation Newsletter reminding clinicians to follow the clinical guidelines which set out the legal and good practice requirements for writing prescriptions for Schedule 2 and 3 controlled drugs for the treatment of drug dependence for dispensing by a community pharmacist. ➢ 1 incident highlighted where a patient was using fentanyl 25mcg patches before admission to hospital was discharged on 75mcg patches without reason as to why it was increased on discharge. The Medication Safety Officers (MSO) has shared trust actions and learning following this which included: Writing all Controlled Drugs strengths in words not as a figure, including when transcribing; Prescription error examples are part of mandatory junior doctor prescription training; discussed learning with surgical lead pharmacist and pharmacy team. ➢ 1 incident had been reported by Optimise Rx where they identified a potential problem with one of their messages when BNSSG CCG were a system user. It related to a 'do not prescribe' message which was set to trigger for patients who had a total hysterectomy to say that they should not be prescribed a progestogen as per NICE guidance. There was concern that the message may have triggered for patients who had a subtotal hysterectomy (rather than total) and so progestogens would be warranted if there was uterine tissue left and that the progestogen has therefore potentially been stopped inappropriately. 3 patients were identified in BNSSG and the necessary safety checks consequently carried out by GP practices. • Incidents continued to be shared for shared learning and investigation with: **Medication Safety Officers** (MSOs**); NHS England** (where the incidents involve a community pharmacy); **Controlled Drugs Accountable Officer** (CDAO) South West (where the incidents involve controlled drugs); Any other relevant clinical teams (e.g. Antibiotics Specialist Pharmacist)