NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Report to Primary Care Commissioning Committee – March 2020

Title: **Primary Care Quality Update Report**

Purpose of paper: To report on recently published reports of CQC inspections of GP Practices, Influenza management, Friends and Family Tests Practice Performance, Health Care Associated Infections(HCAI)Q3, Incidents Q3, Complaints Q3 and Quality Escalations-COVID-19.

For Approval/ Decision	For Review	Receive for assurance	Receive for information
		✔	✔

For Discussion

Executive Summary:

Six practices have 'requires improvement' ratings	**CQC Inspections –** Five practices have been inspected since the January 2020 report. Horizon Health Centre received an overall rating of 'Requires Improvement' and also in the domains of Safe, Effective, Well Led, People with Long Term Conditions, Families and Young Children, Working Age People and People Experiencing Poor Mental Health. Helios received an overall rating of 'Requires Improvement' and also in the domains of Safe, Effective, Well Led, People with Long Term Conditions, Families and Yong Children and Working Age People. Armada Family Practice and Bradley Stoke Surgery received a 'Good' rating overall and in all domains. Charlotte Keele Health Centre has been inspected again and now has 'Good' rating overall and in all domains.
Practices requiring improvement have agreed action plans	CCG Quality and Resilience teams have been involved in ongoing meetings with the management teams and partners at the practices. In some situations Memorandums of Understanding have been signed which set out the aims and objectives to address improvements required.
GP practices in BNSSG are submitting Friends & Family(FFT) data significantly above the national average	**Friends & Family** – January 2020 are the most recent results for FFT data. The most recent results for the Friends and Family Test (FFT) data are for January 2020. This shows that 64 BNSSG CCG practices submitted their data to NHS England as contractually required. This is a compliance rate of 78.0% which is above the national rate of 60.6%.
BNSSG CCG received national recognition in 19/20 for its flu vaccine rates as the highest in the South West.	BNSSG CCG is currently above the national uptake for both 'At risk (6 months – under 65 years)' and 'Pregnant Women'. The CCG is now above the national end of season ambition for '65 and over'. Weekly influenza data collection ceased on 26.1.2020 and changed to monthly until season end on 29.2.2020. The full uptake rates will be available in March 2020, however the end of season de-brief will be delayed due to COVID-19. PCCC will receive an update when the information is available.

There is practice variance in the uptake of vaccinations across BNSSG.	Collaboration with Medicines Management, and Screening and Immunisations Team to improve flu and childhood immunisations uptake.
Incidents	Of the medicines related incidents, most involved the administration and storage of flu vaccines which corresponds to the increase in activity during the seasonal influenza programme. Medicines Optimisation is working with Screening and Immunisation teams to reduce future incidents. There are also themes around the quality of discharge summaries and communicating changes in medicines between care settings. These are discussed at the Medicines Quality and Safety group with key actions being undertaken.
Complaints	Information available to BNSSG about complaints in Primary Care is limited. Numbers reported to the BNSSG Customer Services onto Datix are very low, as GP practices manage their own complaints data. NHSE also manage escalated patient complaints and we are in discussion for that data to also be shared.
Quality Escalations-spread of COVID-19	There is a risk that the spread of COVID-19 across UK will affect a predicted 80% of the population making them unwell, with 1/5 workforce affected. There will be rapidly changing needs as the country moves to a social isolation model which will affect the communication and management of care. Business continuity plans are underway with the establishment at the CCG of an Incident Control Centre and associated work streams which include a Primary Care and Infection Prevention and Control Cell to manage the infection and mitigate the risks. This work will include: Scenario planning, Remote consultation models, involvement of providers, awareness of Infection Control and the management of patients and business Continuity Plans for each GP Practice in place. Routine CQC inspections will also be suspended.
Healthcare Associated Infections (HCAI) Infection with a specific focus on Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Clostridium Difficile and Escheria coli (E.coli) in Primary Care.	There is a focus on: • Methicillin-resistant Staphylococcus aureus (MRSA) alert tool • Improving the use of the community onset Clostridium Difficile reporting tool • HCAI group and E Coli Task and Finish Group meeting attendance by Practice Nurse Lead to ensure information is cascaded to Primary Care through forums where the primary source of E Coli bacteraemia was linked with a Urinary Tract Infection. • Identification of Infection Control Link nurses in each GP Practice • Report together HCAI and system wide antibiotic use in future papers. It has not been possible due to the escalating issues regarding COVID 19 to present the data.
Antimicrobial Stewardship Update	The two main prescribing measures for antibiotic stewardship the CCG is measured on are Antibiotics/STAR-PU and the percentage of all antibiotic prescriptions that are broad spectrum. Antibiotics/STAR-PU looks at overall antibiotic prescribing. Practices who have been struggling with

meeting the antibiotic prescribing targets have been given additional support from the medicines optimisation team.

Urinary Tract Infections:

To support the gram negative bacteraemia reduction target the appropriate treatment of urinary tract infections has been focused on. The BNSSG UTI guideline has been reviewed and re-released and teaching has occurred at all the practice nurse forums. An EMIS template to support the guideline is under production.

Action Required

The Primary Care Commissioning Committee is asked to note contents of this report and support the work programme outlined.

Financial resource implications	There are no specific financial resource implications highlighted in this paper.
Legal implications	No legal implications associated with this paper
Risk implications	CQC inspections of GP practices where they are rated as requires improvement is a potential reputational risk for BNSSG and the potential impact this could have on patient safety. Specific programme risks have been highlighted in relevant sections of the paper. Practices identified as 'at risk' are added to the CCG Risk Register.
Equality & Diversity Impact – reducing health inequalities.	Monitoring of Primary Care Quality and Performance will highlight any areas of Health Inequalities within BNSSG which will then be addressed accordingly.
Engagement with patients and/or public:	Whilst there has not been any direct consultation and communication with the public in production of this paper, most GP practices have established Patient Participation Groups and any issues are reported through the locality Public Involvement Forums (PIF)

Presented by: **Rosi Shepherd, Director of Nursing and Quality**

Prepared by: **Jacci Yuill, Lead Quality Manager – Primary Care**

Nursing & Quality

Jacci Yuill

Primary Care-Summary

Report for : PCCC

Assurance Rating: Green

Reporting Period: Jan/Feb 2020

Current Issues

- 6 practices out of 80 have 'requires improvement' overall ratings from Care Quality Commission(CQC) inspections
- Weston & Worle have lower Friends & Family Test (FFT)submission rates
- Weekly influenza data ceased on 26.1.2020, changing to monthly until year end (29.2.2020) and reported mid March.
- COVID-19 infection spread in UK

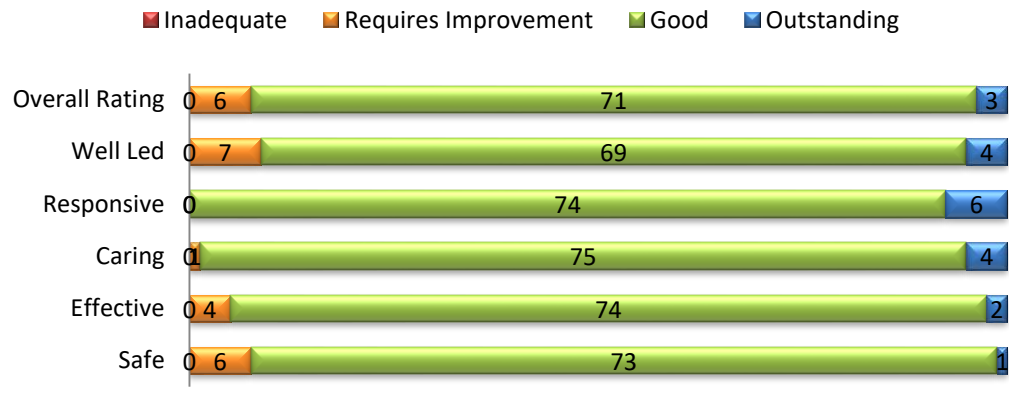
Actions

- Quality Team supporting practices with RI CQC ratings to improve resilience & quality improvement on specific actions
- FFT - Contacting practices with low uptake rates
- Flu – collaboration with Medicines Management and Screening & Immunisations (SCRIMS)to work with lower performing practices to promote uptake progression & action
- COVID-19-involvement in CCG Primary Care Cell and Infection Prevention and Control Cell for business continuity plans and implementation.

