Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

Office of the Nursing & Midwifery Services Director

Tús Áite do Shábháilteacht Othar
Patient Safety First

Report of the Quality and Safety Clinical Governance Development Initiative Primary Care

Sharing our learning

We are all responsible…and together
we are creating a safer healthcare system

An initiative of the HSE Quality Improvement Division in collaboration with the Primary Care Division, April 2015 ©

“Excellence is never an accident. It is always the result of high intention, sincere effort, and intelligent execution; it represents the wise choice of many alternatives - choice, not chance, determines your destiny.”

(Aristotle, 384 BC – 322 BC).

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Foreword

The Primary Care Division and Quality Improvement Division (previously the Quality and Patent Safety Division) of the Health Service Executive (HSE) are constantly seeking ways to support health service providers to improve the way they work and thus deliver a safe higher quality experience to people who access Primary Care services.

Following an invitation from the Quality and Patient Safety Directorate the Primary Care Steering Group, chaired by Mr. Brian Murphy, Primary Care Manager, the Regional Directors of Operations in HSE South and West nominated two Primary Care Teams (PCTs) and associated Management Teams to participate in the Primary Care Quality and Safety Initiative.

During the lifetime of these Action Projects a significant structural reform programme was in progress. The establishment of the HSE Directorate, the Primary Care Division, the Quality Improvement Division and the appointment of Ms. Angela Alder as National Lead for Quality and Patient Safety, Primary Care Division are of particular contextual importance. The Action Projects' progress reporting pathways mirrored these organisational changes.

Over a fifteen month period we worked closely with two Primary Care Action Projects on reviewing and strengthening their governance for quality and safety. Structures and processes for quality and safety were examined and a number of improvements were made by PCTs and Managers. Identifying and organising essential resources supported project success. The main purpose of this report is to share the experience of the PTCs and Managers, to consolidate the learning and to assist other PCTs and Managers as they pursue their own quality and patient safety journeys and in particular in meeting the requirements of the National Standards for Safer Better Healthcare (2012).

The measurements incorporated in these projects demonstrate a significant improvement in participants' understanding before and after the projects (90% improvement in understanding of the ten principles for quality and safety, 81% in the eight processes for quality and safety and 78% in the term clinical governance for quality and safety). Quality does not happen by accident – across this initiative there was tremendous learning which is captured in this report.

Five key themes emerging from the project are:

- **Theme 1:** Leadership and governance matter, with visible and committed leadership at all levels.
- **Theme 2:** Keeping it clear and practical, through effective communication, realistic expectations and practical solutions.
- **Theme 3:** Obtaining wide inclusion, engagement, commitment, and the importance of a team approach which includes and engages with all stakeholders.
- **Theme 4:** Paying attention to motivating and sustaining changes by framing the project in terms of time, process, resources and outcomes.
- **Theme 5:** Providing the essential resources including guidance, training and time.

This report is a companion to the Report of the Quality and Safety Clinical Governance Development Initiative: Sharing our Learning (2014). Together they offer guidance for future quality and safety initiatives across the care continuum. The Action Projects valued teams by listening, empowering and enabling them to continuously improve services in the Primary Care setting.

Using the learning from these Action Projects will facilitate the placement of quality and safety at the top of every agenda and as part of all decision making. Importantly, this learning will also inform the approach to meeting the requirements of the National Standards for Safer Better Healthcare (2012) in Primary Care.

We would like to acknowledge the considerable commitment and enthusiasm of the many participants who are listed in the acknowledgements, we would like to especially thank the PCTs and their Managers who contributed by sharing their experience and learning in strengthening quality and safety structures and processes. Finally, these projects would not have been possible without the commitment and drive of the Project Implementation Support Group. In this regard, we wish to express our gratitude to Maureen Flynn, National Lead and Thora Burgess, Project Manager, Quality and Safety Clinical Governance Development, Quality Improvement Division and in particular we would like to thank the Regional Specialists Primary Care HSE South and West, Sheena Hanrahan and Helena Maguire for their significant and valued contribution to these projects.

Dr Philip Crowley
National Director Quality Improvement

Mr John Hennessy
National Director Primary Care

1 Introduction

This report presents an overview of the Primary Care Quality and Safety Action Projects undertaken by North Cork (Mallow (3) and Buttevant PCTs) and North Sligo PCT over the September 2013 - October 2014 period. These Action Projects reflect the Primary Care element of the overall Quality and Safety Clinical Governance Development Initiative and the experience of the two Primary Care South and West Projects referred to in the Report of the Quality and Safety Clinical Governance Development Initiative: Sharing Our Learning Report (2014) hereafter called "Sharing our Learning". This report provides an overview of the projects and identifies key themes / messages arising from the project experience and evaluation processes. These messages have the potential to assist other PCTs and Managers as they pursue their own quality and patient safety journeys and in particular in meeting the requirements of the National Standards for Safer Better Healthcare (2012) (hereafter referred to as NSSBHC) (Appendix 1).

2 Background and Context

The Quality and Patient Safety Division in 2011, established a renewed focus on clinical governance development and retains that focus as the Quality Improvement Division (formed in 2015). The objective is to create a culture where quality and patient safety is everybody's primary goal and recognises governance for quality and safety (clinical governance) as the system through which all healthcare teams are accountable for the quality, safety and experience of service users in the care they deliver.

In 2011 a national lead and project manager were appointed, an international reference panel formed, with steering and working groups for clinical governance development established. A Governance for Quality and Safety Framework (previously referred to as clinical governance) in healthcare (Appendix 2), underpinned by a suite of ten guiding principles (Appendix 3), was developed. This was based on the following agreed description for the Irish health system:

Governance for Quality and Safety is described as:

the system through which healthcare teams are accountable for the quality, safety and experience of patients in the care they have delivered

For healthcare staff this means:

Specifying the care standards they are going to deliver and showing everyone the measurements they have made to demonstrate that they have done what they set out to do.

In addition, following feedback from stakeholders, consultation and testing within clinical services, a series of resource documents (Appendix 4) were developed. These were targeted to be inclusive of all levels of the health system from the service user to the HSE Directorate.

Initially, over the September 2012–June 2014 period, five hospitals, the Midland Regional Hospital Portlaoise, Connolly Hospital Dublin, Sligo Regional Hospital, Wexford General Hospital and Cork University Hospital, were nominated by the Regional Directors of Operations, to work with the resources, as part of a quality and safety development initiative. An overview of this initiative and the recommendations arising from the learning therein are available in the *Sharing Our Learning Report* (2014).

In September 2012, the Clinical Governance Development Initiative Steering Group agreed to expand its original role to provide strategic direction and advice on supports for the implementation of the NSSBHC to the acute care collaborative, established to support implementation of the standards in the Acute service setting. This presented the opportunity, through the five hospital sites, to use the learning and resources from the Quality and Safety Clinical Governance Development Initiative to support assessment and implementation of actions against Theme 5 Leadership, Governance and Management of the NSSBHC.

In March 2013 the National Director, Quality Improvement invited the National Primary Care Steering Group and Regional Directors of Operations to nominate two PCTs and associated management teams to participate in the initiative. In May 2013, teams in North Cork and North Sligo were selected, complementing the involvement of Sligo Regional and Cork University Hospitals as part of the overall Quality and Safety Clinical Governance Development Initiative.

Source: word cloud from combined Primary Care Action Project Reports

3 Primary Care Quality and Safety Action Projects

Following selection of the PCTs and their associated Primary Care management team the National Lead for Governance for Quality and Safety Development held preparatory meetings with the Area Managers / General Managers in Sligo and Cork. In addition, the National Lead met with the North Sligo PCT and Sligo / Leitrim Primary Care Quality and Safety Governance Committee. Discussions took place between the General Manager, heads of discipline, representatives of the community sector and other key stakeholders in North Cork. These meetings were critical to ensure that all potential participants had clarity regarding the initiative and their roles in its implementation.

3.1 Project Overview

The Quality and Safety Clinical Governance Development Initiative aimed to create a culture where quality and safety is everybody's primary goal and where every clinical and social care action is aligned within a clinical governance system.

The purpose of the initiative, in the Primary Care setting, was to undertake a review of quality and safety (clinical governance arrangements) for nominated PCTs and the associated Primary Care management teams and to make recommendations for strengthening the arrangements (structures and processes) including the development of Quality Improvement Action Plans.

Project Objectives

Project objectives were to:

- complete an assessment by Primary, Community and Continuing Care (PCCC) Managers, of quality and safety (clinical governance) structures and processes for a PCT, using the Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers (2012)[1]
- support the nominated PCT in using the Quality and Safety Prompts for Multidisciplinary Teams (2012) and in identifying areas for further development
- identify gaps, agree priorities and prepare quality improvement plans (with lead responsibilities and time scales) for implementation
- make recommendations to the National Primary Care Steering Group (National Primary Care Division) and PCCC management locally, for strengthening the Primary Care management / PCT governance structures and processes for quality and safety, based on the above analysis
- provide feedback to the Primary Care Steering Group (Primary Care Division) on matters requiring national attention
- provide feedback to the National Quality and Safety Steering Group (Quality Improvement Division) on the design and amendment of the support materials.

Priorities of the overall initiative were to:

- build clinical leadership capacity
- develop cultures supportive of quality and safety
- focus on systems and methodologies for quality and safety.

[1] *The Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers (2012) used in the Acute hospital element of the initiative was modified for use in the primary care setting.*

Benefits identified for the participating PCTs included:

- undertaking a mapping of current quality and safety arrangements for PCT services
- having an opportunity to consider the PCTs quality and safety arrangements in a structured way
- identification of priority quality improvement plans
- preparation and support in meeting the NSSBHC
- having a mechanism and means to highlight any quality and safety gaps (outside of the scope of the team) to local management and the Primary Care Steering Group (Primary Care Division).

3.2 Project Structure

A Primary Care Quality and Safety Project Group was established as a sub group of the local PCCC management team in both areas. In recognition of the importance of team involvement in guiding the projects, each PCT nominated representatives to participate on the Project Group. Each project had an identified Project Lead and Co-ordinator.

Communication, as illustrated in Figures 3.1 and 3.2, was via:

- the Project Lead / Chair to the PCCC management team and to PCT members
- the National Lead for Clinical Governance Development to the National Quality and Safety Steering Group (From March 2014 reports were provided directly to the National Director, Quality Improvement)
- the Regional Specialists Primary Care to the Primary Care Steering Group / Primary Care Division. Communication, with effect from September 2014, was to the Primary Care Division, Quality and Safety Lead.

Existing line management and other reporting and working relationships continued throughout the project period.

