Primary Care Incidents Update Quarter 1 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

- There is a need to establish that all BNSSG GP Practices are aware of how to report incidents
- The numbers of incidents being reported onto Datix are increasing. In quarter 1 of 2021/22 there were a total of 256 incidents submitted onto Datix compared to 93 for the same period in 2020/21. This is an increase of 175% year on year.
- The Datix incidents that are reported are broken down into themes in order that we know what learning is required which is identified in the slides below. These are shared in a newsletters to Primary Care.

Risks

- As a result of the increasing number of incidents being reported a backlog has developed and not all incidents have been closed on the Datix system. There are a total of 623 incidents that are open. 409 are being reviewed, 132 are waiting final approval and 82 are in the holding area pending action.

Assurances

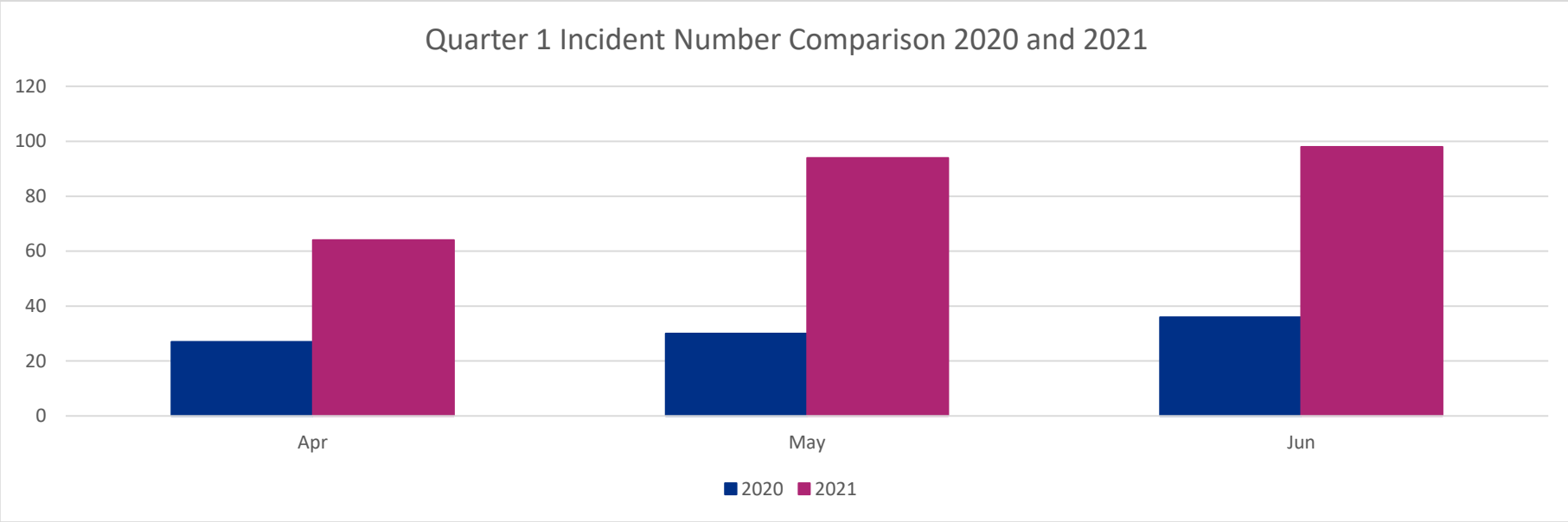
- The Quality and Medicines team view all incidents that are submitted daily and then monitor, respond and chase the providers for immediate actions which need to be undertaken.
- Medicines related incident trends are monitored and shared in newsletters and networks. Incident trends inform the medicines safety related work and projects.
- The quality team provides direct support to GP practices and providers to resolve incidents when they are challenging or more 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.

Next Steps to embed the Patient Safety Strategy in Primary Care

- A Standard Operating Procedure is in development for managing incidents reported onto the CCG Datix system.
- A project has been established to work with practices to ensure that they have robust incident reporting processes (including reporting on Datix)
- A trajectory with time lines is being developed for closing incidents which are currently on the system which will be presented in October.
- The Nursing & Quality team has been successful in securing some non-recurrent funding to provide positions which will support the introduction and development of the Patient Safety and to add resource to Primary Care Patient Safety monitoring.