Risks/assurance gaps

- CQC inspections are more stringent resulting in stress for practices with 'front door' pressures
- Flu vaccination rates were initially affected by late supplies and patient issues for porcine vaccine content in the nasal spray with no alternative
- Widespread COVID-19 spread and implications for containment/treatment/workforce

CQC Domain Ratings



Flu Vaccination Uptake Rates Week 4 (ending 26.1.2020- season data due mid March)

At Risk – (6 mths - Under 65)			65 and Over			Pregnant & NOT in At Risk Group		
End of season ambition	National Uptake	BNSSG	End of season ambition	National Uptake	BNSSG	End of season ambition	National Uptake	BNSSG
55%	43%	47%	75%	71%	76%	55%	41%	45%

CCG specific actions

- Quality Team reviewing CQC inspections, identifying themes , developing fact sheets to support practice , presentations to Practice Managers
- Working on triangulating complaints, patient survey, PPG feedback –bi-monthly meetings with Health Watch to look at priorities and focussed projects.

Recovery actions

- Collaboration across the CCG to support practices
- Primary Care Development Team training programme for developing resilience
- Quality Team working with Horizon and Helios on CQC action plans
- Collaboration with Medicines Management, and Screening and Immunisations to improve flu and childhood immunisations uptake
- Charlotte Keel/Lawrence Hill Practices are considering Saturday clinics and text reminders sent by local Imam

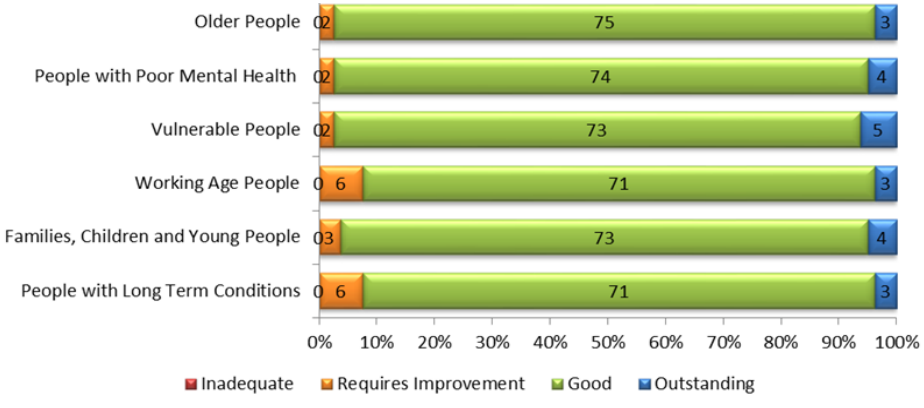
Assurance

- Monitored by BNSSG Influenza Seasonal Planning Group. Key issues are being collated to ensure lessons are learnt to 2020/21
- Quality Assurance practice visits reports are reported to PCOG/PCCC
- No GP practices have been assessed as inadequate in any domain
- Practices with CQC improvement plans are reported to PCCC (closed)

Primary Care-Care Quality Commission Published Reports In Jan/Feb 2020

	Horizon	Armada	Bradley Stoke	Helios	Charlotte Keel
Published Date	22.1.2020	30.1.2020	14.2.2020	14.2.2020	27.2.2020
CQC Domains					
Overall	Requires Improvement	Good	Good	Requires Improvement	Good
Safe	Requires Improvement	Good	Good	Good	Good
Effective	Requires Improvement	Good	Good	Requires Improvement	Good
Caring	Good	Good	Good	Good	Good
Responsive	Good	Good	Good	Good	Good
Well Led	Requires Improvement	Good	Good	Requires Improvement	Good
Population Groups					
People with LTC	Requires Improvement	Good	Good	Requires Improvement	Good
Families, Children and Young People	Good	Good	Good	Requires Improvement	Good
Older People	Requires Improvement	Good	Good	Good	Good
Working Age People	Requires Improvement	Good	Good	Requires Improvement	Good
People Experiencing Poor Mental Health	Good	Good	Good	Good	Good
People Whose Circumstances make them Vulnerable	Requires Improvement	Good	Good	Good	Good

CQC Ratings for population groups



Helios

Must Do Actions	Should Do Actions
Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.	Continue to implement actions to improve uptake for cervical screening

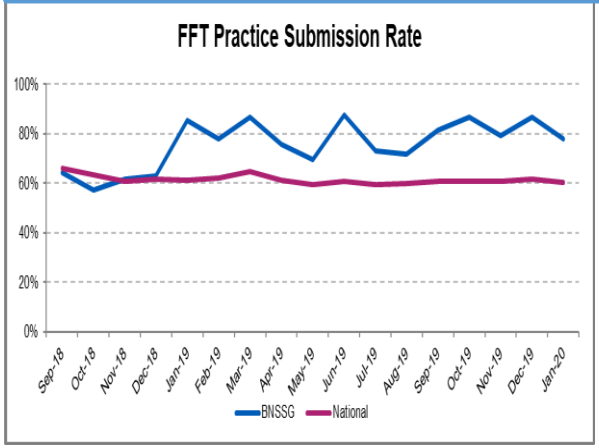
Horizon Health Centre

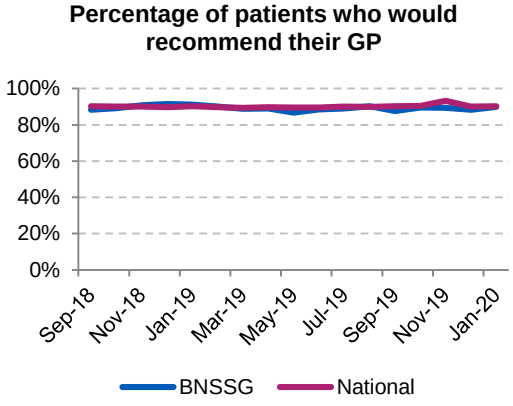
Must Do Actions	Should Do Actions
Ensure care and treatment is provided in a safe way to patients.	Complete the review of patient records to confirm or identify patients considered vulnerable; and to create or review their care plans.
Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.	Continue to improve performance to ensure positive patients outcomes for patients with long term conditions (including diabetes, asthma and COPD); and mental health conditions.
Ensure sufficient numbers of suitably qualified competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.	Improve performance in uptake of childhood immunisations; and cervical cancer screening for eligible women.
	Continue to analyse patient population data and complete the remodelling of services and capacity to better address needs.
	Continue to monitor and improve phone access for patients.

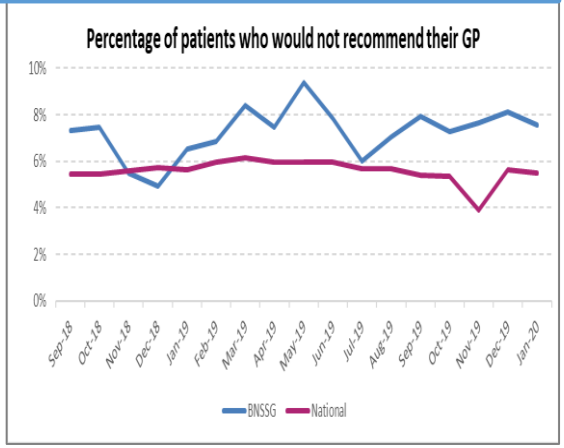
Helios:
The practice has been contacted regarding their action plan following the inspection.

