Optimising Patient Safety in Primary Care

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In my experience….

- Patient safety project- safety culture, patient focus groups
- Incident reporting- NRLS
- Serious Incident Closure Group- NHS England SC
- Supporting GP practices in Special Measures, encouraging PPG involvement
- Patient Safety Academy, Oxford

…there were people missing

What does patient safety feel/look like?

Challenge- to learn and act

Involving patients

New models of care- new opportunities

PPG Focus groups

What does a ‘safe’ practice look and feel like? How do you know it’s safe?

PATIENT TRUST- “feel safe”

- ‘Trust’ in Clinicians
- Frontline/reception staff- help to ‘feel safe’….or not
- Access
- Systems and processes that help or hinder
- Medication/prescription errors and delayed/mis-diagnoses- most common concern
- Want feedback that lessons have been learnt

Challenge: **to effectively learn from mistakes** and to act to reduce the risk of it happening again **and then share with patients and feedback**

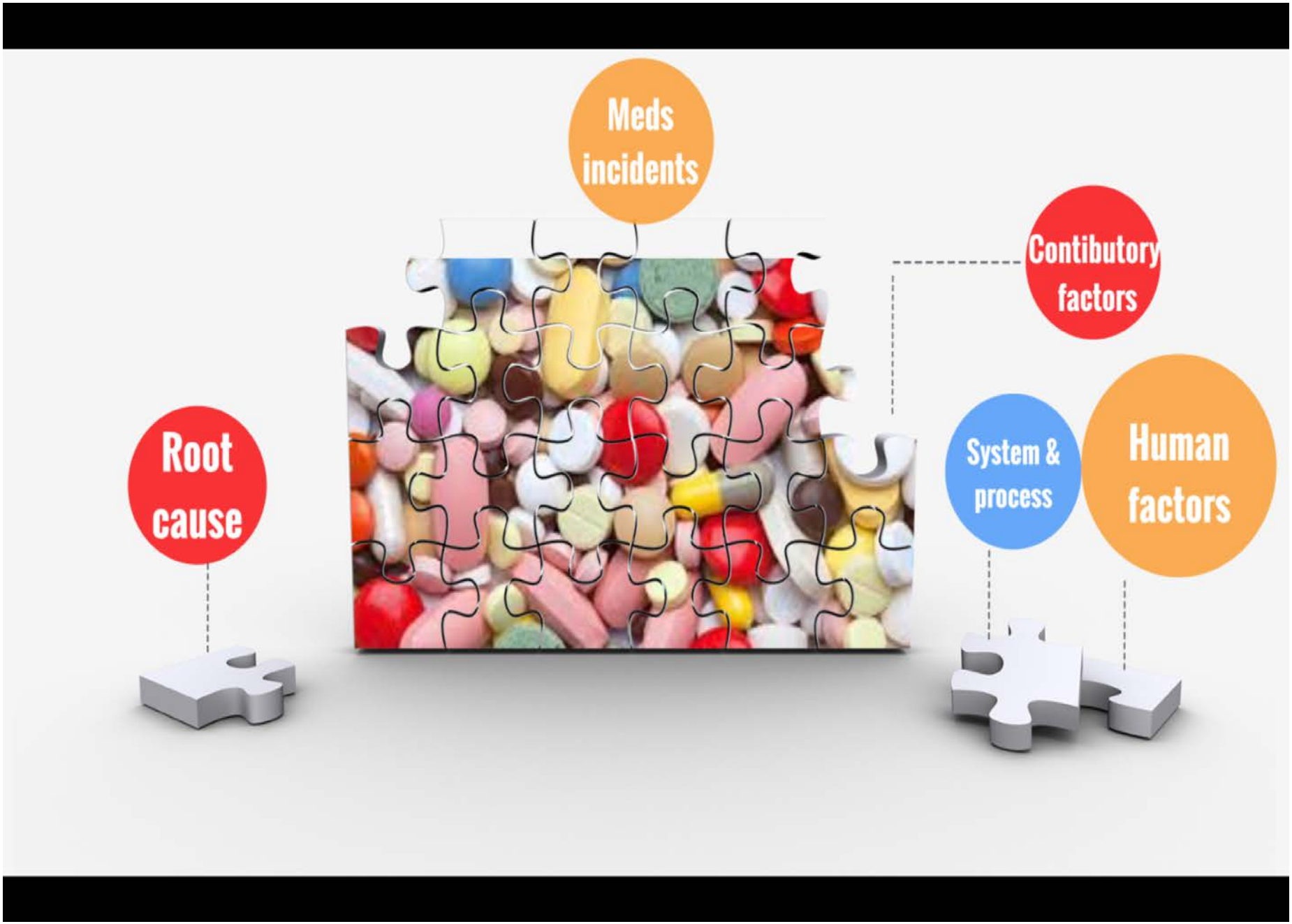
We don't want something bad to happen to someone else