Figure 3.1: North Sligo Quality and Safety Action Project Reporting Structure

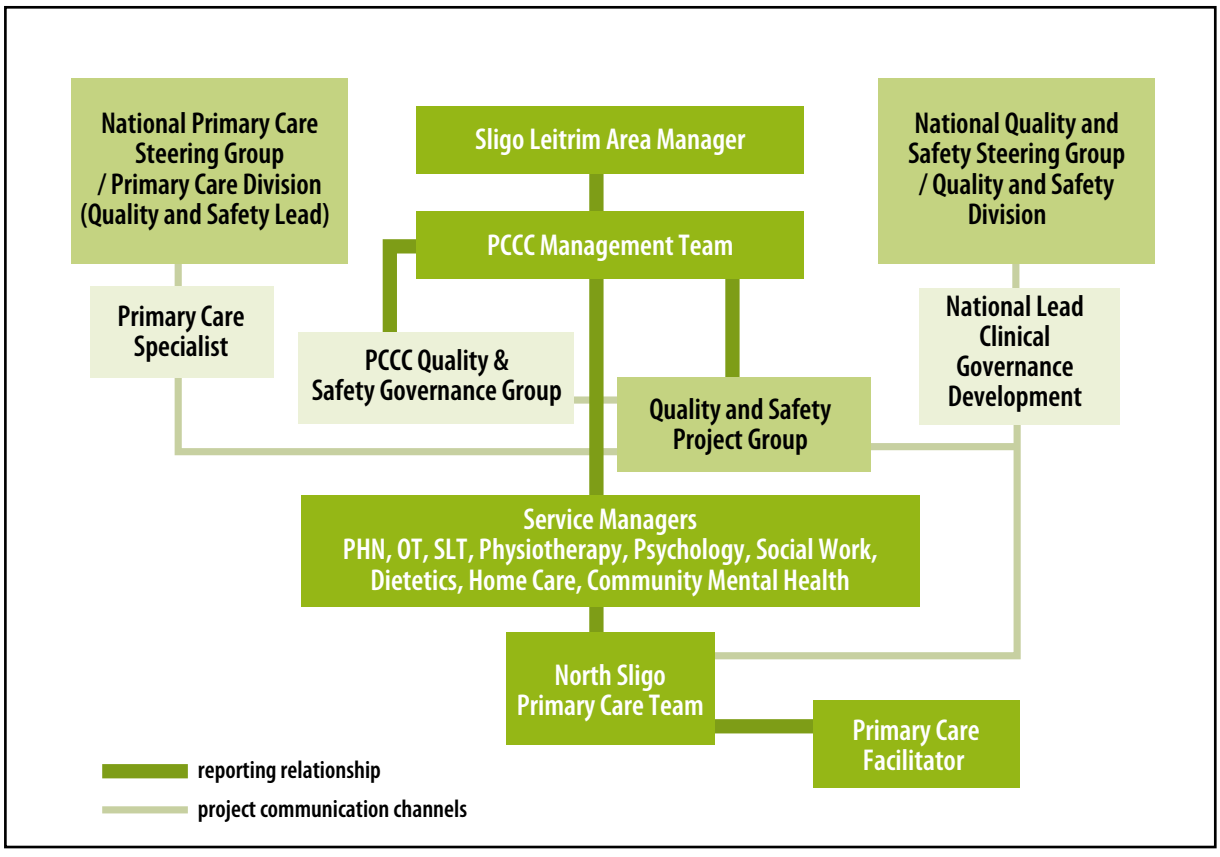
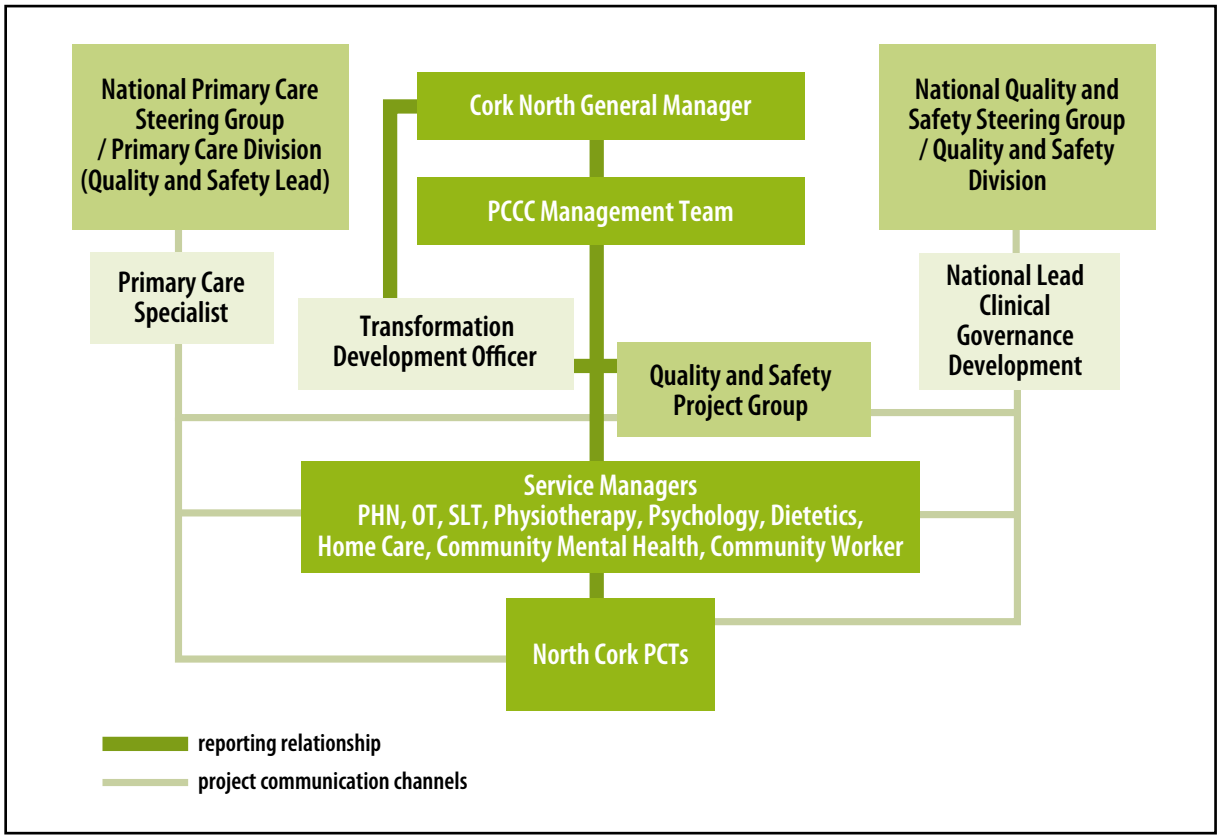


Figure 3.2: North Cork Quality and Safety Action Project Reporting Structure



Terms of reference for the projects were proposed and agreed by each Project Group and associated General Manager. The projects commenced in Autumn 2013. The North Sligo Action Project had a change in Project Lead in February 2014 with a successor lead identified from May 2014.

A Project Implementation Support Group with representatives of the project sponsors i.e. the Quality Improvement and Primary Care Divisions was also established. This group provided overall guidance and direction to the initiative in keeping with its terms of reference.

At the outset, it was acknowledged that the governance arrangements in place would change following the implementation of the Report and the Recommendations of the Integrated Service Review Group for Community Healthcare Organisations (2014). However, the projects were seen as an opportunity to further strengthen Primary Care governance for quality and safety in the interim and to contribute to the readiness to meet the requirements of the NSSBHC as per the experience in the Acute hospital element of the initiative.

4 Overview of Primary Care Teams and Action Projects

4.1 Primary Care Teams and Health and Social Care Networks

The Primary Care Strategy, Primary Care: A New Direction (2001) proposed an inter-disciplinary team-based approach to Primary Care provision by PCTs, ideally located on the same site or in very close proximity, and by health and social care networks. Community participation in Primary Care would be strengthened with PCTs encouraged to ensure user participation in service planning and delivery.

A PCT is a multidisciplinary team of health and social care professionals who work closely together to deliver local accessible health and personal social services to meet the health and social care needs of a defined population (approximately 7,000-10,000). Professionals on a team include General Practitioners and Practice Nurses, Community Nursing i.e. Public Health Nurses and Community Registered General Nurses, Physiotherapists, Occupational Therapists, etc.

Health and Social Care Networks (HSCNs) support a number of PCTs and include a wider network of professionals such as Dieticians, Psychologists, Podiatrists etc., who provide services for members of their population group. Members of the network work with more than one PCT.

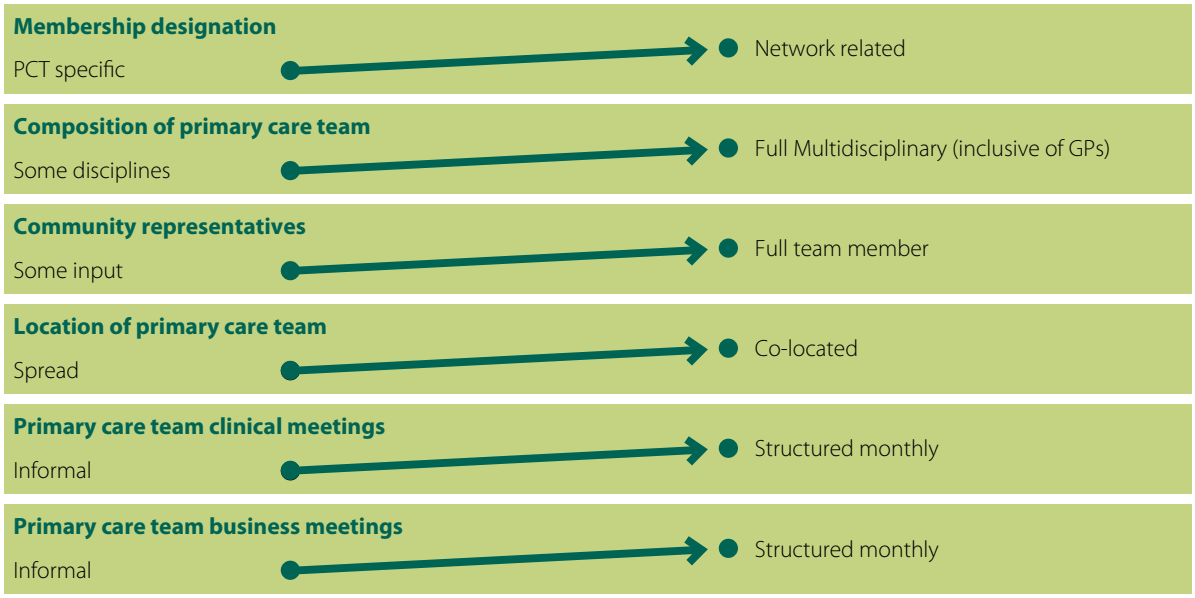
To ensure better continuity of care, a system of voluntary enrolment where individuals would be encouraged to enrol with a PCT and with a particular General Practitioner within the team would be promoted. Appropriate electronic communications and record systems with electronic health records based on a unique client identifier would be developed to support the operation of the PCT and the wider network of professionals.

Clinical team meetings whereby PCT members would come together for a structured meeting to develop a plan of care, for implementation, to meet the increasingly complex needs of service users would support the achievement of the Strategy's envisaged person centred integrated care. Close working relationships with the Acute and Primary Care sectors would also be promoted through the development of local referral protocols, discharge plans, individual care plans, integrated care pathways and shared care arrangements as essential elements of seamless care provision.

PCT business meetings would provide a forum for the discussion, review and agreement of business agenda items, e.g. service planning, performance indicators, training, community health needs assessments, pilot projects, etc and would also facilitate integrated working.

Since the publication of the Primary Care Strategy in 2001, there have been and continue to be many challenges, at many levels, in implementing the proposed model. At the end of 2014 there were 326 PCTs in place (Primary Care Division Operational Plan 2015). These PCTs, since establishment, have progressed to varying extents along the continuum of PCT development, as illustrated in Figure 4.1.

Figure 4.1: Continuum of Primary Care Team Development



The Governance for Quality and Safety Framework acknowledges that clinical governance operates in specific contexts and at different levels. PCTs engaging in patient quality and safety initiatives to foster and grow the capability of team members to improve the quality and safety processes at work therefore need to take cognisance of their context and their stage of development.

A further consideration and challenge for PCTs is the structural and associated governance changes currently underway in response to the implementation of the Report and the Recommendations of the Integrated Service Review Group for Community Healthcare Organisations (2014). This completes the move away from integrated area management arrangements and the establishment of distinct organisational structures, Community Healthcare Organisations (CHOs) and Hospital Groups. Nonetheless integrated care delivery and improvements in service user experience remain core objectives in quality healthcare provision.

4.2 North Cork Primary Care Teams

The North Cork Mallow (3) and Buttevant PCTs were established in 2006. The teams comprise Public Health Nurses, Community Nurses, Speech & Language Therapists, Physiotherapists, Occupational Therapists, Home Support Services, Administration and participating General Practitioners. The PCTs are supported by the HSCN comprising Psychology, Podiatry, Dietetics, Community Workers, Mental Health staff including Psychiatrists and Community Mental Health Nurses, Dentists and Community Pharmacists. The PCTs and HSCN together deliver primary health-care to the local population in the Mallow and Buttevant areas of Co. Cork. The majority of services are provided from the Mallow Primary Healthcare Centre and a number of small health centres in the locality. This catchment area has a population of 29,002 and represents a revised HSCN from the original geomapping exercise of 2005 which comprised three PCTs in Mallow. Community input for this project was facilitated through the participation on the project team and in the workshops of HSE Community Workers who support a number of active, participative service user fora and from which views and developments were streamed.