Horizon:
Quality Team and CCG colleagues have been continuing to work closely with the practice to progress their action plan.

Primary Care-Friends and Family Test (FFT) January 2020 Data



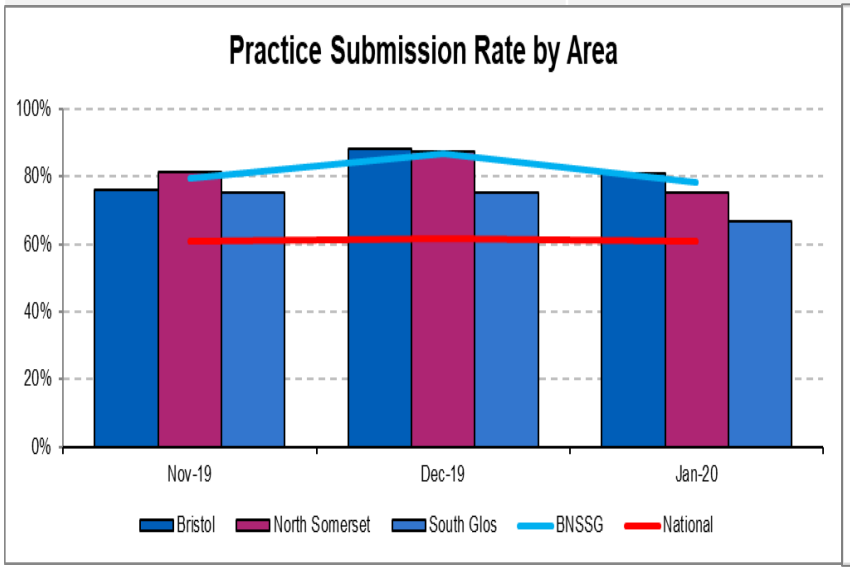


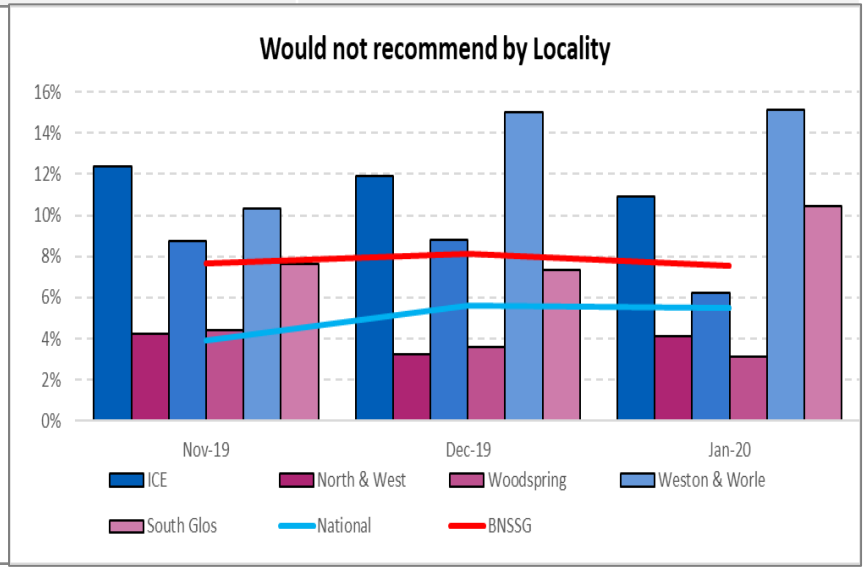


The most recent results for the Friends and Family Test (FFT) data are for January 2020. This shows that 64 BNSSG CCG practices submitted their data to NHS England as contractually required. This is a compliance rate of 78.0% which is above the national rate of 60.6%.

Recommendation rates: Across BNSSG CCG 89.8% of respondents would recommend their GP Practice; this is 0.4% below the national average and a 1.4% increase from the previous month. In January 2020,

The percentage of patients who would not recommend their GP practice was 7.6%. This is 2.5% higher the national average and a 0.6% decrease on the previous month.





Primary Care – Q3 Incidents and complaints

Primary Care Datix Reports Q3	Oct 2019	Nov 2019	Dec 2019	Total
Diagnostic incident including delay	0	0	1	1
Medication incident	7	0	5	12
Treatment delay	1	1	0	2
Total	8	1	6	15

Medication errors	
Prescription error	1
Administration error	7
Storage issue	3
Medication change not communicated	1

Treatment delay	
Vaccine delay	1
Communication of change in Meds	1

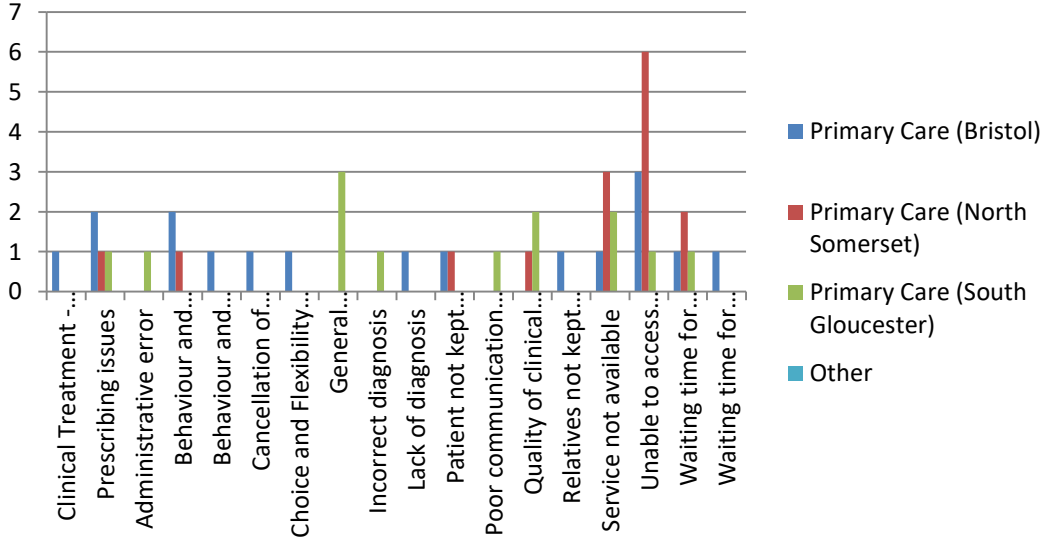
Diagnostic delay	
Test results not acted on	1

Of the medicines related incidents, 7 involved the administration (5) or storage (2) of flu vaccines. This corresponds to the increased activity between October and December. The majority of incidents are reported by Practice Nurses. The Medicines Optimisation team is working with the Screening and Immunisation teams on how incidents can be reduced in future, and to minimise the admin time required to report vaccination incidents.

Incidents around the quality of discharge summaries/communicating changes in medicines between care settings continue to be reported. The majority of these incidents are reported by PCN pharmacists and have already been fully resolved by the time the Datix is submitted. Community pharmacy dispensing errors are investigated with the pharmacy and prescriber and shared with NHS England.

Incident themes and medication issues are discussed at the Medicines Quality and Safety group. Working groups are established on key areas identified. Currently work is in progress to increase the number of incidents reported onto Datix, as it is acknowledged there is likely to be under reporting.
The BNSSG GP Incident reporting policy will be presented to PCCC this month for approval.

Concerns reported by locality



This chart shows patient complaints reported via BNSSG Customer Services reported onto Datix. The highest category of concern in the data available is 'Unable to access appointments' however the numbers are so small that the data is not significant.

