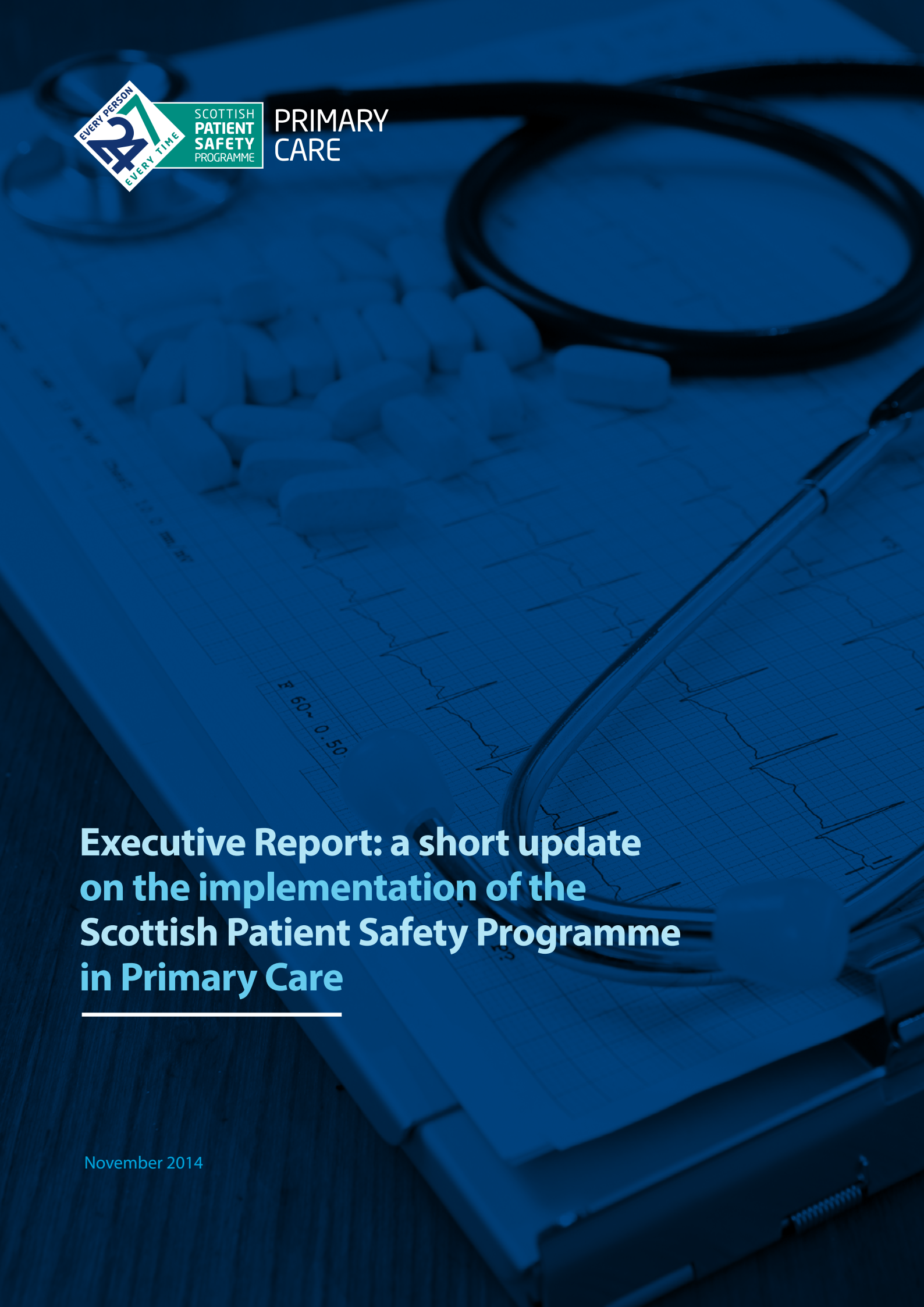

SCOTTISH PATIENT SAFETY PROGRAMME

PRIMARY CARE

Executive Report: a short update on the implementation of the Scottish Patient Safety Programme in Primary Care

November 2014

What are the context, ambition and aims of the programme?