4.3 North Sligo Primary Care Team

The North Sligo PCT was established in 2007. The team comprises Nurses (Public Health Nurses and Community Mental Health Nurse), Speech & Language Therapist, Physiotherapist, Occupational Therapist, Home Support Services, participating General Practitioners, Practice Nurses and administrative staff. It delivers primary healthcare, from a number of facilities, to the local population in the Rathcormac, Drumcliffe, Grange and Cliffoney areas of Co. Sligo i.e. to an area covering a population of 8,206. Following a series of public meetings, a Community Health Forum was established in 2011, with two community representatives selected to be members of the North Sligo PCT. The community representatives attend the quarterly PCT business meetings and participated in the Project Group for this Action Project. A comprehensive Community Needs Assessment was completed in January 2012 which highlighted the key health and social care needs of the local community.

4.4 Action Project Actions and Quality Improvement Plans

The projects commenced in September 2013 with the setting up of a project team to manage each project. Six facilitated half day workshops were held across the two projects, three for PCT members and three for Primary Care Managers. Workshop participants completed the Quality & Safety Prompts for Multidisciplinary Teams and the Assurance Check for Health Service Providers (modified for the Primary Care setting) (available at www.hse.ie/go/clinicalgovernance) as appropriate.

Completion of the tools facilitated the development of actions / quality improvement plans. Key actions focused on strengthening Primary Care quality and safety structures and processes in keeping with the Governance for Quality and Safety Framework. Actions identified and prioritised by the projects directly addressed essential elements of quality in twenty two of the NSSBHC as illustrated in Table 4.1.

Table 4.1: QA+ I Tool Essential Element Addressed in Action Projects

Themes of NSSBH	QA+I Essential Element[2]	
1. Person Centred Care and Support	1.1	Service user involvement
	1.2	Fair access to healthcare services
	1.3	Protecting service user rights
	1.4	Shared decision making
	1.8	Effective management of service user feedback
	1.9	Enabling better health and wellbeing
2. Effective Care and Support	2.8	Monitoring and improving healthcare
3. Safe Care and Support	3.2	Responding to and learning from quality & safety information
	3.3	Effective incident management and investigation
4. Better Health and Wellbeing	4.1	Supporting a culture of better health and wellbeing
5. Leadership Governance and Management	5.1	Clear accountability
	5.2	Strong governance
	5.5	Effective operational planning
	5.6	Promoting a culture of quality and safety
	5.7	Supporting staff in delivering quality and safety
	5.8	Monitoring arrangements for quality and safety
	5.10	Compliance with legislation
	5.11	Implementation of standards, alerts, guidance and recommendations
6. Workforce	6.3	Maintaining competent staff
	6.4	Support systems for staff
7. Use of Resources	7.2	Best outcomes and values for resources used
8. Use of Information	8.3	Effective management of healthcare records

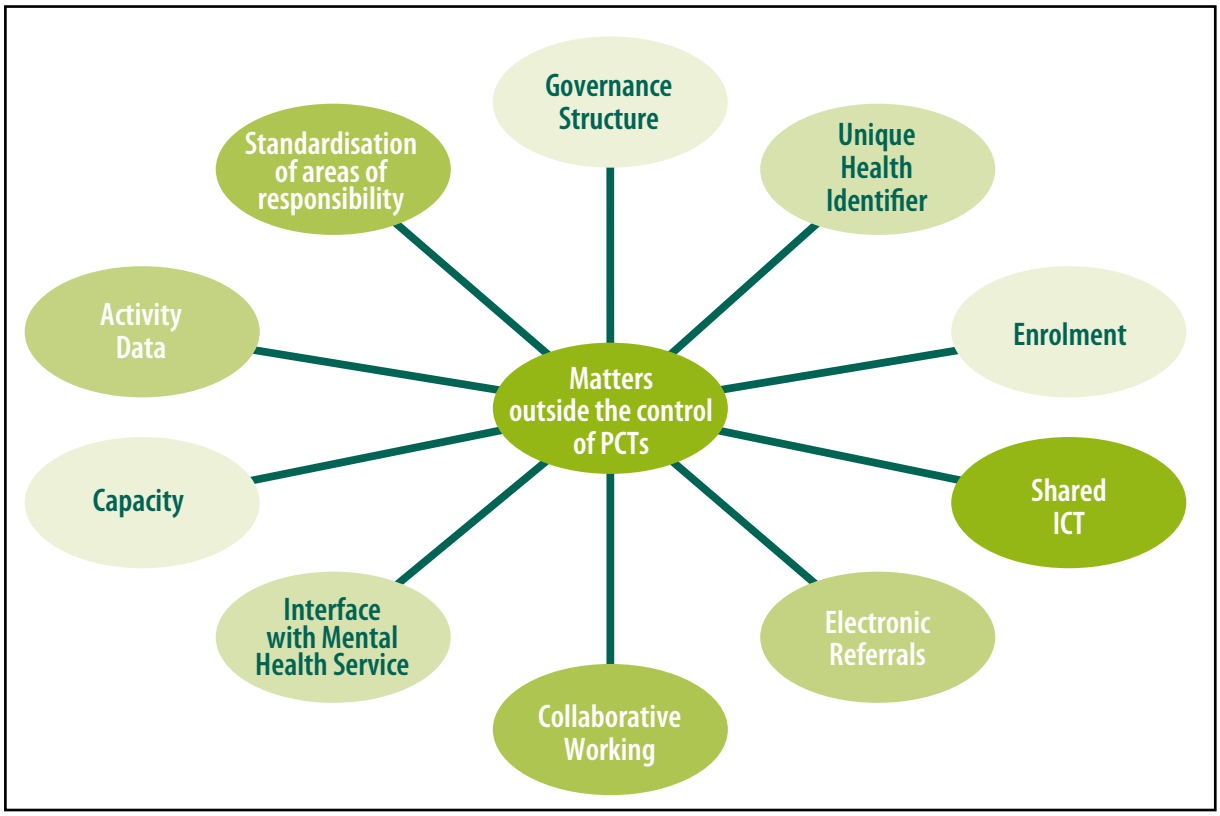
The teams also identified the following requirements (see also figure 4.2) to be addressed but as they were outside the remit of these projects they were escalated to the National Primary Care Office:

- **Governance Structure**: absence of clinical or management governance structure at PCT or HSCN levels with existing governance via discipline specific management of services
- **Unique Health Identifier**: requirement for a unique health identifier for all service users to facilitate the creation of PCT registers
- **Enrolment:** requirement for enrolment process to be put in place and eligibility for services to be clarified
- **Shared ICT:** requirement for integrated ICT shared records system for PCTs
- **Electronic Referrals:** requirement to develop a standard electronic referral form for use by PCT members within and beyond the PCT
- **Standardisation of Areas of Responsibility:** requirement for a standardised approach in determining areas of responsibility held by Primary Care Managers and / or Heads of Discipline, taking into account population, needs, geographic area and complexity. A standardised approach for the provision of support and resources is also required

[2] *Quality Assessment and Improvement Tool (QA+I) essential elements are those elements of quality which are representative of what a service should have in place to support the provision of safe, high quality care. They are set out in the HSE Primary Care QA+I Tool Practical Guide Resource for the National Standards for Safer Better Healthcare (2014).*

- **Activity Data:** requirement to identify meaningful activity data for measurement that is cross-referenced with capacity (clinic space and staff capacity) and complexity for all Primary Care services
- **Capacity:** requirement to address the non replacement of staff on leave and vacancies
- **Interface with Mental Health Services:** clarification on the inclusion of and interface between Mental Health services and PCT services
- **Collaborative working:** assistance needed to strengthen links and collaborative working with General Practitioners and Practice Nurses. General Practitioners are critical participants in effective PCT working.

Figure 4.2: Matters Identified Outside the Remit of the Action Projects Escalated to the Primary Care Division



The North Cork Project raised their identified issues directly with the Head of Planning and Performance Management Primary Care at a meeting. Both Project Groups subsequently escalated the issues identified via their respective processes to the Primary Care Division in their final reports.

It is recognised that many of the matters identified are reflective of outstanding actions from the implementation of the Primary Care Strategy (2001). The establishment of the CHOs and the implementation of the structures and the associated processes set out in the Report and the Recommendations of the Integrated Service Review Group for Community Health Organisations (2014) will address many of the identified requirements. The HSE National Service Plan 2015 and associated Primary Care Division Operational Plan 2015 also set out a number of relevant priority actions including implementation of the initial phases of the Health Identifier Project, review of the GMS contract etc.

Both projects prioritised their action lists / quality improvement plans to identify actions for implementation during the project period. A number of these actions were successfully completed during the project with others continuing to be implemented. A sample of the actions achieved / being achieved and how they align to the essential elements of quality as identified in the HSE Primary Care Quality Assessment and Improvement Tool developed to support implementation of the NSSBHC are detailed in Table 4.2.

Table 4.2: Action Project Actions with Alignment to QA+I Tool Essential Elements

Domains	Action Project Actions	National Standard for Safer Better Healthcare QA+1 Essential Element [3]
Structures for Quality and Safety	• *Primary Care Managers Operational Group / Primary Care Managers Group established*	5.1 Clear accountability
	• *Quality Risk and Safety Managers Committee established*	5.2 Strong governance
	• Organisation charts for primary care and community services developed	5.1 Clear accountability
Processes for Quality and Safety	• Training on means to collect service user feedback provided	1.3 Protecting service user rights
	• A more structured way to gather feedback from service users on their experiences introduced	1.1 Service user involvement
	• Profile and use of *'Your Service your Say'* and *'You and Your Service'* raised	1.1 Service user involvement
	• Compliments and complaints received shared with PCT members	1.1 Service user involvement 1.8 Effective management of service user feedback
	• Community Health Forum role further developed with the inclusion of new members	1.1 Service user involvement 1.4 Shared decision making 1.8 Effective management of service user feedback
	• Social inclusion toolkit for primary care teams developed	1.1 Service user involvement 1.3 Protecting service user rights
	• The PCT section of the HSE Website populated	1.2 Fair access to healthcare services
	• The HSE A-Z of health conditions utilised	1.9 Enabling better health and wellbeing 4.1 Supporting a culture of better health and wellbeing
	• Process for service users to access their personal diagnostic image records in acute services streamlined	1.4 Shared decision making
	• PCT directory of services with contact details and methods of referral developed	1.2 Fair access to healthcare services
	• PCT Group email established	5.5 Effective operational planning
	• Shared drive for policies, procedures and guidelines pertinent to primary care services, established	5.5 Effective operational planning 5.10 Compliance with legislation 5.11 Implementation of standards, alerts, guidance and recommendations

[3] Quality Assessment and Improvement Tool (QA+I) essential elements are those elements of quality which are representative of what a service should have in place to support the provision of safe, high quality care. They are set out in the HSE Primary Care QA+I Tool Practical Guide Resource for the National Standards for Safer Better Healthcare (2014).

Table 4.2: Action Project Action with Aligned to QA+I Tool Essential Element (continued)

Domains	Action Project Actions	National Standard for Safer Better Healthcare QA+1 Essential Element
Processes for Quality and Safety	• Standardisation of filing for patient records across disciplines	8.3 Effective management of healthcare records
	• *Community Quality and Safety Governance Group* meeting agenda amended to include PCT standing agenda item	5.2 Strong governance 5.6 Promoting a culture of quality and safety
	• Learning from events / incidents facilitated through the creation of standing agenda item and discussion at each PCT business meeting	3.2 Responding to and learning from quality and safety information 3.3. Effective incident management and investigation 5.8 Monitoring arrangements for quality and safety
	• Review of discipline risk registers undertaken to identify areas of common concern	5.6 Promoting a culture of quality and safety
	• *Patient Safety Culture Survey* in primary care tested to establish a baseline of staff perceptions of safety culture	5.6 Promoting a culture of quality and safety
	• Standard agendas for PCT clinical and business meetings introduced	2.8 Monitoring and improving healthcare quality 5.2 Strong governance 5.7 Supporting staff in delivering quality and safety
	• PCT specific performance reports developed	2.8 Monitoring and improving healthcare 7.2 Best outcomes and value for resources used
	• Targeted programme of support for the health and well being of PCT members introduced	6.4 Support systems for staff 4.1 Supporting a culture of better health and wellbeing
	• Formal process for the introduction of new team members to the PCT introduced	6.3 Maintaining competent staff
	• Information slot introduced on the monthly clinical team meeting agenda to flag upcoming training events and conferences	6.3 Maintaining competent staff
	• Access for non-HSE PCT members to training resources on HSE land set up	6.3 Maintaining competent staff
Outcomes for Quality and Safety		Patient Care Patient Experience Staff Experience Service Improvement

In April / May 2014 both Project Groups completed interim progress reviews and reports where they assessed and documented their progress to date, identified changes in structures and processes for quality and safety achieved and agreed their next steps. Each Action Project shared their project's progress with their counterparts in the other Action Project area. This sharing of progress stimulated interest in the 'other' Action Projects, particularly in relation to identified quality improvement actions and proved a stimulus to communication and some sharing of experience. Copies of the interim reports were submitted to the National Director Primary Care and the National Director Quality and Patient Safety.