Information available to BNSSG about complaints in Primary Care is limited. Numbers are very low as GP practices manage their own complaints data. We are in discussion with Practice Managers about sharing this information on a monthly basis which will be aggregated and reported by area in future reports. NHSE manage escalated patient complaints and we are in discussion for that data to also be shared.

Risks:

- Spread of COVID-19 across UK with predicted 80% population unwell and 1/5 workforce affected
- Rapidly changing needs as the country moves to social isolation model which will affect communication and management of care
- Suspending routine CQC inspections

Mitigations:

- BNSSG CCG Primary Care Cell to manage business continuity
- Communications through the Primary Care Cell to practices to support local management
- Implementation of remote consultation models
- Provider involvement to include One Care/Severnside/Locum agencies/LMC across the system
- Communication links to the BNSSG CCG Infection Prevention and Control Cell which is being managed by the Nursing & Quality Team in the management of those with COVID-19 which are known and understood throughout the organisation (including fit testing training, Personal Protective Equipment (PPE) refresher training, and hand washing training/refresher)
- Business Continuity Plans for each GP Practice in place
- Involvement of Local Prescribing Committee and Medicines Management
- Collaboration with CQC who are working on remote methods to give assurance of safety and quality of care where it may relate to some inspection activity where there may be safeguarding concerns

- https://www.gov.uk/government/publications/wn-cov-guidance-for-primary-care

- https://campaignresources.phe.gov.uk/resources/campaigns/101-coronavirus-/resources

Primary Care Q3 Healthcare Associated Infections (HCAI)

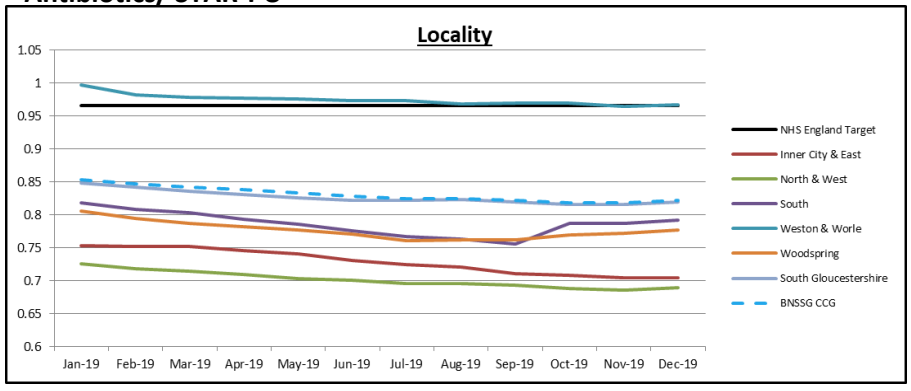
The purpose of this section is to provide an update for Infection, Prevention and Control for BNSSG in Primary Care which includes information on all reported healthcare associated infections including Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Clostridium Difficile and Escheria coli (E.coli). It has not been possible due to the escalating issues regarding COVID 19 to present the data.

Actions:

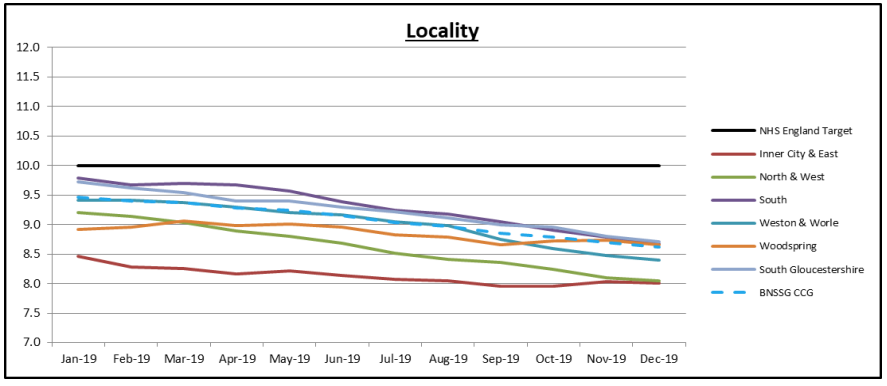
- A Methicillin-resistant Staphylococcus aureus (MRSA) alert tool has been developed, which all providers involved in a patients' care can contribute to following the identification of a MRSA bacteraemia
- Support to improve use of the community onset Clostridium Difficile reporting tool, reviewing cases and identification of learning which is ongoing.
- Work with providers through the HCAI group bi-monthly meeting to ensure that GPs and practice nurses have access to the catheter passport and are involved in the work to address E.coli where the primary source of bacteraemia was linked with a Urinary Tract Infection. BNSSG CCG Practice Nurse Leads to take action on this
- BNSSG Quality and Practice Nurse Leads to continue to attend the E.coli Task and Finish Group to represent Primary Care and will feedback through Practice Nurse Steering Group and PN Forum
- Identification of Infection Control Link nurses in each GP Practice who will cascade actions from the HCAI meetings. BNSSG CCG Practice Nurse Leads to action this and feedback
- Report together HCAI and system wide antibiotic use in future papers.

Medical - CE	Antimicrobial stewardship update	Assurance Rating: Green No Concerns
Elizabeth Jonas	Report for : PCOG/ PCCC	Reporting Period: Quarter 3

Antibiotics/ STAR-PU



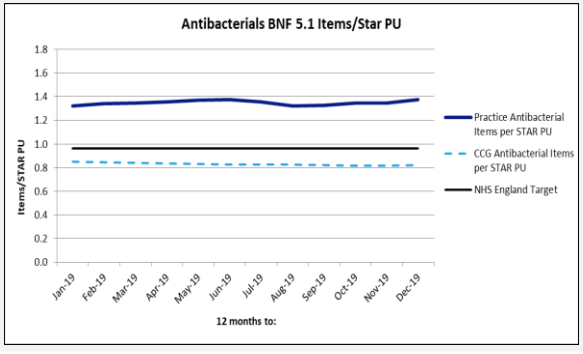
Percentage of cephalosporins, quinolones and co-amoxiclav



Nationally Set Targets

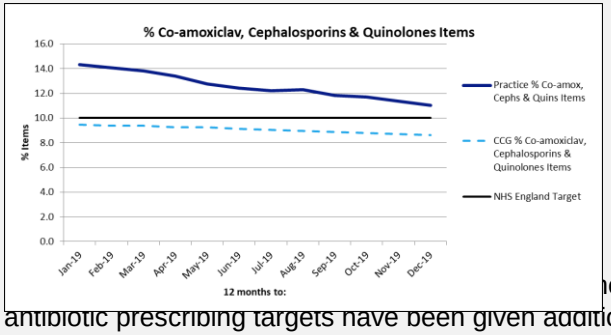
- The two main prescribing measures for antibiotic stewardship the CCG is measured on are Antibiotics/STAR-PU and the percentage of all antibiotic prescriptions that are broad spectrum.
- Antibiotics/STAR-PU looks at overall antibiotic prescribing. The nationally set target is 0.985 antibiotics/STAR-PU. Weston and Worle is the only locality that is not meeting the target. There are 11 practices that are not meeting the target of which 5 are in Weston and Worle. Horizon health care are having significant issues meeting the target where as other practices are just above target.

Horizon Healthcare Antibiotics/STAR-PU



- 10% or less of all antibiotics should be cephalosporins, quionolones and co-amoxiclav. All localities are meeting this target and continue to reduce.
- Nine practices are not meeting the target, this is down from 23 in March 2019. There has been great improvement in several practices including those not yet meeting the target. Three Shires medical practice which has the highest percentage have reduced from 14.3% in January 2019 to 11% in December 2019

Three Shires Medical Practice Broad spectrum prescribing



- ...he antibiotic prescribing targets have been given additional support from the medicines optimisation team.