The Scottish Patient Safety Programme in Primary Care is part of the wider Scottish Patient Safety Programme (SPSP) and was launched in March 2013. The overall ambition of the primary care programme is to reduce the number of events which cause avoidable harm to people from healthcare delivered in any primary care setting in Scotland. This is supported by the aim of all NHS territorial boards which is, that by April 2016, 95% of primary care clinical teams will be developing their safety culture and achieving reliability in three high risk areas.

To achieve this aim, the programme comprises three workstreams. These workstreams provide a menu of options from which NHS boards select elements to implement and improve reliability over the duration of the programme (March 2013–April 2106). These workstreams are aligned to those of the wider SPSP and include the following.

- ***Safety culture and leadership:*** improving patient safety through the use of trigger tools (structured case note reviews) and safety climate surveys.
- ***Safer medicines:*** including the prescribing and monitoring of high risk medications, such as warfarin and disease-modifying anti-rheumatic drugs (DMARDs), and developing reliable systems for medicines reconciliation in the community.
- ***Safety across the interface:*** focusing on developing reliable systems for handling written and electronic communication and implementing measures to ensure reliable care for patients.

How is the programme being delivered?

The programme is being delivered through a phased approach, with the first phase focusing on General Medical Services (GMS). The programme's workplan includes spread to the wider community in phase 2, and testing in community pharmacy and nursing is now taking place (see table below).

Phase 1	General Medical Services, for example GP practices	Proto-type and testing 2010–2012 Launched March 2013
Phase 2	Community pharmacy and nursing	Proto-type and testing from Autumn 2014
Phase 3	Dentistry and optometry	Exploratory work from late 2014

The collaborative approach

The programme is being delivered using a new methodology of a 'collaborative within a collaborative'. This is adapted from the Institute for Healthcare Improvement's Breakthrough Series Collaborative[1] approach. Each NHS board participates in the national collaborative, and attends national learning events, to learn about the tools and interventions within the programme. Participants then deliver events at NHS board level, supporting the local collaboratives.

[1]The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. Available from: www.IHI.org

How are we improving safety process reliability?

NHS boards are supporting the implementation of the programme through the use of local enhanced services. The majority of NHS boards have negotiated these enhanced services to focus on the key areas of harm that they identified as a priority.

The nationally agreed care bundles provide a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes. This means ensuring that patients receive optimum care at every contact. Care bundles have been developed for each of the high risk areas (warfarin, DMARDs, medicines reconciliation and outpatient communications). Practices are collecting data on the measures to show improvement, and reliable change. To date, 819 practices across Scotland have introduced care bundles, with 83% implementing at least one bundle.

How are we improving safety culture and leadership?

Safety climate survey

Building a safety culture is strongly promoted as an important activity for SPSP in Primary Care. Negotiated as part of the Quality and Outcomes Framework under the GMS contract, the safety climate survey requires practice staff to complete the questionnaire anonymously on an annual basis. Participants' scores are aggregated to provide a 'snapshot' of the practice's overall safety climate and of those factors known to be important aspects of safety climate in the workforce. This includes, leadership, teamwork, communication, workload and safety systems. The report generated provides an opportunity for the whole practice team to meet and discuss openly how they can improve their safety culture: it allows issues to be raised and prioritised for action.

Since SPSP in Primary Care began, the number of practices participating in the survey has increased to 90% across Scotland.