Both Project Groups held final meetings at the end of the project period. A review was undertaken of all of the actions / quality improvement plans generated by the project. Processes to progress any outstanding actions were put in place under the governance of the Primary Care Managers Operational Group / Primary Care Managers Group established during the projects and will support the implementation of the NSSBHC. Copies of the final reports were submitted to the National Director Primary Care and the National Director Quality and Patient Safety.

Figures 4.3 and 4.4 present an overview of the project timelines and key milestones for each project.

Figure 4.3: Time line and Key Milestones for North Cork Action Project

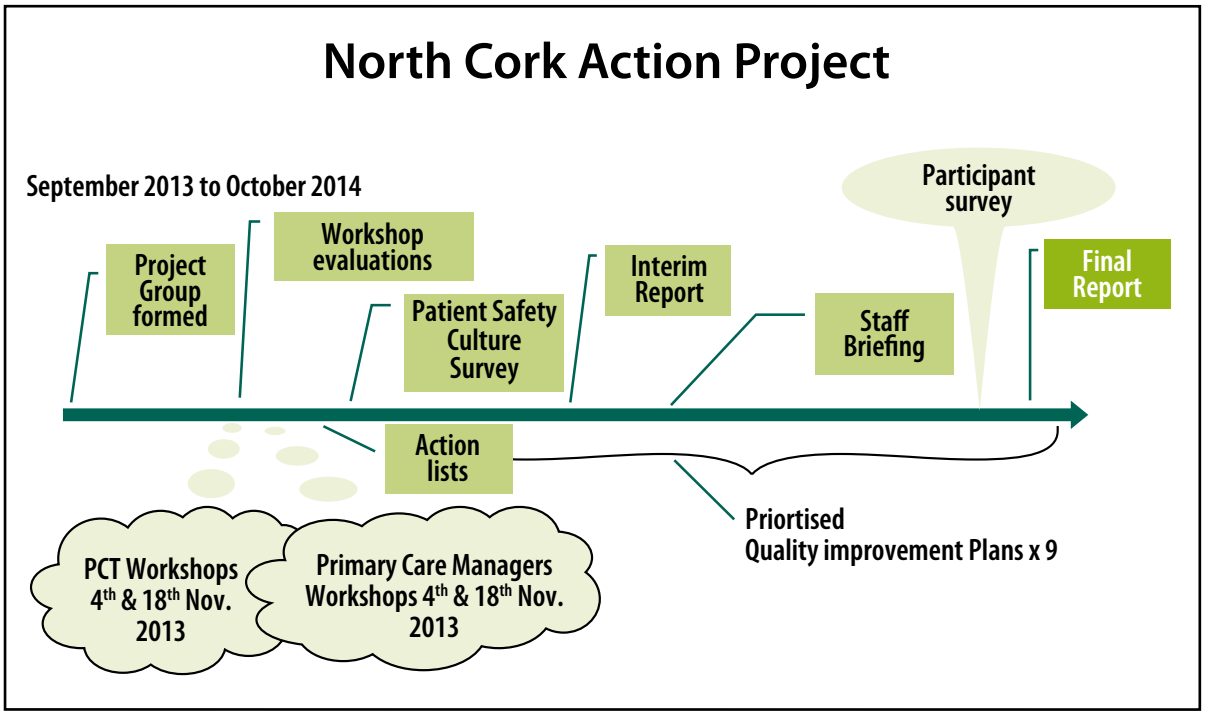
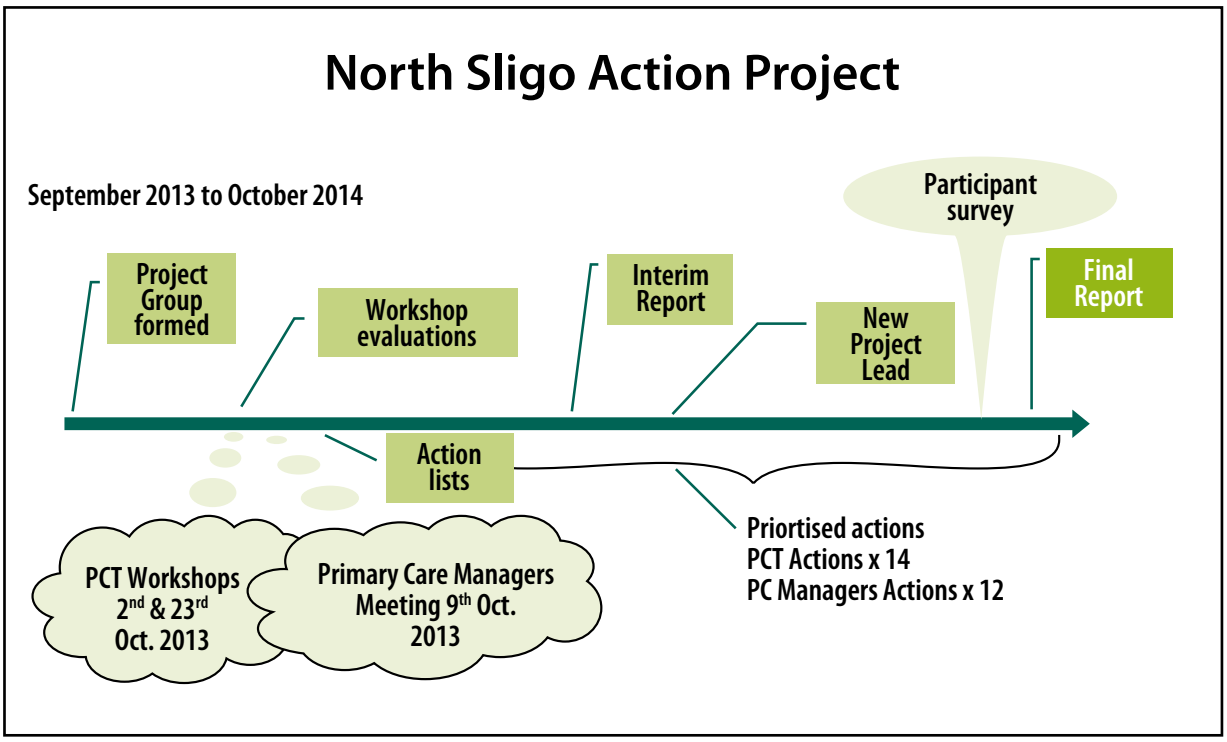


Figure 4.4: Time line and Key Milestones for North Sligo Action Project



Members of the Project Group, PCT members, Area Managers and members of the Primary Care and Quality and Patient Safety Divisions participated in a joint learning event in November 2014. The event provided a forum to gather and share the learning from the two Primary Care Quality and Safety Action Projects and to identify how the learning can be disseminated and used.

5 Identifying Learning

The success of the two Primary Care Action Projects as part of the overall Quality and Safety Clinical Governance Development Initiative rests not only on their individual attainments, reflective learning and associated quality improvements but also on how their learning contributes to wider organisation development and improvement. To this end an evaluation framework was developed as part of the project plan with five key points of evaluation identified as shown in Table 5.1.

Table 5.1: Points of Evaluation

	Method	North Cork (PCT=4)	North Sligo (PCT=1)	Total
1	Workshop evaluation (n=6) (Oct/Nov 13) [92% and 69% response]	69	20	89
2	Interim report (April/May 2014)	1	1	2
3	Patient Safety Culture Survey (Feb/March 14) [38% response]	23	n/a	23
4	Final report (Oct 14)	1	1	2
5	Participant evaluation survey (Oct 14) [37% and 42% response]	19	13	32
Total		**113**	**35**	**148**

5.1 Workshop Evaluations

Six facilitated workshops were held across the two projects, three for PCT members and three for Primary Care Managers. The workshops focused on assessment of structures and processes using the Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers (PC Managers) and the Quality and Safety Prompts for Multidisciplinary Teams (PCTs). The workshops led to the development of prioritised actions / quality improvement plans (see Section 4.4). A structured evaluation of the six workshops was undertaken using a self completion questionnaire with a response rate of 92% for North Cork PCTs and 69% for North Sligo PCT.

The workshop evaluation found that the multi-disciplinary approach was welcomed and advocated as a model for future meetings, communication, workshops and learning events with its potential to enhance team working particularly recognised. Particular reference was made to the advantage of having external facilitation, with a view that this led to more open discussion.

It was clear from the workshop discussion and feedback that setting up a team is just one step towards a fully functioning PCT. Significant investment in team development, including appropriate structures, processes and resources is required with the availability of technical expertise to advise and guide teams considered highly important. The absence of appropriate information and communication technologies in supporting team development and practice was highlighted.

5.2 Patient Safety Culture Survey: Establishing the Baseline

Understanding the culture within an organisation, across all staff groups, and at every level of the organisation, enables the service to improve systems and ensure that robust quality and patient safety processes are implemented effectively.

To this end, the North Cork PCTs undertook a patient safety culture survey, during the Action Project (see Appendix 5). The survey tool used was a recognised, validated and widely used Patient Safety Culture Survey tool developed by the Agency for Healthcare Research and Quality in the USA (Medical Office Survey on Patient Safety) which was adapted to the Irish healthcare setting.

The report of the survey was presented to the North Cork Project Group and shared with all team members at a briefing in June 2014. The survey findings are being used by the newly formed Primary Care Managers Group in North Cork as part of their ongoing commitment to improvements in quality and patient safety.

The North Sligo Team considered but did not complete the survey due to concerns regarding governance for any emerging actions.

5.3 Progress Reports

Both the interim and final reports on the Action Projects included a summary of the achievement of the projects at the specified points in time and identified learning from the project experience. Each Project Group was requested to reflect and report on what had worked well, what did not work well and what needed to be done differently in any future project rollouts.

Key learning recognised the value of:

- Listening to teams and enabling them to identify and implement quality improvements
- Multi-disciplinary team input including General Practitioner, Community Representative and HSE personnel participation
- Primary Care management leadership and support for the projects
- The input of the National Lead for Governance for Quality and Safety Development to facilitate the project / work with the Project Lead and Co-ordinator
- The workshop format for communication and 'buy-in' purposes which provided a good basis from which to proceed
- Project resources / tool kit although some of the resources / tools were complex and may prove too challenging for less established teams
- Realistic timeframes and ambitions.

The need to consider the stage of development / evolution of the PCT was recognised as a key determinant in shaping the outcome of the project with the cohesiveness of an already functioning team considered to be significant in success.