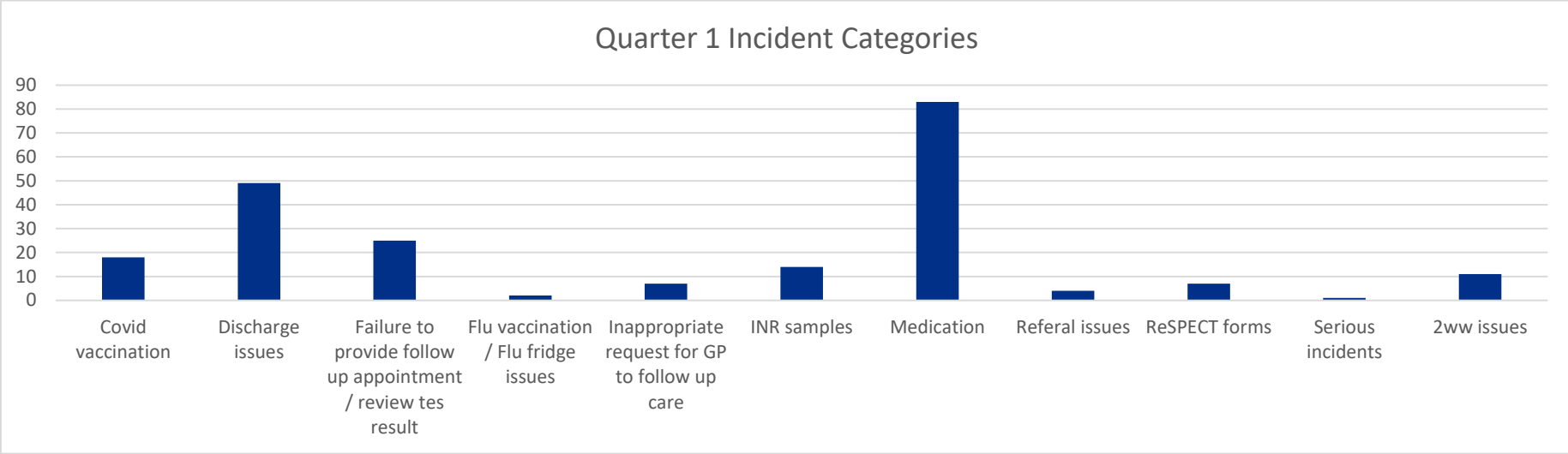
The aim is the actions above will contribute to embedding the Patient Safety Strategy in primary care to enable a focus on outcomes and shared learning across the system and into all GP Practices/PCNs/Localities.

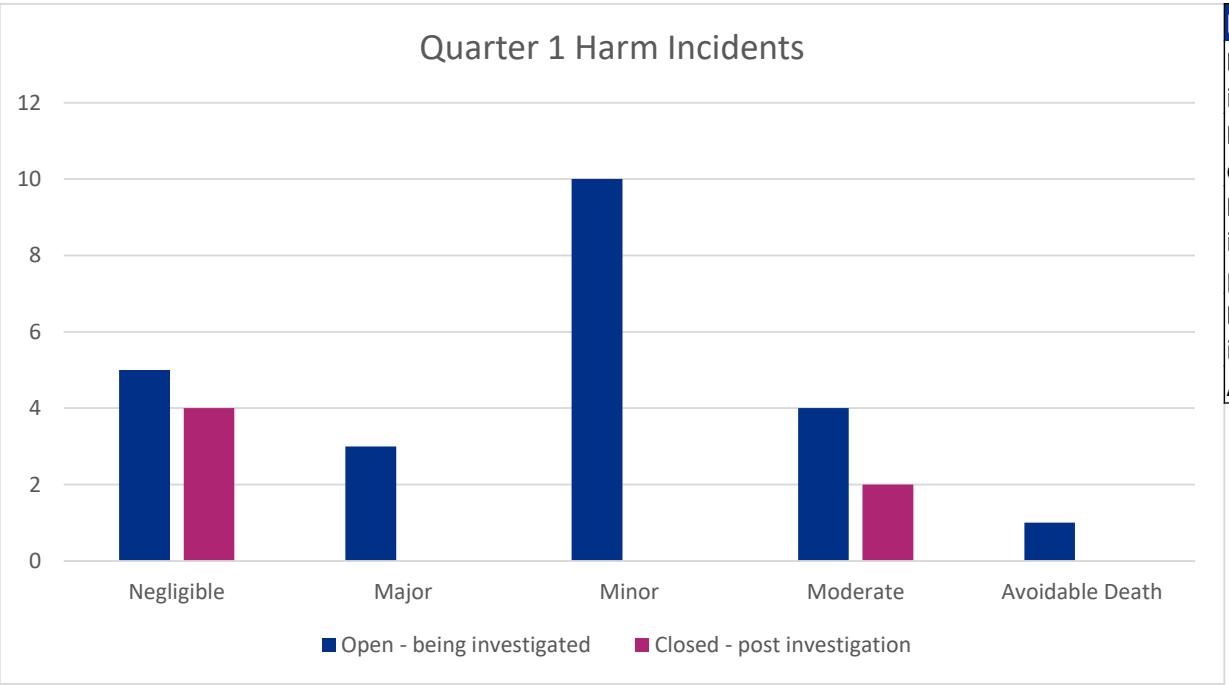
Primary Care Incidents | Quarter 1: April-June 2021