We want to know a GP has learnt lessons


RC GP
Royal College of General Practitioners
Patient Safety Toolkit
School for Primary Care Research
The NIHR Greater Manchester Primary Care Patient Safety Translational Research Centre
NHS
National Institute for Health Research
Patient Safety Toolkit
Manchester Patient Safety Framework
Prescribing Safety Indicators
Patient Safety Questionnaire
Concise Safe Systems Checklist
Safety Check-list for General Practice
Medicines Reconciliation Tool
Significant Event Audit
The Trigger Tool
Primary Care SafeQuest

MaPSaF

- All different staff groups within the practice
- Perceived level of maturity
- Dimensions with widest spread, were the most problematic issues
- Involving patients in patient safety incidents
- Needs to result in actions

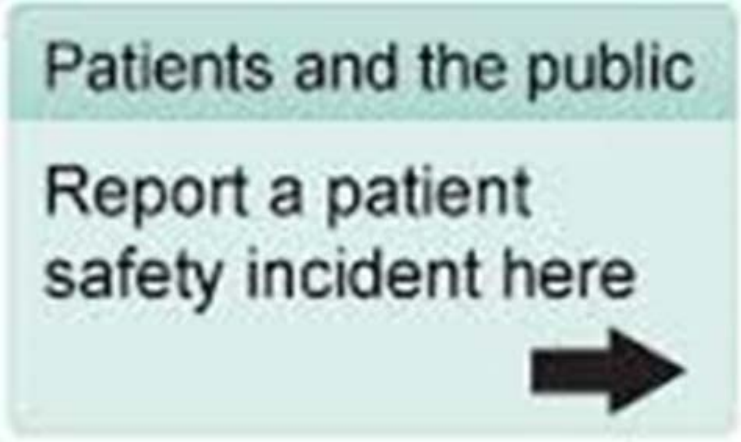

Meds incidents
Contibutory factors
Root cause
System & process
Human factors

MaPSaF, CQC and SEA

- Are the non clinical team aware of their role in patient safety?
- Leading through learning- continuous learning
- Involve your wider team- problem/solution
- How are you involving patients?
- How do patients know lessons have been learnt?
- Is analysis and sharing resulting in actions?
- Identify, manage and monitor risks

Involving Patients

- Involve PPG in improvement programmes
- PPG – patient safety champion
- Share trends/themes with PPG
- Involve patients in analysis/learning
- Provide feedback
- Self care- encourage reporting



New models of care- new opportunities

- GP at scale
- New roles- Clinical Pharmacist, Medical Assistant, Physician's Assistant
- MCP, PACS, Primary Care Home
- Build on foundations of existing work

Primary Care Home Model

- Multi professional, cross boundaries, sense of ownership, safety cultures.
- New systems and processes that help or hinder?
- Patient -centred

Patient centred model

Will patients be at the centre when things go wrong?

Will patients be able to be part of the solution?

Points to consider:

- How do patients know how safe?
- Patient and wider team involvement
- Wider sense of ‘us’ to own, learn and act
- New roles, models, systems and processes- opportunities and risks?