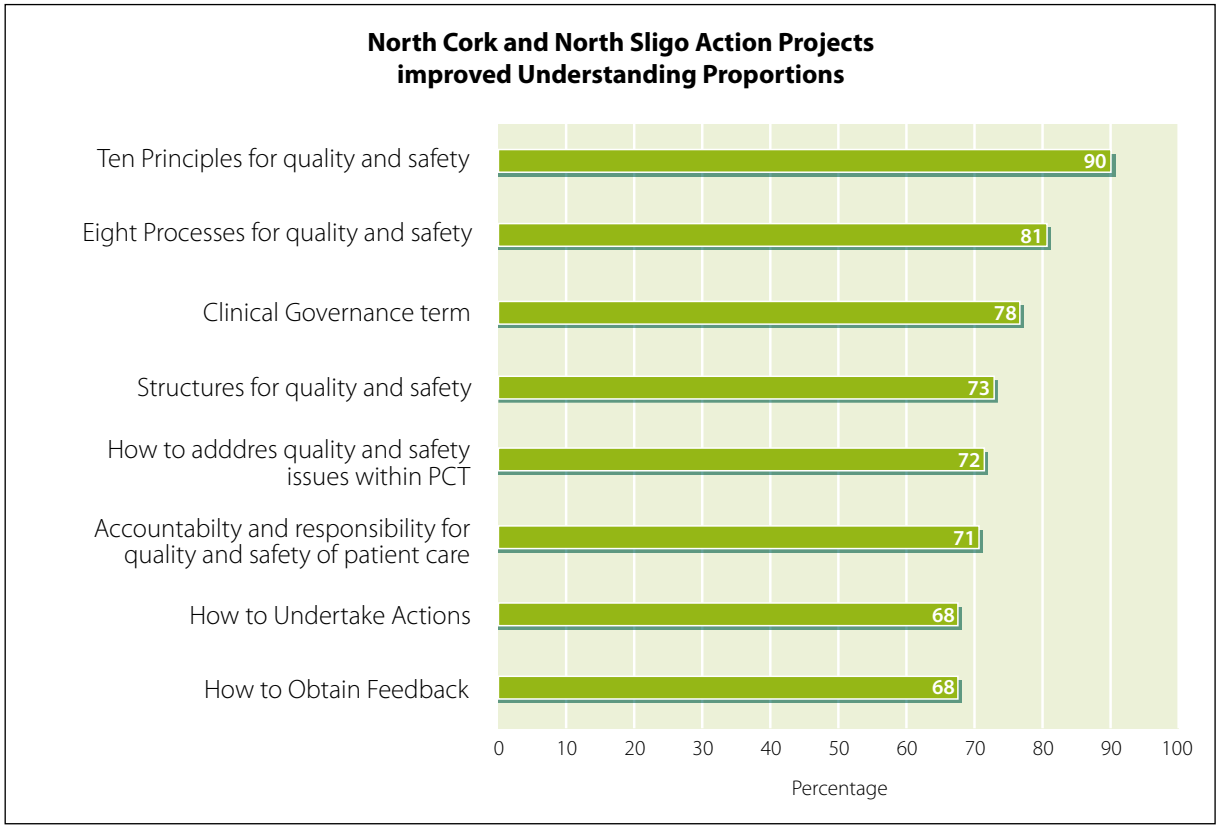
It is clear from the final reports that the Action Projects led to changes in structures and processes to strengthen governance for quality and safety. Specific actions for improvement are detailed in Section 4.4.

5.4 Participant Evaluation Survey

All participants (PCT members, PC Managers and Project Group members) in both Primary Care Quality and Safety Action Project teams were invited to complete a structured evaluation survey (Appendix 6) at the end of the initiative. In total 82 surveys were distributed with a 39% overall response rate. 51% of respondents were either PCT members or PCT members and Project Group members. See Appendix 6 for a profile of the survey respondents.

The survey demonstrated significant improved understanding proportions (i.e. proportions with a higher ranking after the project) for key aspects of quality and safety systems as illustrated in Figure 5.1 and Appendix 6.

Figure 5.1: Improved Understanding Proportions



Of note is the improved understanding in respect of:

- knowledge of quality and safety principles, processes, structures and terminology
- how to address quality and safety issues, take actions and obtain feedback.

Greater confidence is expressed in terms of understanding of the principles and the processes than how to undertake actions and how to obtain feedback.

Feedback on the Resources Used

In keeping with the projects terms of reference to provide feedback to the National Quality and Safety Steering Group on the design and amendment of the support materials, respondents were requested to provide feedback on the resources used in the Action Projects. The focus was on the three key resource materials used: (available at www.hse.ie/go/clinicalgovernance)

- Quality and Safety Clinical Governance Information Leaflet
- Quality and Safety Prompts for Multidisciplinary Teams
- Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers (modified for the Primary Care setting).

The Safety Pause Information Sheet was shared and considered at the PCT workshops but was not used by the teams. Feedback was sought on its potential usefulness in the Primary Care setting rather than on the experience of its utilisation there. Positive response proportions (i.e. proportions with a 'strongly agree' or 'agree' response) and comments are detailed in Figure 5.2.

Figure 5.2: Positive Response Proportions Action Project Resources

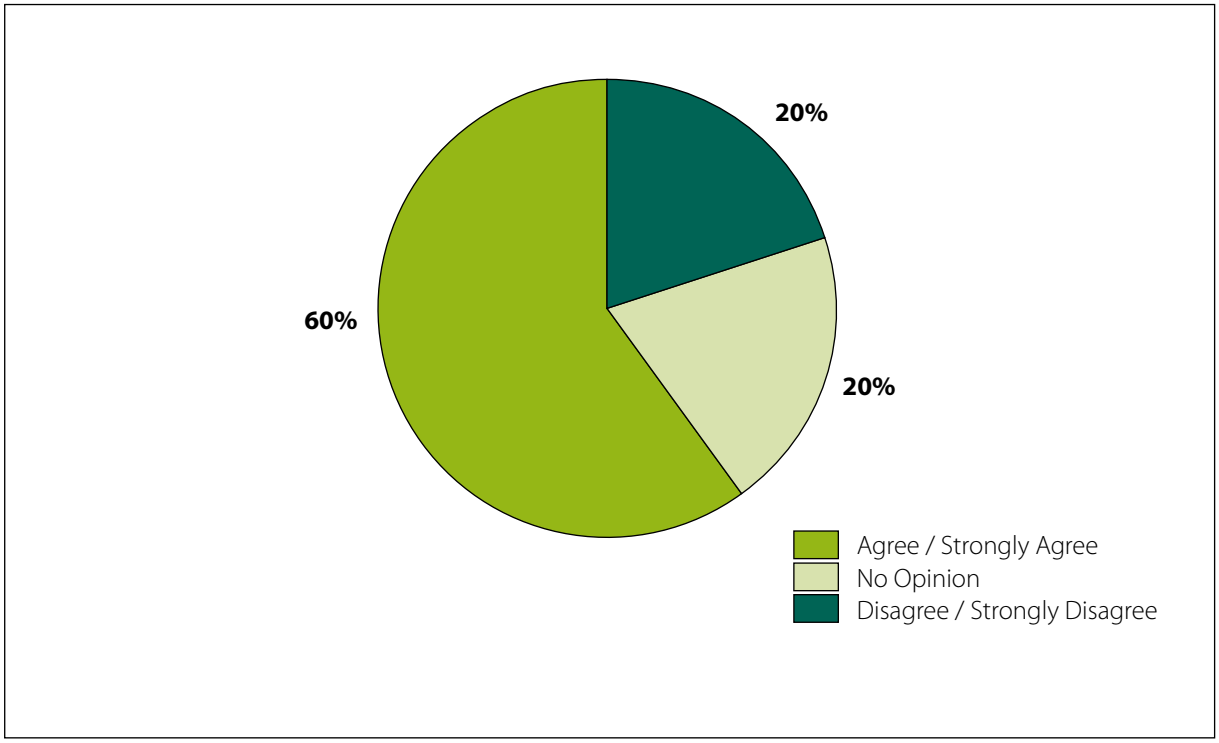
Resource	Question	Positive Responses %	Comments
	Leaflet provided an understanding of clinical governance?	84	• Quick reference • Easy to use tool • Very useful for Primary Care
	Prompts were applicable to our PCT?	74	• Multidisciplinary prompts were described as detailed • Many prompts took time to complete and led to repetition in discussion
	Prompts helped our PCT identify actions for improvement?	86	
	Prompts recommended for use by other primary care teams/managers?	63	
	Assurance Check was useful in assessing structures and processes?	58	• Complicated • Perhaps was premature until the further development of a governance framework for PCTs
	Assurance Check helped identify actions for improvement?	*71*	
	Assurance Check recommended for use by other primary managers?	*57*	
	Information Sheet is useful for PC?	*50*	• Could be a useful tool for Primary Care

Note: The Assurance Check document used in Acute services was modified for the primary care setting

Overall Assessment

At the end of the survey respondents were invited to provide an overall assessment of their satisfaction with the outcome of the Action Projects. Overall, there was a positive response with over half of participants 60% (agreeing or strongly agreeing) they were satisfied with the outcome of the Action Projects (see Figure 5.3). However comments included in completed surveys indicated a range of views from those who had concerns about the timing of the project to those who fully embraced the opportunity and wished to maintain the momentum. (See Appendix 6 for copy of the survey tool and key findings).

Figure 5.3: Overall Satisfaction with Primary Care Quality and Safety Action Projects



5.5 Joint Learning Event

On completion of the Action Projects a joint learning event was held in November 2014. The event was attended by PCT members, Project Group members, Area Managers and members of the Primary Care and Quality and Patient Safety Divisions (see Appendix 7 for the agenda). The aim of the event was to gather and share the learning from the two Primary Care Quality and Safety Action Projects. The event objectives were to:

- explore what worked for each Action Project
- gain specific understanding of the learning from identified actions / quality improvement plans
- explore how the overall learning could be harnessed to support the assessment and implementation process for the NSSBHC
- identify how the learning could be disseminated and used.

Individual written feedback and facilitated group discussion were used to gather feedback on four key questions relating to the individuals experience of the Action Project and the application of this experience to similar projects and, importantly, the implementation of the NSSBHC. The questions were:

- what worked for me?
- what worked for the project overall?
- how would you advise a colleague undertaking a similar project?
- what were the key 'must do's' for the NSSBHC implementation process and for sustaining continuous improvement?

The facilitated discussions produced a rich stream of learning with very similar points made in relation to the project learning and the 'must do's' for implementation of the NSSBHC. The Action Projects had prepared the way for the self assessment, gap analysis and improvement planning processes which are required for implementation of the standards.

Some of the key messages expressed at the learning event were:

- The importance of committed, engaged and visible senior Managers
- Leadership and the identification of project leaders / quality champions
- Adopting a project management approach with a work plan in 'bite sized pieces'
- Multi-disciplinary working with recognition that not all will 'buy-in' at the start
- Availability of necessary resources – tools / supports / guidance, administrative support
- Realistic timeframes and actions / tasks which are integrated in daily work – not an add on
- Effective communication, including keeping the matter on all agendas and ensuring the language used / information provided is clear and simple
- Ensuring some quick wins.

6 Main Messages

The Primary Care Quality and Safety Action Projects were characterised by significant effort and commitment. This commitment was evident not only in the 'doing' of the actions but in the willingness to reflect and comment on how the related processes and resources worked in the broad context of Primary Care delivery. As detailed in Section 5, this reflective learning was captured at five key points of evaluation and from which, when analysed in its entirety, strong and clear messages emerged. These messages have been grouped as five key themes and together capture rich and important learning for all levels of the organisation.

6.1 Theme 1: Leadership and governance matter

Visible and committed leadership was identified as integral to the project and by implication an essential aspect of NSSBHC implementation.

Leadership was also identified in terms of national involvement and the positioning of the project in relation to national policy. The 'hands on' involvement of the National Lead for Governance for Quality and Safety Development afforded consistency to the process, supported capacity building and contributed to multilevel learning.

The importance of leadership was ascribed to structure, process and outcomes. The local operationalisation and coordination of the project was strengthened by the identification of a designated project lead and co-ordinator with overall success seen as dependent on the involvement of a senior manager with the authority to drive the agenda.

Identification of leadership at PCT level was viewed as important to the success of the self assessment process and development and implementation of Quality Improvement Plans (QIPs) and related actions. The identification of 'quality champions' to take responsibility for progressing key elements of the project or lead subgroups strengthened the process and outcomes.

PCT governance arrangements in place at the commencement of the project presented challenges for multidisciplinary team based quality and safety self assessment. In this context the assurance check resource received a mixed review. Nonetheless the assurance check process did prompt the identification of areas where governance related QIPs could be developed and implemented and where matters needed to be escalated, some to national level.

Governance and management of risk and accountability associated with Theme Five: Leadership, Governance and Management (NSSBHC) in particular highlights the interconnectedness of primary and secondary care and the need to manage quality and safety across the care continuum and from a 'patient journey' perspective. The importance of the risk assessment and escalation process was seen as core to quality assurance and as such needs to be clearly understood and utilised by all.

6.2 Theme 2: Keeping it clear and practical

Strong messages related to clarity and practicality were evident from all points of evaluation.

Keeping language clear and messages simple and easily understood by all participants was a recurring theme. Variations in understanding within the PCT and organisation need to be recognised. The broader purpose and

context of projects, related aims and processes need to be effectively communicated and clearly linked to improving services for patients / service users.

Information overload presents particular barriers. Information which is provided needs to be jargon free and abbreviations kept to a minimum. Documents should be provided in a timely manner and in colour where appropriate e.g. documents which contain pathways and charts where the use of colour provides greater clarity lose impact when circulated in monochrome.

QIPs should be realistic, achievable and of a manageable number with a focus on some quick wins, linked to other projects where possible and cognisant of current workloads. A Quality Improvement Log (QIL) with QIPs prioritised and progress recorded provides a clear and practical method of tracking and demonstrating progress.