Practice teams reviewed their report and highlighted a wide range of identified improvements. Feedback from practices indicates that the tool has been well received, and across NHS boards, themes are being collated and shared with practices, as well as board governance and executive groups. The method for sharing the feedback varies from NHS board to NHS board, and includes:

- presentation and discussion at local and national learning sessions
- newsletters and flash reports
- themed reports shared with other practices, and at NHS board meetings, including Quality Improvement and SPSP Steering Group meetings
- on NHS board intranets and the SPSP in Primary Care knowledge site, and
- discussion with individual practices when local patient safety teams carry out practice support visits.

Leadership walkrounds

Some NHS boards have started to carry out walkrounds within GP practices. Senior leaders are encouraged to use patient safety leadership walkrounds to demonstrate their organisation's commitment to building a culture of safety. They provide an informal method for leaders to talk with frontline staff about safety issues in the organisation and show their support for staff-reported errors. The national SPSP in Primary Care team will support NHS boards throughout the walkrounds testing phase.

How are we reducing patient safety incidents?

As part of the Quality and Outcomes Framework, practices are asked to conduct two structured case note reviews each year, using a validated tool, to detect patient safety incidents. The trigger tool (structured case note review) is a simple checklist for a number of selected clinical 'triggers'. A reviewer looks for these triggers when screening a sample of medical records for patients who may have been unintentionally harmed. The practice team meets to discuss the results and shares a reflective report on actions, which can be themed within the NHS board. Participating in the reviews requires confidence that identifying and sharing of concerns and 'near-misses' will lead to learning and change for improvement.

Aggregation of the case note reviews has helped some NHS boards theme areas for improvement relating to:

- prescribing
- communication (with staff and patients and across interfaces)
- clinical (hospital admission and treatment)
- administration
- learning points for clinicians, and
- safety systems (protocols).

Practices have implemented a number of improvements including educational sessions, protocol development and significant adverse event reviews. One practice stated that the tool helped them to find 'What we didn't know we didn't know'.

How are we engaging with NHSScotland?

NHS boards can engage with the programme by participating in WebEx calls, SPSP in Primary Care group meetings, networking events and local learning sessions. WebEx calls are supplemented by two face-to-face meetings each year. We will also continue to support individual NHS boards with annual site visits.

Since March 2013, SPSP in Primary Care has delivered three national learning sessions attended by all territorial NHS boards. Each NHS board then runs its own local learning sessions to share knowledge and improvement methodology. To date, 2557 participants have attended 60 local learning sessions across Scotland.

What are the key findings from site visits?

Members of the SPSP in Primary Care team have met with each NHS board implementing the programme to gather information on progress. These visits allow dedicated time to meet the key individuals responsible for implementing and spreading the programme within each NHS board. They also provide an opportunity for the NHS board's local team to outline specific challenges it may be facing. There is time for NHS boards to update the national team on topics, such as capacity building, establishment of local teams, IT and data collection arrangements, as well as receiving an overview of progress from a national perspective. Key findings from the site visits include the following:

- strong clinical leadership is vital, as is executive support, to maintain the local collaborative
- focus for area of harm is influenced by local NHS board priorities
- data collection and aggregation are a challenge as the programme is not linked to existing practice IT systems, and
- SPSP in Primary Care presents as one of a number of competing priorities within primary care.

Examples of good practice across NHSScotland were identified throughout the visits, some of which are highlighted below.

Safety culture

- A number of NHS boards are testing leadership walkrounds, adapting the NHS Lothian templates for local use.
- NHS Grampian is planning to spread leadership walkrounds to involve the wider community, in particular community pharmacy.
- NHS Greater Glasgow and Clyde is combining patient safety leadership walkrounds with the quality improvement visits which take place annually in one quarter of the NHS board's practices.
- Initial discussions are taking place around using the safety climate survey in HMP Grampian.
- NHS Fife produced an annual report which was shared with practices, as well as at Board level through governance groups and committees.
- A number of NHS boards are building on existing capacity and capability with quality improvement (QI) experts delivering training to medical trainees.
- Most NHS boards are now beginning to spread the programme to community nursing.
- The team in NHS Highland has used the well-established practice manager network to support the implementation of the safety programme.
- To facilitate discussions around the safety climate survey report, NHS board teams are providing support and guidance as required.