In quarter 1 of 2021/22 there were a total of 256 incidents submitted onto the DATIX system compared to 93 for the same period in 2020/21. This is an increase of 175% year on year which has been helped by the CCG Prescribing Quality Scheme Medicines Safety Project for 2020/21 which aimed to increase the number reported and coding on Datix with practices reviewing their own internal reporting processes. The break down of the medication incidents can be seen in the charts on slide 4. It is therefore positive to note that this has allowed better sharing of learning across the area.

Primary Care Incidents | Quarter 1



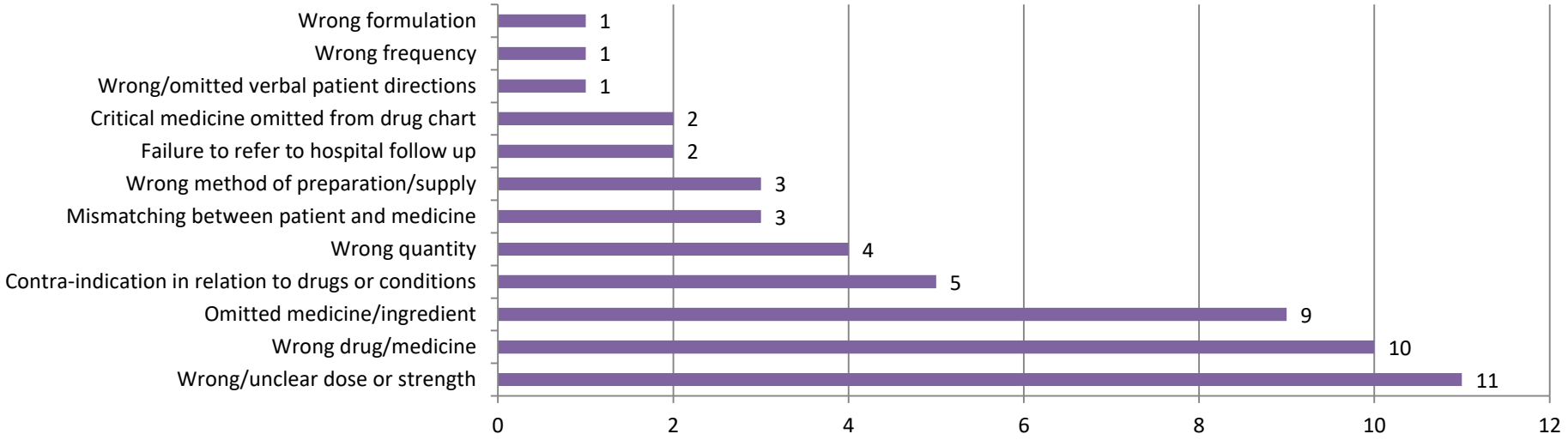


Harm Classification:
Low Harm: minimal injury needing no / minimal intervention
Major: major injury leading to longterm incapacity or disability (Gd4 press ulcer, long term effects)
Minor: minor injury or illness requiring minor intervention (increase hosp stay 1-3 days of Gd2 press ulcer)
Moderate: moderate injury requiring professional intervention (increase 4-15 days or Gd3 press ulcer)
Avoidable death