Key steps in a QIP need to be identified and while timeframes need to be realistic in terms of what can be achieved, deadlines are important to give structure and focus to the process.

Practical solutions to project implementation in some cases reflected the limited ICT infrastructure available to PCTs. Solutions included group emails, letters, briefings, shared IT folders, setting up or engaging with a learning hub / repository of information and hosting workshops / focus group events. Workload commitments often point to lunchtime meetings with a light lunch provided as a practical option.

6.3 Theme 3: Obtaining wide inclusion, engagement and commitment

The importance of a team approach which includes and engages with all stakeholders in Primary Care was emphasised. In this regard, the process should embrace community representatives, General Practitioners and practice staff, HSE personnel and service users.

Communication at all stages was identified as essential to harnessing commitment and ensuring ownership of the project. This message is highly pertinent to the assessment process for the NSSBHC. Particular reference was made to the importance of listening to staff, service users and other stakeholders and providing an opportunity for them to influence and make decisions. Provision of feedback is an important element of the communication loop.

The establishment of small working groups to lead on different aspects of the project, particularly development and implementation of QIPs, allows for efficient use of resources and broader engagement.

6.4 Theme 4: Paying attention to motivating and sustaining changes

Projects need to be framed in terms of time, process and resources. The results of monitoring progress and evaluating outcomes can act as a motivator and in this regard mechanisms for measuring, collection, analysis and dissemination of related results need to be built into the work from the outset. Local progress should also be compared to national progress through the use of metrics, dashboards etc.

Communication between stakeholders needs to be regular and comprehensive with positive developments recognised and celebrated. Communication also needs to take place with other teams to ensure learning and successes are shared. To this end, well organised and appropriately facilitated, non-judgemental learning events are highly beneficial.

Experience suggests that it is best to approach the implementation of the standards as a series of steps. Each team should assess its current level of development honestly based on appropriate available supporting evidence. The teams' next steps then need to focus on priorities with the associated improvement plans implemented as an integral part of the existing work.

6.5 Theme 5: Providing the essential resources

Identifying and organising essential resources supports project success. The key resources identified for this project and considered essential for implementation of the NSSBHC were knowledge and support, training, toolkits / resource documentation, ICT, time and administrative support.

The need for knowledge and the appropriate skillset to provide support was identified as a major resource requirement for both the project and the NSSBHC process. In the case of the NSSBHC this skill set will be provided through Quality Leads within the CHOs with support from the Primary Care Division.

Locally the appointment of a project lead as point of contact ensures efficient and effective two way communication. The appointment of a project co-ordinator and protected administrative time to support project teams operating across disperse geographical locations, disciplinary boundaries and community interests are identified as essential for project progress and success.

Training should be provided in a flexible and adaptable manner appropriate to the concerns, interests and availability of different disciplines and other key stakeholders. A particular need to support clinical staff in framing their everyday practice i.e. client care within the themes of the NSSBHC was highlighted, with training programmes delivered from the service user and patient pathways perspectives.

Meeting the NSSBHC requires robust and timely information, efficiently captured and appropriately shared. Suitably designed and available ICT is a necessary requirement for meeting this need.

Toolkits can be useful, however, they need to be appropriate and reflective of service delivery within the Primary Care setting. The majority of those who completed the Participant Evaluation Survey recommended the use of both the Quality & Safety Prompts for Multidisciplinary Teams and the Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers. However, reservations about the complexity of the Assurance Check, the timing of its use in the context of evolving PCT governance structures and the overly detailed nature of the Prompts need to be taken into account. The need for appropriate tools for baseline measurements in order to track improvements was therefore considered important.

6.6 Similarities in Messages from Quality and Safety Clinical Governance Initiative in the Primary Care and Acute Hospital Settings

While the messages from the Primary Care Quality and Safety Action Projects are distinct and meaningful for those working within a Primary Care context, there are remarkable similarities to some of the key learning points from the initiative in the acute hospital setting. While both elements of the initiative focused on teams learning together and the development of the whole team, the approach used in the acute hospital setting focused on the senior

management teams while a wider approach involving both PCTs and their Managers was used in the Primary Care setting.

It is important, that in keeping with the objective of creating a culture where quality and patient safety is the primary goal of all and whereby the system of healthcare is provided in a person centred, seamless fashion such points of commonality need to be embraced and indeed recognised as opportunities for continued dialogue / action within the spirit of the overall Quality and Safety Clinical Governance Development Initiative. This is particularly significant in the context of the developing CHOs and Hospital Groups with each having distinct and separate cultures, management structures etc.

Commonality exists between the Primary Care and Acute Hospital Action Projects in relation to leadership and governance, in particular the need to have clarity around ownership and accountability with senior management involvement being identified as essential. The experience in the Primary Care setting echoes that of the Acute service setting whereby - "leadership is central to holding the vision" and "real change in improving quality and safety requires total executive management team buy in" with "staff members knowing and understanding their personal and team role and responsibilities at all times" (Sharing the Learning (2014)).

Similarly the matter of sustainability was identified by both Acute and Primary Care projects and in particular the need to have dedicated resources and support mechanisms. The focus on quality and safety was found to best occur with the input of a guide. In both elements of the initiative, the central support provided by the National Lead for Governance for Quality and Safety Development was acknowledged with project participants leading and responding well to the available focused quality and safety support at a time when there were a lot of competing demands. For the Primary Care element of the initiative, the Action Projects were timely in relation to other drivers including the NSSBHC with the participating teams deemed to be well placed with respect to the assessment and implementation processes of the NSSBHC due to their Action Project participation. This is also reflective of the experience in the acute hospital setting. In addition the publication of the Report and the Recommendations of the Integrated Service Review Group for Community Healthcare Organisations (2014) was timely as governance for quality and safety is about having the right structures and processes in place to achieve quality and safety of services and the proposed Primary Care structures have the potential to facilitate this.

Protecting staff wellbeing was another common theme across a number of learning points such as valuing staff through fostering full involvement, embedding good communication, using simple clear language in the way business is conducted, putting in place appropriate training and organising work and resources within realistic timeframes. In both settings it was recognised that "culture change requires long investment with 'bite size' chunks of development in order to sustain motivation and achievement."

7 Recommendations

While aspects of the learning from the two action projects are specific to the context of each team, there are also valuable wider organisational learning opportunities. In this context it is recommended that Chief Officers and CHO management teams optimise such learning by:

1. Sharing this report from the Primary Care Quality and Safety Action Projects widely within CHOs, management teams and primary care services
2. Considering how the main messages from the Primary Care Quality and Safety Action Projects can inform CHOs in their approach to the self assessment and quality improvement planning processes necessary for meeting the NSSBHC

8 Conclusion

Quality does not happen by chance nor is quality an end point; rather quality is a journey towards excellence … a journey which all involved in the provision of healthcare undertake.

The North Cork and North Sligo PCTs and associated PCCC management teams commenced that journey, in 2013, as Action Projects in the Primary Care element of the Quality and Safety Clinical Governance Development Initiative. Today they continue on that journey having completed, evaluated and celebrated their achievements as part of the formal aspect of the project.

This report outlines details of that formal journey, which under the guidance of the Project Implementation Support Group involved the teams using the project tools i.e. the Quality and Safety Prompts for Multidisciplinary Teams and Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers, which was modified for the Primary Care setting, to identify structures and processes requiring action in order to strengthen governance for quality and safety. It also included the development of quality improvement action plans which the teams prioritised and implemented during the project period to October 2014.

The assessment and development of improvement plan processes prepared the teams for similar processes as part of the implementation of the NSSBHC. The identified actions met twenty two of the QA +1 Tool essential elements of quality across eight themes of the National Standards and strengthen the transferability of learning from this element of the initiative across the Primary Care setting. While the resource tools were found to be useful and remain available it is not intended to develop them further, as a suite of workbooks for implementation of the National Standards i.e. the HSE Primary Care Quality Assessment and Improvement Practical Guide Resource (2014) are now available and fulfil a similar purpose. This resource will therefore be the main tool for use by the CHOs in their self assessments against the NSSBHC, including their assessment against Theme 5, Leadership, Governance and Management.

The Quality and Safety Clinical Governance Development Initiative, was part of a journey focused on creating a culture where quality and safety is everyone's primary goal. In the spirit of this journey, learning from the five acute hospital projects, as part of the acute hospital element of the initiative, was subsequently applied to the Primary Care Action Projects in two specific ways:

- Primary Care Action Project design paid particular attention to direct involvement of team members and enabling them to make quality improvement changes

- Measurement was built into the Primary Care Action Projects – clear measures of teams and Managers improved understanding of governance for quality and safety arising from the projects.

While acknowledging that there was a limitation to the number of teams that could be involved, the focus on the involvement of PCT members not only impacted on the specifics of the projects, but shaped the emergent messages and deepened their applicability. The importance of PCT members' direct involvement is particularly evident in relation to key messages relating to process clarity and practicality, inclusion, engagement and commitment and the need for appropriate resources, including training.

Building measurement of understanding into the Primary Care Action Projects and the resultant demonstration of improvement has learning beyond the specific projects. Results demonstrated a clear improvement in understanding across all participants. Such understanding is essential for buy-in and commitment and from a governance and leadership perspective. However, such improvement needs to be considered alongside the strong messages regarding the importance of a team approach and leadership by senior managers as provided for in this initiative.

Such leadership by the Chief Officers and CHO management teams, as well as a team approach is a key factor in the successful implementation of the NSSBHC currently underway in Primary Care.

The Primary Care Action Projects demonstrated commitment to the delivery of quality and safe healthcare at PCT and PCT management levels. While it is not intended that these Action Projects will be repeated, it is clear that the learning from the projects has direct relevance to the implementation of the NSSBHC and in this regard this report offers insight and guidance to others.

Important messages have emerged. Some of these messages may present challenges, however the timing is opportune following the Report and the Recommendations of the Integrated Service Review Group for Community Healthcare Organisations (2014) and the resultant new governance arrangements. While these new arrangements move away from integration in terms of the structural management arrangements previously in place, integrated care remains a core organising objective. It is accepted that person centred, safe and effective care and support necessitates that service users experience care provision in an integrated, seamless fashion. It follows therefore that quality and safety need to be managed across the primary – secondary care continuum and from a patient journey perspective. In this regard, the Acute and Primary Care Action Projects have illuminated a number of points of commonality. These commonalities present an opportunity for continued dialogue and joint working towards the primary goal of a healthcare system whereby quality and safety is everyone's responsibility and where patient safety comes first, regardless of care setting.

Reference

Agency for Healthcare Research and Quality (2012). Hospital Survey on Patient Safety Culture. Data Entry and Analysis Tool. Accessed in February 2014 at

http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital

Agency for Healthcare Research and Quality (2011), Medical Office Survey on Patient Safety. Accessed in February 2014 at
http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/medical-office/

Collins, A (2014) Measuring and monitoring safety: a primary care perspective. The Health Foundation

http://www.health.org.uk/publications/measuring-and-monitoring-safety-a-primary-care-perspective/

Esmail A, (2013) Measuring what really matters Towards a coherent measurement system to support person-centred care. The Health Foundation
http://www.health.org.uk/publications/measuring-what-really-matters/

Gauld, R., Horsburg, S. and Brown, J. (2011), 'The clinical governance development index: results from a New Zealand study', British Medical Journal Quality and Safety, 20(11): 947-952.

HSE National Service Plan (2015), Dublin: Health Service Executive

National Standards for Safer Better Healthcare (2012), Dublin: Health Information and Quality Authority

Nieva, A.F, Sorra, J., (2003), 'Safety Culture assessment: a tool for improving patient safety in healthcare organizations'. Quality and Safety in Healthcare. Accessed February 2014 at
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1765782

Primary Care A New Direction (2001), Dublin: The Stationary Office

Primary Care Operational Plan (2015), Dublin: Health Service Executive

Primary Care Quality Assessment and Improvement Practical Guide Resource (2014), Dublin: Health Service Executive

Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers (2012), Dublin: Health Service Executive

Quality and Safety Prompts for Multidisciplinary Teams (2012), Dublin: Health Service Executive

Report and the Recommendations of the Integrated Service Review Group for Community Healthcare Organisations (2014), Dublin: Health Service Executive

Report of the Quality and Safety Clinical Governance Development Initiative Sharing our learning Report (2014), Dublin: Health Service Executive

Sorra J.S, Nieva., V, F, (2004), Hospital Survey on Patient Safety Culture. (Prepared by Westat, under Contract No. 290-96-0004). Agency for Healthcare Research and Quality, Publication No. 04-0041. Rockville, MD: Agency for Healthcare research and Quality.