Urinary Tract Infections

- To support the gram negative bacteraemia reduction target the appropriate treatment of urinary tract infections has been focused on. The BNSSG UTI guideline has been reviewed and re-released and teaching has occurred at all the practice nurse forums. An EMIS template to support the guideline is under production.

Next steps

- To continue to support practices in meeting and maintaining antibiotic prescribing targets.
- To review the TARGET antibiotic stewardship self-assessment sheets that all practices have completed as part of the prescribing quality scheme this year – sharing good practice and actioning areas for improvement.
- Focusing on the appropriate labelling of penicillin allergies and intolerances as part of the 2020/21 prescribing quality scheme.
- A continued review of the BNSSG antibiotic guidelines, especially with the release of NICE antibiotic guidelines. Antibiotic prescribing in children will be a particular focus.

NHS
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Clinical Commissioning Group

Report to Primary Care Commissioning Committee – March 2020

Title: **General Practice Significant Incident Reporting Guidance**

Purpose of paper: This guide aims to support staff working in Primary Care by providing guidance on which significant incidents need to be escalated to the CCG.

For Approval/ Decision	For Review	Receive for assurance	Receive for information
		✔	✔

For Discussion

Executive Summary:

Responding appropriately when things go wrong in healthcare is a key part of the way the NHS can continuously improve the safety of patients.	At General Practice level, having systems in place to effectively report and manage patient safety incidents is essential as it supports clinicians and the whole practice team to learn about the root cause of an incident and what can be done locally to keep patients and staff safe from avoidable harm.
The Role of BNSSG CCG in Significant Incident reporting	We want to encourage practices to identify and report significant incidents and then share the learning from these incidents within the practice and the wider BNSSG area. The incidence of significant incidents, which need reporting to the CCG, that occur in a General Practice is likely to be very low, probably no more than 3-4 per year.
Definition of a Serious Incident	A serious incident requiring investigation is defined by the NHSE Serious Incident Framework as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:- **Unexpected /avoidable death; Serious Harm; Unexpected or avoidable event/injury; Actual or alleged abuse; Service Delivery**
Process for Reporting and Managing Significant Incidents from Primary Care	All significant incidents should be reported through the BNSSG Significant Incident Portal. Once the practice has identified and agreed an incident meets the criteria of a significant incident it will need escalating to the CCG using the BNSSG Datix Portal that can be accessed using this link: **https://bnssg-datix.scwcsu.nhs.uk/index.php**
Investigating and Managing Significant Incident in Primary Care	Significant Incident Analysis should be carried out by the practice, with the CCG offering practical support and advice on conducting the analysis.

Action Required

The Primary Care Commissioning Committee is asked to note contents of this report and support the work programme outlined.

Financial resource implications	There are no specific financial resource implications highlighted in this paper.
Legal implications	No legal implications associated with this paper

Risk implications	Specific programme risks have been highlighted in relevant sections of the paper.
Equality & Diversity Impact – reducing health inequalities.	Monitoring of incident trends may highlight any areas of Health Inequalities within BNSSG which will then be addressed accordingly. Any projects undertaken will have an individualised EIA undertaken.
Engagement with patients and/or public:	Whilst there has not been any direct consultation and communication with the public in production of this paper, most GP practices have established Patient Participation Groups and individual projects will have consultations or advice sought when required.

Presented by: **Rosi Shepherd, Director of Nursing and Quality**
Prepared by: **Jacci Yuill, Lead Quality Manager – Primary Care**

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General Practice Significant Incident Reporting Guidance

1. Introduction

Responding appropriately when things go wrong in healthcare is a key part of the way the NHS can continuously improve the safety of patients. At General Practice level, having systems in place to effectively report and manage patient safety incidents is essential as it supports clinicians and the whole practice team to learn about the root cause of an incident and what can be done locally to keep patients and staff safe from avoidable harm.

This guide aims to support staff working in Primary Care by providing guidance on which significant incidents need to be escalated to the CCG.

2. The Role of BNSSG CCG in Significant Incident reporting

We want to encourage practices to identify and report significant incidents and then share the learning from these incidents within the practice and the wider BNSSG through Primary Care Networks (PCN), Localities and Clinical/Practice Manager/Nurse/Quality Forums. The incidence of significant incidents, which need escalating to the CCG, that occur in a General Practice is likely to be very low, probably no more than 3-4 per year.

As part of the Care Quality Commission (CQC) registration, every GP practice should have an incident policy/procedure in place. This is to ensure in the event of an incident, including near-misses and significant events, there is a clear reporting and investigation process for incidents that take place at the practice.

The GMC requires GPs to declare and reflect on those significant events in which they have been personally named or involved and in which a patient or patients could have or did come to harm. This means that all **significant events** that meet the GMC threshold of harm must be reported and managed through the GP Practice process. Those that are identified as **'Significant (serious) Incidents',** and meet the criteria, need escalating to the CCG.

NHS England requires Acute, Mental Health, Community Providers, Ambulance Services and Urgent Care Providers to report significant incidents, calling them 'Serious Incidents'. The volume of incidents reported in secondary care is significantly higher

than in GP practices. However there are some useful definitions which may help practice staff identify any significant incidents as they occur.

3. Definition of a Serious Incident

A serious incident requiring investigation is defined by the NHSE Serious Incident Framework as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:-

- **Unexpected or avoidable** death of one or more patients, staff, visitors or members of the public;
  E.g. a patient dies in a GP surgery toilet and goes unnoticed for 10 minutes or a patient who has expressed feeling desperate, was being treated with medication by the GP, makes an appointment to come back for a review, does not attend and is not followed up by the practice. Three days later police inform practice the patient has taken his own life.
  Deaths on premises also need to be reported to Care Quality Commission.

- **Serious Harm** to one or more patients, staff, visitors or members of the public or where the outcome requires life-threatening intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
  E.g. an unwell patient was placed in the Treatment Room in a side room without appropriate instructions to the staff regarding monitoring. They had a cardiac arrest, an ambulance was called and they died in hospital days later.

- **Unexpected or avoidable event/injury** to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user; or serious harm;
  E.g. a Treatment Room vaccination fridge was unplugged by a cleaner. It was then plugged back in in the morning by administrative staff without realising, which destroyed the efficacy of the vaccines. The vaccines were used without the staff realising which resulted in patients having to be revaccinated.
  Please refer to Section 8 for details on the reporting of vaccination incidents as they also need to be reported to the Screening and Immunisation team.

- **Actual or alleged abuse**; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery
  E.g. a patient discloses to a practice nurse that the GP carried out an intimate examination inappropriately.
  The usual Safeguarding process should also be followed as well as reporting to the appropriate professional body (GMC/NMC) and NHSE.

- **Service delivery;** A scenario that prevents or threatens to prevent a GP practices ability to continue to deliver health care services, for example, actual or potential loss of personal/ organisational information, damage to property, reputation or the environment, or IT failure;
  E.g. system failure of EMIS and GPs cannot access patient records for several hours or a practice has a fire over the weekend which destroys much of the practice.

*More examples are set out in appendix 4

The commissioning of Primary Care was delegated to BNSSG CCG from NHS England in April 2018. The CCG seeks assurance of quality services, as it does with all providers. BNSSG CCG is responsible for oversight of Significant Incidents from all providers. Sharing significant incidents with the CCG supports identification of themes and wider learning across localities.

4. Process for Reporting and Managing Significant Incidents from Primary Care

All significant incidents should be reported through the **BNSSG Significant Incident Portal.** A '**significant incident**' (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented. Incidents are currently managed in GP Practices through the significant event processes.

Reporting significant incidents to a local central system helps protect patients from avoidable harm by increasing opportunities for the NHS locally to learn from things that go wrong. These reports are used to spot any emerging patterns of similar incidents or anything of particular concern. This will help protect patients and practice staff by raising awareness of the risks through shared learning with general practices and other health providers across BNSSG.