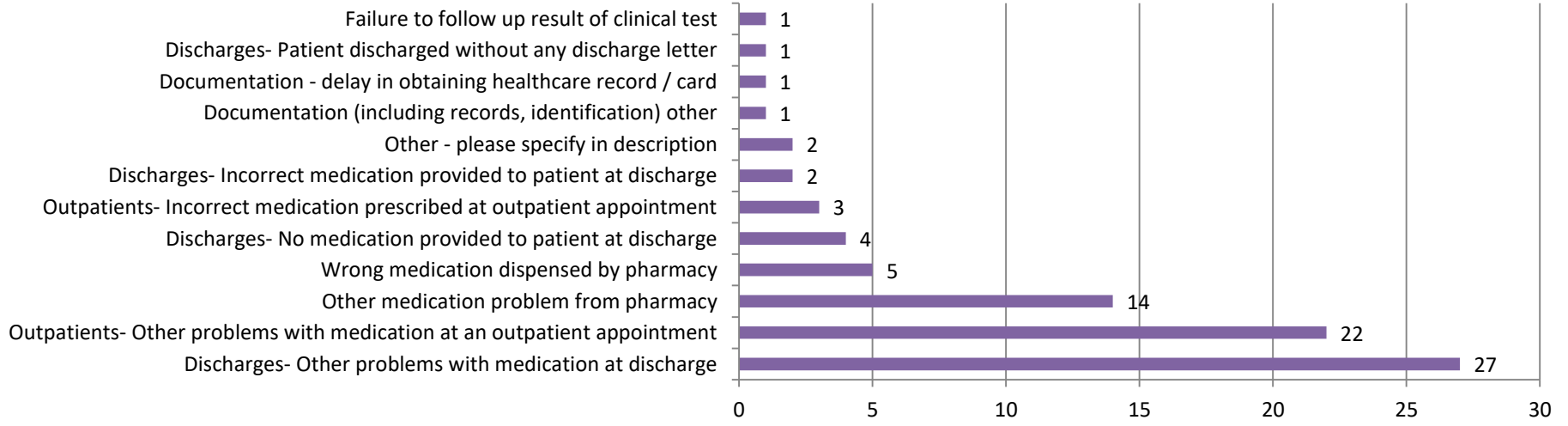
The data does not include incidents that meet the Serious Incident reporting criteria.
The potential avoidable death relates to a covid vaccine incident which is being investigated by the NHSE Regional Mass Vaccination team and reported through the governance routes of Clinical Delivery Group and Mass Vaccination Group.

Primary Care Medication Incidents | Quarter 1

Number of Datix incidents by medication error Q1 2021 (total 52)



No. Medication Incidents by Adverse Event Q1 2021



Primary Care Incidents	Quarter 1

Themes	Actions/Outcomes/Shared Learning
Hospital Discharges	• Discussions and meetings are ongoing with various CCG teams and providers in relation to discharge issues to take learning and improvements forwards. • Inaccurate discharge summaries are a recurrent theme from all providers who discharge patients. • When one provider was investigated it was discovered that an internal process for distributing the summaries to GP Practices had been changed which resulted in some being sent out before the patient had been discharged which has now been rectified. • The most reported theme in this quarter is medication related. This can be broken down into medication adverse events and error type. Current trends by adverse event are showing discharge related issues, outpatient related issues and community pharmacy related incidents. Most frequent trends by type of error were wrong dose/strength, wrong drug, and omitted drug. Individual incidents were shared with the relevant trust Medicines Safety Officers (MSO) or NHS England for further investigation and review.

Medicines	• Incident reports relating to medicines continue to be reported from across BNSSG, monitored for trends and learning shared where appropriate.
	• Actions taken this quarter include:
	  • Sharing learning with relevant groups such as the Medicines, Quality and Safety group and its subgroups including highlighting incidents relating to harm. An incident highlighted specific learning relevant to Pharmacy Technicians and so this was shared with their local forum. Incidents relating to practice nursing have been shared with the local nurse forums.
	  • Other specific actions following incidents include developing a standard operating procedure in relation to cancelling electronic prescriptions prompted by an incident relating to a controlled drug.
	  • Also following an incident and feedback in relation to ScriptSwitch, the Medicines Optimisation team have made the messaging clearer on some switches where the suggested alternative is a change to a similar drug but not the same medication as not all switches are a simple brand swap of the same medication.
	  • Action was also taken following an incident which related to drug interactions with anticoagulants. This was shared with the anticoagulant safety group, trust anticoagulant pharmacist and a newsletter article written to raise awareness of these interactions.
	• Close working with the Trust Medicines Safety Officers at the local Trusts continues and following an incident affecting both primary and secondary care relating to changing between lithium formulations (liquid to tablets) a helpful newsletter article was written and will be shared in the next system medicines safety newsletter.