The Health Foundation (2011) Evidence Scan. Improving safety in primary care
http://www.health.org.uk/publications/improving-safety-in-primary-care/

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Appendix 1 National Standards for Safer Better Healthcare (2012)

Figure: National Standards for Safer Better Healthcare: Themes for Quality and Safety

Table: National Standards for Safer Better Healthcare: Number of Standards and Essential Elements [4]

Theme		Number of standards	Number of essential elements
Theme 1	Person centred care and support	9	9
Theme 2	Effective care and support	8	10
Theme 3	Safe care and support	7	12
Theme 4	Better health and wellbeing	1	1
Theme 5	Leadership, governance and management	11	12
Theme 6	Workforce	4	4
Theme 7	Use of resources	2	2
Theme 8	Use of information	3	3
Total		**45**	**53**

[4] Quality Assessment and Improvement Tool (QA+I) essential elements are those elements of quality which are representative of what a service should have in place to support the provision of safe, igh quality care. These are set out in the HSE Primary Care AQ+I Tool Practical Guide Resource for the National Standards for Safer Better Healthcare (2014).

Appendix 2 Governance for Quality and Safety Framework

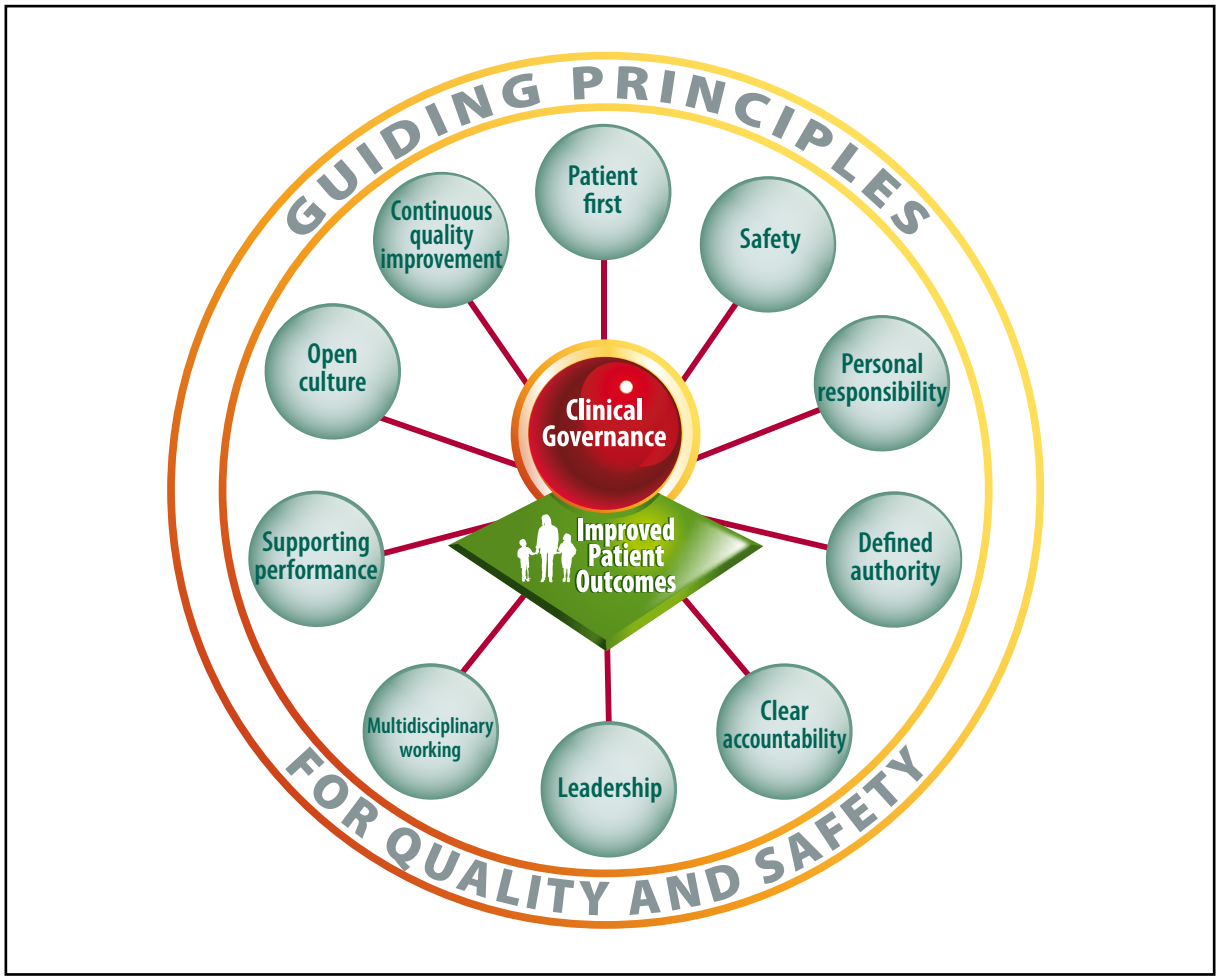
Concept	Governance for Quality and Safety		
Domains	**Structure**	**Process**	**Outcome**
	Board/Community Healthcare Organisation Quality and Safety Board Committee Executive Management Team Quality and Safety Executive Committee Directorates Clinical leadership Accountability spine	Quality and performance indicators Learning and sharing information Patient and public involvement Risk management and patient safety* Clinical effectiveness and audit Staffing and staff management Information management Capacity and capability	Patient care Patient experience Staff experience Service improvement
Context	Individual Practitioner Service/Department/Directorate Senior/Executive Management Team Board/Community Healthcare Organisation National Health Body		

* **Note:** for further information on the HSE Incident Management Policy and Guidance developed for Incident and Complaint investigations see www.hse.ie/go/qps.

Appendix 3 Guiding Principles for Quality and Safety

Ten guiding principles for quality and safety governance development, for the Irish health context, are provided with a title and descriptor. It is proposed that the principles inform each action and provide the guidance in choosing between options in the development of the model of care.

Figure: Guiding principles for quality and safety



It is recommended that each decision (at every level) in relation to quality and safety be tested against the principles set out in the figure above and described in the table on the next page.

Table: Guiding principles for quality and safety

Principle	Descriptor
Patient First	Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
Safety	Identification and control of risks to achieve effective efficient and positive outcomes for patients and staff.
Personal responsibility	Where individuals as members of healthcare teams, patients and members of the population take personal responsibility for their own and others health needs. Where each employee has a current job-description setting out the purpose, responsibilities, accountabilities and standards required in their role.
Defined authority	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.
Clear accountability	A system whereby individuals, functions or committees agree accountability to a single individual.
Leadership	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
Multi-disciplinary working	Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Inter-disciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
Supporting performance	Managing performance in a supportive way, in a continuous process, taking account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service and employees thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the patients experience being central in performance measurement (as set out in the National Charter, 2010).
Open culture	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research and improvement, and appropriate action taken where there have been failings in the delivery of care.
Continuous quality improvement	A learning environment and system that seeks to improve the provision of services with an emphasis on maintaining quality in the future not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing.

Appendix 4 Quality and Safety Resources

A *Quality and Patient Safety: Clinical Governance Information Leaflet* (February, 2012). This leaflet provides a succinct overview of quality and safety clinical governance descriptor vision, principles and matrix. The document is designed to be easily accessible and provide a summary for all staff in understanding that we are all responsible in creating a safer healthcare system.

A *Quality and Patient Safety: Clinical Governance Development assurance check for health service providers* (February, 2012). This document provides a series of practical statements which are grouped into two parts i) clinical governance structures and ii) clinical governance processes. The completion of the assurance check assists Boards/CEO/GMs or equivalent in determining what clinical governance arrangements are in place. It is designed as a development tool and is not intended as a reporting mechanism. Review of the statements in the assurance check assists in preparation for meeting theme 5 leadership governance and management of the National Standards for Safer Better Healthcare (2012). For this project the statements within the assurance check document were tailored for primary care.

Quality and safety prompts for multidisciplinary teams (October, 2012). This is an easily accessible, practical guide, for local multidisciplinary teams to use in discussing quality and safety at regular team meetings. The approach was tested with over twenty teams, is based on the principles for good clinical governance and aligned with the themes of the National Standards for Safer Better Healthcare (2012).

Toolbox talks for QPS DNE (March, 2013). This Dublin North East regional initiative incorporates some of the national resources (as above) in addition to a 'talk' applying the principles of quality and patient safety to the workplace.

Quality and Safety Committee(s): Guidance and Sample Terms of Reference (May, 2013). This document provides guidance and sample terms of reference for organisations to use in the establishment of both i) Quality and Safety Board Committees and ii) Quality and Safety Executive Committees. This guidance contains a standard meeting agenda aligned with the themes of the National Standards for Safety Better Healthcare (2012) and can be adapted to suit particular context and environments.

Quality and Safety Walk-rounds: Toolkit (May, 2013). In a systematic review leadership walk rounds and multi-faceted unit-based strategies are the two strategies with some stronger evidence to support a positive impact on patient safety culture in hospitals (Morello et al. 2012). This toolkit provides a structured process to bring senior managers and front line staff together to have conversations about quality and safety to prevent, detect and mitigate patient/staff harm. The walk-round can be focused on any location or service that may affect patient care and safety.

The Safety Pause: Information Sheet (May, 2013). This guide is based on a practical, why, who, when and how approach to the Safety Pause which heightens safety awareness and assists teams in being proactive about the challenges they face in providing safe high quality care for patients. It centres on one question 'what patient safety issues do we need to be aware of today' resulting in immediate actions.

The documents above can be located at www.hse.ie/go/clinicalgovernance

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Patient Safety Culture Survey

North Cork Primary Care Teams

Introduction

This survey is being undertaken as part of your participation in the North Cork Primary Care Quality and Safety Development Project.

About the Survey

The aim is to provide you with a measure of your perceptions, of your patient safety culture, at the start of the project with the possibility of measuring this again at a further time.

The survey results will be shared with you and the North Cork project team which will provide an insight and baseline of your perceptions of the patient safety culture within your Primary Care Team (PCT) - areas of strength and assist you in identifying areas for improvement.

All information will be treated confidentially. No individuals will be identifiable in any way. The HSE Quality and Patient Safety Directorate (QPSD) will provide assistance by analysing the results – all information will be returned to the project team and the study findings will not be used for any other purpose. A survey report will be sent to the Project Lead for circulation to the PCT members. The data, staff comments and analysis will be returned to the Project Lead. No information will be retained by the QPSD.

Your participation is confidential and voluntary.

SURVEY INSTRUCTIONS

This survey asks for your opinions about patient safety issues, medical errors and adverse event reporting in your Primary Care Team (PCT) and will take about 15 minutes to complete.

Think about your PCT and provide your opinions on issues that affect the overall safety and quality of the care provided to patients in your PCT.

- In this survey, the term clinician refers to doctors, nurses and health and social care professionals who diagnose, treat/care for patients, and prescribe medications.
- The term staff refers to all who work in the PCT.
  - To mark your answer just put an X in the box. [X]
  - If a question does not apply to you or you don't know the answer, please check "Does Not Apply or Don't Know."
  - If you work in more than one location, when answering only answer the questions from the perspective of the service you provide as part of the PCT.

Your contribution to the development of patient quality and safety initiatives is essential and we value the time you have given to assisting this by completing this survey.

Agency for Healthcare Research in Quality. Adapted to the Irish Healthcare Setting by the Quality and Patient Safety Directorate, Health Service Executive, 2013.

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DEFINITIONS

Patient Safety - the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery (AHRQ).

Incident - an event or circumstance which could have, or did lead to unintended and/or unnecessary harm (WHO 2009 and DoH 2010) and includes adverse events and near misses. Incidents can be clinical or non-clinical. Incidents include complaints which are associated with harm that may be caused by acts or omissions on the part of the HSE and as such these complaints are service user reported incidents.

Adverse event - an incident which results in harm.

Near misses - an incident which could have resulted in harm, but did not either by chance or timely intervention.