All patient safety incidents (clinical and non-clinical) should be recorded within the practice and then reported if they are identified as Significant Incidents to the CCG. Once the practice has identified and agreed an incident meets the criteria of a significant incident it will need escalating to the CCG using the **BNSSG Datix Portal** that can be accessed using this link:

https://bnssg-datix.scwcsu.nhs.uk/index.php

The **BNSSG Datix Portal** is a web based system created to enable GP Practices, clinical and non-clinical staff to report **significant incidents** that occur in the practice.

The form is simple to complete and has drop down boxes to complete information required such as the date of the incident, the locality, which GP practice and 'free text' boxes to describe what happened and what action was taken.

If you are not sure how to complete the form or need advice about reporting a significant incident please contact the CCG Quality Team;

- **by email: bnssg.pc.quality@nhs.net**
- **by telephone: 0117 900 2451**

The Sgnificant Incident will be acknowledged by the Quality Team and reviewed. The CCG will check if the incident meets the threshold for significant incident reporting as required by national guidance. If the incident meets the criteria, the incident will be reported onto NHS Improvement Strategic Executive Information System (**STEIS**) by the CCG on behalf of the practice within two working days, as set out in the NHS Improvement Serious Incident Framework. The CCG will inform the GP Practice within two working days of the action required regarding the incident process.

If an incident is deemed serious and reported onto the StEIS database the practice will be notified and offered support and guidance to undertake an investigation. In line with national guidance, each provider organisation has 60 working days, according to the NHS Improvement Framework, to investigate and formulate a Significant Incident Analysis (or Root Cause Analysis or 'RCA') report. The final investigation report and action plan are submitted to the CCG for review by a multidisciplinary team from the Quality Team against the Closure Checklist in the Serious Incident Framework. Where the report is robust and the actions address the findings, the multidisciplinary team at BNSSG CCG will agree to close the incident on STEIS. Feedback will be sent to the provider

Where there are outstanding issues that are not sufficiently addressed, the multidisciplinary review members will ask the provider for further information or to amend the report. Closure is not recommended until adequate assurance is provided that all necessary actions are included. Once closed, the action plan is monitored to ensure that issues identified in the RCA are addressed appropriately. BNSSG CCG will check the outcome from the action plan once the actions are scheduled to be complete.

5. Investigating Significant Incident in Primary Care

Significant Incident Analysis should be carried out by the practice, with the CCG offering practical support and advice on conducting the analysis. The report must be anonymised (no patient or staff names), contain a high level of detail and completed where possible by a multidisciplinary team.

Refer to Appendix 1 for an example of a Significant Incident report template. It describes in each section what information should be included as part of the investigation. This process and template is needed for serious incidents but would also work equally well with the GP Significant Events and Learning Events.

Appendix 2 sets out a tool called a 'fishbone analysis' which may help the practice investigate, organise and document their findings as part of the investigation.

If you need any help and support or training in regard to significant incidents please contact the CCG Quality Team.

If a member of staff is directly involved in the Significant Incident, they should not be the lead investigator, but they can contribute information.

6. Managing Significant Incidents from Primary Care

BNSSG CCG will have oversight of the investigation undertaken by the practice. Support will be given by BNSSG Quality Team as appropriate. If the practice believes they are not able to undertake the investigation, they should contact the Quality Team to discuss. The CCG will agree the best options to progress the investigation. The plan for management of a Significant Incident will be communicated to the practice by the BNSSG CCG Quality Team and the StEIS database will be updated.

In scenarios where more than one provider is required to contribute to a Serious Incident investigation, BNSSG CCG will usually coordinate this process. There will be shared information and decision making in each case.

Once a Significant Incident is closed, the action plan is monitored to ensure that issues identified in the investigation are addressed appropriately. BNSSG CCG will check the outcome from the action plan once the actions are scheduled to be complete.

We want to encourage practices to identify and report incidents and then share anonymous learning from these incidents within the practice and the wider BNSSG system through Primary Care Networks (PCN), Localities and Clinical/Practice Manager/Nurse/Quality Forums. This will enable a consistent approach to improve the quality and safety of patient care. The Quality Team will share the learning from incidents on the GP Portal and Team Net.

The BNSSG CCG Quality Forum is a workspace which provides a safe environment to share experiences, outcomes and learning from any issues that arise when providing care. All information is redacted and only visible to the users of the site. The membership is open to quality representatives from the practices, members from key teams at the CCG (Quality, Safeguarding, Medicines management etc.) as well as all the CCG Clinical leads.

7. Reporting Public Health Incidents including Immunisations or Screening Services

Public Health Commissioned Services
A requirement of the public health (PH) service contract is that any adverse incidents relating to public health services should be reported to public health to ensure appropriate action is taken. Actions which might be taken as a result of such report may be to:-

- provide additional training,
- change protocols in the light of identified issues
- share learning from incidents to improve patient care.

Please use the **BNSSG Datix Portal** to report all significant PH events and we will forward these to the PH commissioner.

Immunisation and Screening
The NHS England and Improvement Public Health Commissioning Team (NHSE PHCT) commission immunisation and screening services from Primary Care and are supported by the Public Health England Screening & Immunisation Team.

Immunisations
All practices should report incidents related to immunisation to the Screening & Immunisation Team via email:
england.swscreeningandimms@nhs.net
This includes reporting all vaccine incidents and errors as well as cold chain issues. The Screening & Immunisation Team will support practices with guidance and recommendations for action.

Both Public Health and BNSSG Nursing and Quality teams will review the incident and agree a lead commissioner and shared response. It may be that the incident includes elements of both CCG and NHSE services. This type of incident would be jointly managed.

Immunisation resources
There is information available in Public Health England's 'Vaccine incident guidance: responding to errors in vaccine storage, handling and administration' that practices will find useful:
https://www.gov.uk/government/publications/vaccine-incident-guidance-responding-to-vaccine-errors
(updated September 2019)

Additional cold chain guidance can be found in Chapter 3 of the Green Book 'Storage, distribution and disposal of vaccines':
https://www.gov.uk/government/publications/storage-distribution-and-disposal-of-vaccines-the-green-book-chapter-3

https://www.gov.uk/government/publications/keep-your-vaccines-healthy-poster

Screening

Issues and concerns relating to screening programmes should also be reported to the Screening & Immunisation Team via email:

england.swscreeningandimms@nhs.net

Appendix 1 – guide for completing a Significant Incident Analysis (investigation)