Safer medicines

- In NHS Borders, 'teach-back'[1] is being tested through an improvement project led by a community nurse, focusing on improving safety by increasing patients' understanding and knowledge of the medicines they are taking.
- Some NHS boards are using process mapping with practices before beginning bundle data collection.

Safety at the interface

- Following recognition that there is a requirement to collect data on interface issues, NHS Borders has introduced a primary care feedback form. These issues are then followed up by the NHS board team. This allows primary care teams to feedback on issues identified with challenges of interface working. The introduction of this tool has helped to build the will to make improvements in this area.
- A number of practices in NHS Greater Glasgow and Clyde are piloting results handling. Data show improved compliance over time, leading to various improvements in practice.
- The Clinical Support Unit within NHS Grampian is well used. It provides a platform to build bridges between primary and secondary care, as well as providing the opportunity to build more reliable systems.
- Local systems have been developed to support district nurses to collect SPSP in Primary Care data in NHS Greater Glasgow and Clyde. This system has been built to use data which are being collected as standard, therefore no additional work is required by those using the system. It has received positive feedback from staff and is an excellent way of capturing data within community nursing.

How are we involving patients as partners?

We are involving patients in developing safety tools, practice protocols and patient education. For example, NHS boards and practices are asking patients to test patient information leaflets, such as for warfarin, before they are introduced more widely. In Healthcare Improvement Scotland, there is public partner representation on the SPSP in Primary Care governance and oversight groups. Patient representatives also attend local and national learning sessions.

How are we increasing capability and capacity?

Through local site visits to each NHS board, we are providing individual support for programme delivery and improvement methodology. We are using the SPSP in Primary Care knowledge site to deliver a range of resources relating to patient safety in primary care. NHS boards are keen to share information and learning on how they are delivering SPSP in Primary Care across Scotland.

[1]Scottish Health Council. The Participation Toolkit supporting patient focus and public involvement in NHSScotland. February 2014. Available from: www.scottishhealthcouncil.org

How are we supporting NHS boards to use data for improvement?

We have developed a data and measurement framework that will allow NHS boards to monitor and assess their progress against the programme's milestones. In autumn 2014, we began testing the reporting template. This will highlight how the NHS board is achieving reliability, where patient safety processes can be improved using a sampling approach. We have aligned our reporting structure and frequency with the other safety programmes.

What are the next steps?

Pharmacy in Primary Care Collaborative

The aim of this collaborative is to improve patient safety by strengthening both the contribution of pharmacists in primary care and improving communication within a more integrated primary care team. Pharmacists have a unique role to play in patient safety within the wider primary care team. Effective communication between GPs, hospital staff and pharmacists in primary care is essential within a whole systems approach to patient safety. This collaborative will run from July 2014 for two years, supported by funding from the Health Foundation's Closing the Gap in Patient Safety Programme[1]. Four NHS boards across Scotland have been recruited. These are NHS Highland, NHS Grampian, NHS Fife and NHS Greater Glasgow and Clyde. A national pharmacy clinical lead has been appointed to support this collaborative. The initial induction event for the four NHS boards was held on 20-21 August 2014, with the national launch taking place 25-26 November 2014.

Phase 2

To ensure the programme is focusing on the topics which are of greatest relevance to primary care, SPSP in Primary Care carried out a scoping exercise. This included a review of current literature, strategic drivers and a survey of primary care staff to ensure future areas of focus reflect key areas of harm. SPSP in Primary Care will support community nursing and pharmacy to improve patient safety and will use intelligence gathered from the scoping report to develop driver diagrams, change packages, and process and outcome measures for the key areas.

Tools and resources are available on our website:
www.scottishpatientsafetyprogramme.scot.nhs.uk

[1]This project is part of the Health Foundation's Closing the Gap in Patient Safety programme.
The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

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