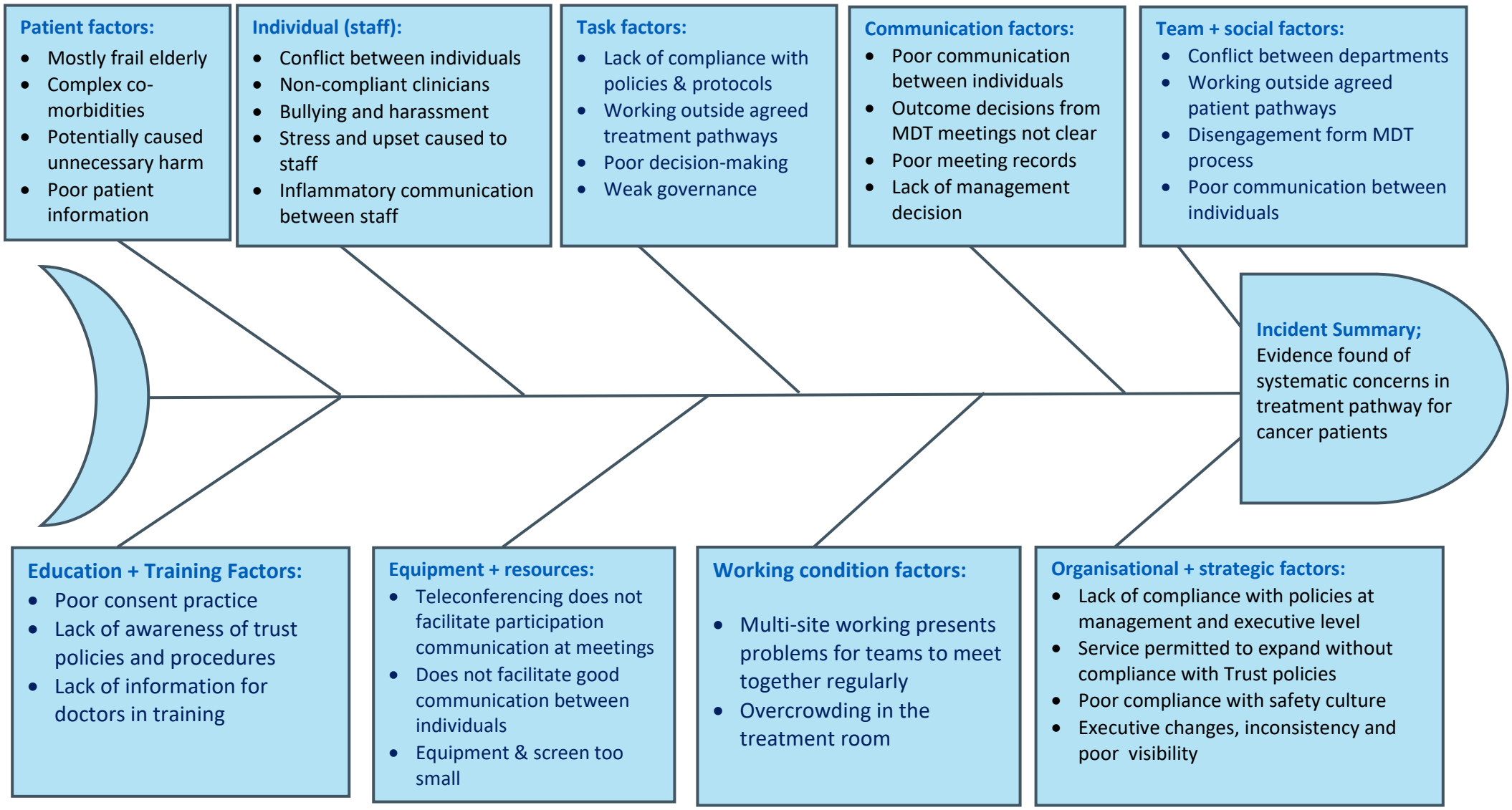
	Guidance Notes
Summary incident description and consequences:	A clear, concise description of the significant incident and the effect that it had on the patient, staff, service and stakeholders. Only relevant consequences should be described and consideration should be given to both physical and non-physical (e.g. emotional, social, psychological) consequences.
Incident date:	
Incident type:	
Actual effect on patient:	A description of the level of harm/injury or impact on the patient
Incident description:	Describe what happened ensuring entire report is anonymised with no patient or staff names.
Involvement and support of patients and relatives:	Patient and/or carer/relative involvement must be considered under Duty of Candour guidance and a copy of the investigation should be offered.
Involvement and support of staff:	Provide information on formal and informal support offered to all staff involved with the significant incident and subsequent investigation.
Detection of incident:	It is helpful to know how the incident was identified, who it was identified by and whether this was detected during routine checks or during any notable deviations from standard protocol.
Care and service delivery problems:	This section highlights what went wrong. Care: Any problem that relates to the direct provision of care (normally acts or omissions by members of staff, e.g. failure to monitor; failure to escalate; incorrect prescribing, incorrect action) Service: Any problem that arises as a direct result of the way a whole service is delivered (e.g. telephone system failure; inappropriate clinic template in use) These are points where something that should have happened did not, or something did happen that should not have. There should be an emphasis on what happened, not on why or how in this section (i.e. what was the failing and not the cause). The analysis of these problems is then given in the section below.
Contributory factors:	This section provides the explanation of why the problems occurred. This is where the 'why' is explained from your analysis of how and what happened. Problems in the delivery of care rarely occur in isolation to a single act and usually link to many contributing factors, which influenced the decisions made. These are key to explore as they often lead to the learning to prevent recurrence. It may include: • Patient factors e.g. patient was taking contra-indicated medication prescribed for another person • Individual factors e.g. physical, social domestic issues • Task factors e.g. follow up appointment not booked, policy not followed • Communication factors e.g. key information not documented in patient notes • Education/training factors e.g. staff member was not up to date with training Equipment and resource factors e.g. positioning, usability, faulty

	• Working conditions e.g. staffing, workload, design of working environment
Root causes:	These should be numbered and listed. There should be a direct link between evidence found during the course of investigation and the stated cause (e.g. "the allergy status recorded in the patient's records was not accurate and this impacted on what medication was prescribed")
Lessons learned:	Lessons learned may not always be linked to the significant incident – they may at times be incidental findings that were picked up during the course of investigation. It is important that these are included in this section so as to facilitate learning.
Recommendations:	Should be clear and concise. They may be specific to the area where the incident occurred, common to only the practice or unless they relate to a system failure.
Arrangements for sharing and learning:	Consideration should be given as to whether learning needs to be shared and, if so, how this is to be done within the practice, PCN or practice managers forum.
Action Planning and Solutions:	Action plans will provide details of how each recommendation will be implemented; ensure that named individuals are responsible for each action point and that there is a specific time frame for completion. It is important to ensure that the implementation of action plans is monitored to provide assurance that necessary steps are being followed in a timely manner.
Author:	Date:

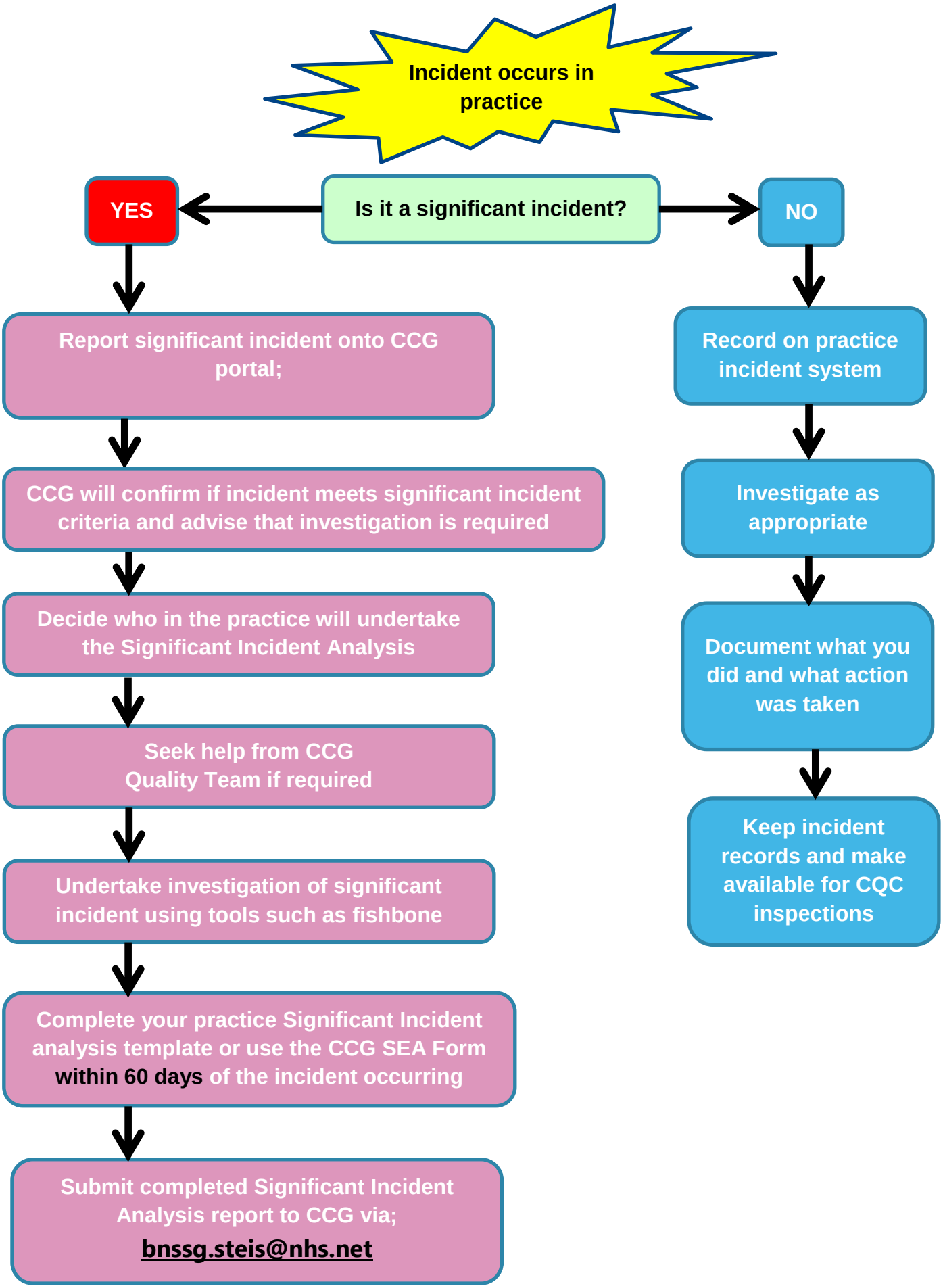
Chronology/Timeline of incident:

Date	Time	Incident

Appendix 2 – Fishbone Analysis tool – example to help map out findings



Appendix 3 – Flowchart for GP Significant Incident reporting



Appendix 4 - Further Examples of incidents in primary care

Example 1

Mike is 48 he has had a tough year with a recent divorce and loss of his job.
Three months ago he went to see his GP because he felt things were getting on top of him and he was feeling desperate. The GP begins to treat Mike with some medication asking Mike to return in a couple of weeks so he can review how he is getting on. Mike makes an appointment to come back but he does not attend, the practice does not make contact with Mike.
Three days later the practice is informed by the police that Mike had been found dead as a result of suicide.

Is this a serious incident?

YES: because Mike's death was unexpected. He was in receipt of care from his GP for mental health issues. Therefore the practice must review the death to see if there was anything that could have been done differently.

- Had the GP asked Mike if he was thinking of harming himself?
- Were there missed opportunities to refer Mike into support services?
- Should the practice have followed Mike up more proactively?

In cases like this the practice is also likely to be asked for information by the coroner.

Example 2

Primary Care Support England (PCSE) sends a batch of 25 patient records to your practice. The records include electronic copies of letters and communications about treatment the patients have received. Practice staff realise that the records sent to them do not relate to any of the practices patients.

Is this a serious incident?

YES: The first step with any IG incident is to use the IG toolkit to support you in deciding if the incident needs to be reported externally. This incident is a SI but not for your practice, you may still be the ones to raise it firstly with PCSE, then the CCG but also the ICO.
This can happen when work is outsourced to a private company.

Example 3

As part of the retinopathy screening programme diabetic patients attend high street optometrists for initial testing. Two patients from your practice attends a routine screening appointment and it is found that a further follow up in secondary care is required. The optometrist writes to the GP practice asking for an onward referral into secondary care.
The practice files the letters away without arranging the appointments.
The incident comes to light when the ophthalmologist is contacted by a patient saying they had not heard anything from the hospital.

Is this a serious incident?

YES: Although a small number of patients were affected it was part of a national screening programme. The SI framework requires incidents relating to national programmes like this to be reported as SI's.

Example 4

Mabel is 86 years old and she comes in to the surgery to get her annual flu vaccination. When her name is called she gets up from her chair and begins to walk to the nurses room. As she does so she begins to feel dizzy and falls onto the floor.
Surgery staff gave Mabel some help and Mabel is eventually able to get up, she has a small bruise on her leg but no other injury

Is this a serious incident?
No, as Mabel did not suffer any harm as a result of the incident. It would have been different if Mabel had sustained a serious injury such as a broken hip or significant head injury.

The practice would still need to ensure this is reported as an internal incident and make sure that a review is undertaken to ensure there were no factors that might have contributed to her falling such as a trip hazard

Example 5
David is 56 years old and has numerous health problems which have resulted in him needing to use a wheelchair all the time. He is married and he and his wife manage at home although sometimes it is a bit of a struggle for David to get in and out of his chair. As a result he tends to spend most of his time sat in his wheelchair. He doesn't have any involvement from Community Nurses.

David does not like to complain but does attend the surgery regularly for appointments for his high blood pressure and asthma. One day David becomes unwell and is admitted to hospital, he is found to have a deep pressure ulcer to his bottom

Is this a serious incident?
YES - Grade 3 and 4 pressure ulcers are considered to be significant harms to patients. They all must be reviewed by the organisation responsible for the patients care at the time they acquired the pressure ulcer. In this case this is the GP practice

The practice would be asked to consider if there was more that could have been done to help prevent the pressure ulcer from developing in the first place

Example 6
Matilda is 84 years old and lives in a residential home. She has dementia and is incontinent of urine. From time to time she becomes aggressive this is often associated with a urine infection. Over the past 6 weeks Matilda has been treated 4 times by her GP for a suspected urine infection, she has been given 4 courses of antibiotics.

Two days after starting her fourth course she begins to suffer from severe diarrhoea and abdominal pain. She becomes dehydrated and is admitted to the local hospital as an emergency. A sample is taken in ED and C.difficile is identified and treatment started, unfortunately Matilda is so unwell that she passes away, the cause of death is recorded as C.difficile

Is this a serious incident:
YES - If a death is caused by C.difficile then it is automatically a SI and is reportable on STEIS and to the Health Protection Agency. (14 day time frame)
The same is true for any case of MRSA blood stream infection

The investigation would be led by either the CCG (infection control team) or sometimes by secondary care.

The practice must support the investigation and agree to implement any actions that are agreed at the end of the investigation.

Example 7

Mary has several moles, one mole is causing her discomfort and is bleeding. The GP runs a minor ops service and agrees to remove Mary's troublesome mole. The GP removes the wrong mole during the procedure and Mary makes a complaint.

Is this a serious incident?

YES: This is actually a NEVER EVENT for Wrong Site Surgery

Appendix 5 - Further Information

Royal College of GPs

https://www.rcgp.org.uk/training-exams/practice/revalidation/mythbusters-appraisal-and-revalidation/significant-events.aspx

CQC guidance

https://www.cqc.org.uk/sites/default/files/documents/statutory_notifications_for_nhs_bodies_-_provider_guidance_v6.pdf

https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-3-significant-event-analysis-sea

NHS Improvement guidance

https://improvement.nhs.uk/resources/reporting-patient-safety-incidents-general-practice/

https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

Screening and Immunisation Guidance

The NHS England Public Health Commissioning Team (NHSE PHCT) commission immunisation and screening services from Primary Care. There is a separate and distinct reporting process for these incidents set out in the 'Green Book'. All practices should report incidents related to screening and immunisation services to Screening and Immunisations:

england.swscreeningandimms@nhs.net

Both Public Health England and BNSSG Quality teams will review the incident and agree a lead commissioner and shared response. It may be that the incident includes elements of both CCG and NHSE services. This type of incident would be jointly managed.

BNSSG Cold Chain Guidance:

https://www.gov.uk/government/publications/keep-your-vaccines-healthy-poster