Clinical Governance - the system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver.

Clinical Leader - is a competent professional involved in providing direct and indirect clinical care, who enables oneself and influences others to improve.

Clinical Leadership - is about driving service improvement and the effective management of teams to provide excellence in patient care.

Clinicians - for the purpose of this survey 'clinicians' encompasses in its broadest context all clinical staff.

Open Disclosure - is "an open, consistent approach to communicating with patients when things go wrong in healthcare. It includes expressing regret for what has happened, keeping the patient informed, providing feedback on any investigations and the steps taken to prevent a recurrence of the adverse event". (The Australian Commission on Safety and Quality in Health Care).

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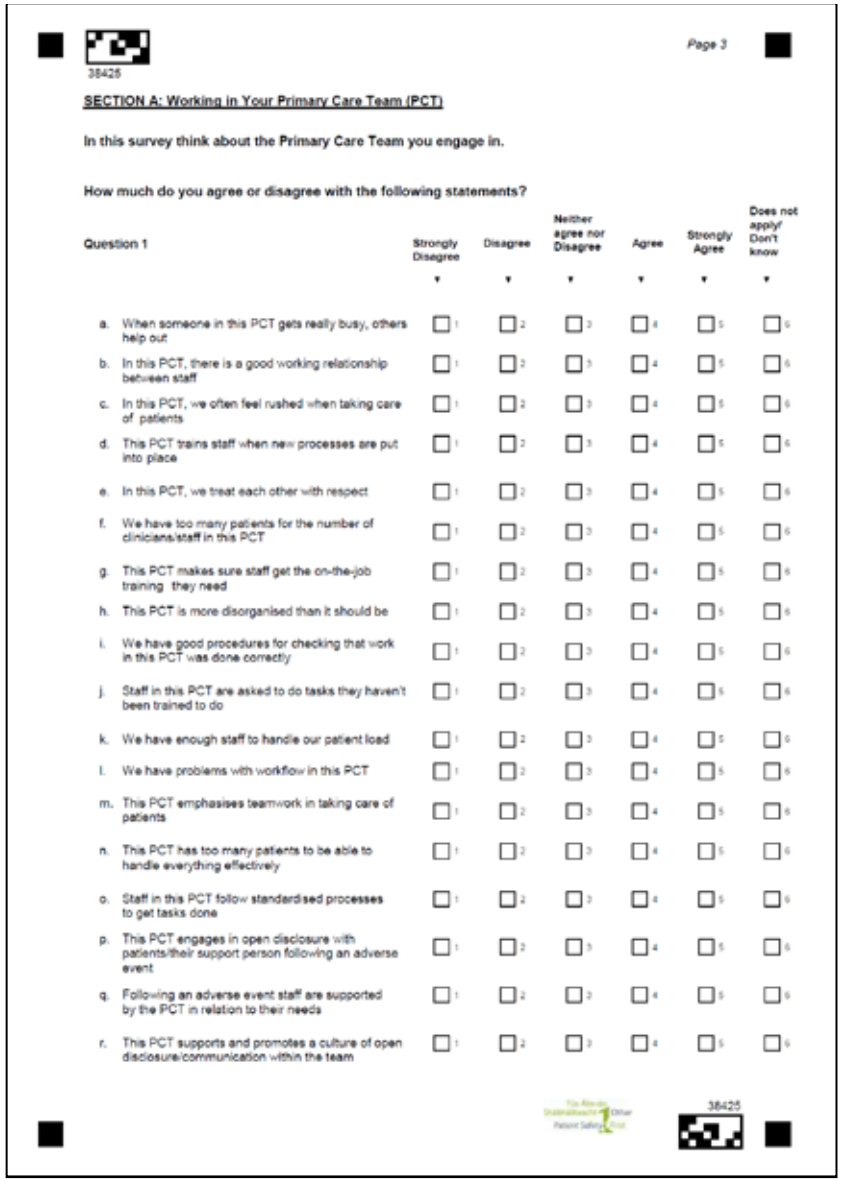

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SECTION A: Working in Your Primary Care Team (PCT)

In this survey think about the Primary Care Team you engage in.

How much do you agree or disagree with the following statements?

Question 1	Strongly Disagree ▼	Disagree ▼	Neither agree nor Disagree ▼	Agree ▼	Strongly Agree ▼	Does not apply/ Don't know ▼
a. When someone in this PCT gets really busy, others help out	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b. In this PCT, there is a good working relationship between staff	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c. In this PCT, we often feel rushed when taking care of patients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d. This PCT trains staff when new processes are put into place	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e. In this PCT, we treat each other with respect	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f. We have too many patients for the number of clinicians/staff in this PCT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g. This PCT makes sure staff get the on-the-job training they need	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h. This PCT is more disorganised than it should be	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
i. We have good procedures for checking that work in this PCT was done correctly	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
j. Staff in this PCT are asked to do tasks they haven't been trained to do	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
k. We have enough staff to handle our patient load	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
l. We have problems with workflow in this PCT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
m. This PCT emphasises teamwork in taking care of patients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
n. This PCT has too many patients to be able to handle everything effectively	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
o. Staff in this PCT follow standardised processes to get tasks done	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
p. This PCT engages in open disclosure with patients/their support person following an adverse event	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
q. Following an adverse event staff are supported by the PCT in relation to their needs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
r. This PCT supports and promotes a culture of open disclosure/communication within the team	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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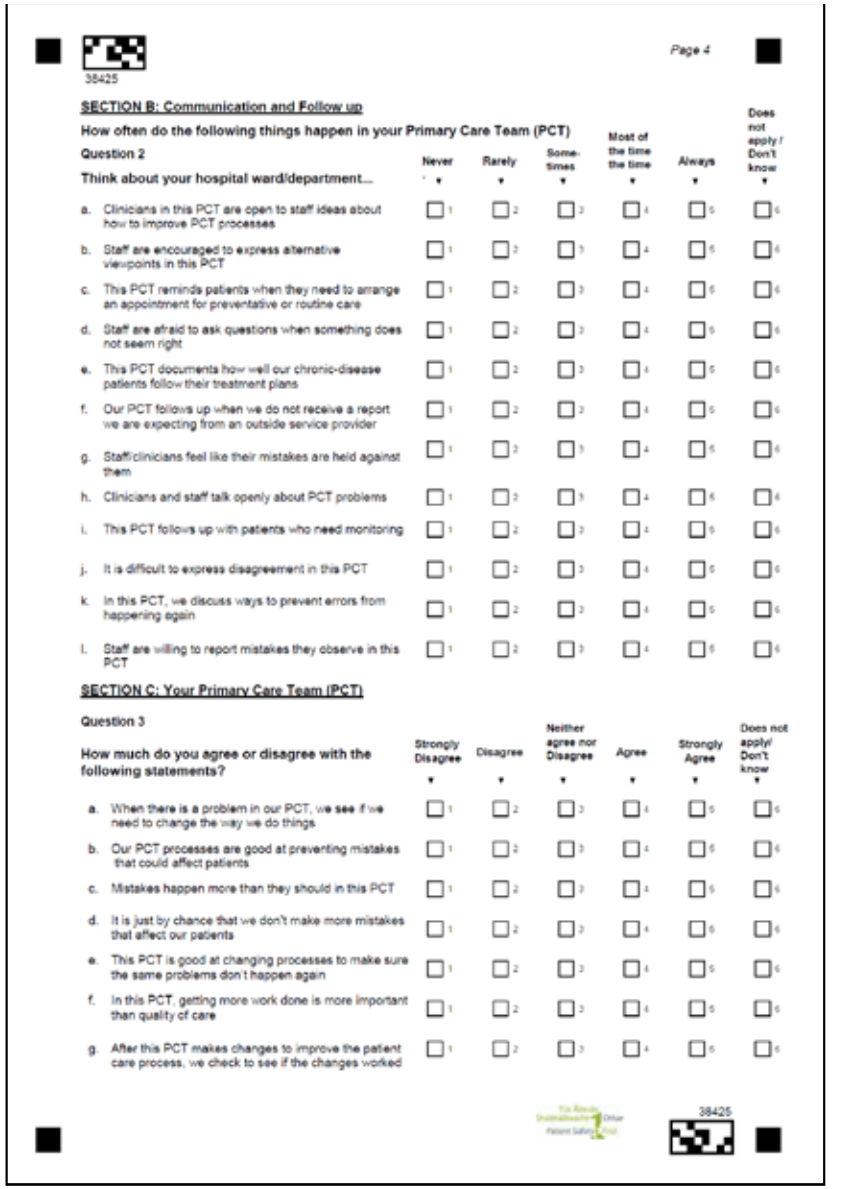

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SECTION B: Communication and Follow up

How often do the following things happen in your Primary Care Team (PCT)

Question 2 Think about your hospital ward/department...	Never ▼	Rarely ▼	Some-times ▼	Most of the time the time ▼	Always ▼	Does not apply / Don't know ▼
a. Clinicians in this PCT are open to staff ideas about how to improve PCT processes	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b. Staff are encouraged to express alternative viewpoints in this PCT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c. This PCT reminds patients when they need to arrange an appointment for preventative or routine care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d. Staff are afraid to ask questions when something does not seem right	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e. This PCT documents how well our chronic-disease patients follow their treatment plans	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f. Our PCT follows up when we do not receive a report we are expecting from an outside service provider	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g. Staff/clinicians feel like their mistakes are held against them	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h. Clinicians and staff talk openly about PCT problems	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
i. This PCT follows up with patients who need monitoring	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
j. It is difficult to express disagreement in this PCT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
k. In this PCT, we discuss ways to prevent errors from happening again	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
l. Staff are willing to report mistakes they observe in this PCT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

SECTION C: Your Primary Care Team (PCT)

Question 3 How much do you agree or disagree with the following statements?	Strongly Disagree ▼	Disagree ▼	Neither agree nor Disagree ▼	Agree ▼	Strongly Agree ▼	Does not apply/ Don't know ▼
a. When there is a problem in our PCT, we see if we need to change the way we do things	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b. Our PCT processes are good at preventing mistakes that could affect patients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c. Mistakes happen more than they should in this PCT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d. It is just by chance that we don't make more mistakes that affect our patients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e. This PCT is good at changing processes to make sure the same problems don't happen again	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f. In this PCT, getting more work done is more important than quality of care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g. After this PCT makes changes to improve the patient care process, we check to see if the changes worked	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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SECTION D: Frequency of Events Reported

Question 4

In your PCT, when the following mistakes happen, how often are they reported?	Never	Rarely	Some-times	Most of the time	Always
a. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	☐1	☐2	☐3	☐4	☐5
b. When a mistake is made, but has no potential to harm the patient, how often is this reported?	☐1	☐2	☐3	☐4	☐5
c. When a mistake is made that could harm the patient, but does not, how often is this reported?	☐1	☐2	☐3	☐4	☐5
d. When a mistake is made that caused harm to a patient how often is this reported?	☐1	☐2	☐3	☐4	☐5

SECTION E: Number of Events Reported

Question 5

In the past 12 months, how many incident reports have you filled out and submitted?

- ☐ a. No incident reports
- ☐ b. 1 to 2 incident reports
- ☐ c. 3 to 5 incident reports
- ☐ d. 6 to 10 incident reports
- ☐ e. 11 to 20 incident reports
- ☐ f. 21 incident reports or more

SECTION F: Overall Ratings

Question 6

Overall how would you rate your PCT on each of the following areas of health care quality?	Poor	Fair	Good	Very Good	Excellent
a. Patient Centered Is responsive to individual patient preferences, needs and values	☐1	☐2	☐3	☐4	☐5
b. Effective Is based on scientific knowledge	☐1	☐2	☐3	☐4	☐5
c. Timely Minimises waits and potentially harmful delays	☐1	☐2	☐3	☐4	☐5
d. Efficient Ensures cost-effective care (avoids waste, overuse, and misuse of services)	☐1	☐2	☐3	☐4	☐5
e. Equitable Provides the same quality of care to all individuals regardless of gender, race, ethnicity, socioeconomic status, language, etc	☐1	☐2	☐3	☐4	☐5

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Overall Rating on Patient Safety

Question 7

Overall, how would you rate the systems and clinical processes your PCT has in place to prevent, catch, and correct problems that have the potential to affect patients?.

☐ A	☐ B	☐ C	☐ D	☐ E
Poor	Fair	Good	Very Good	Excellent

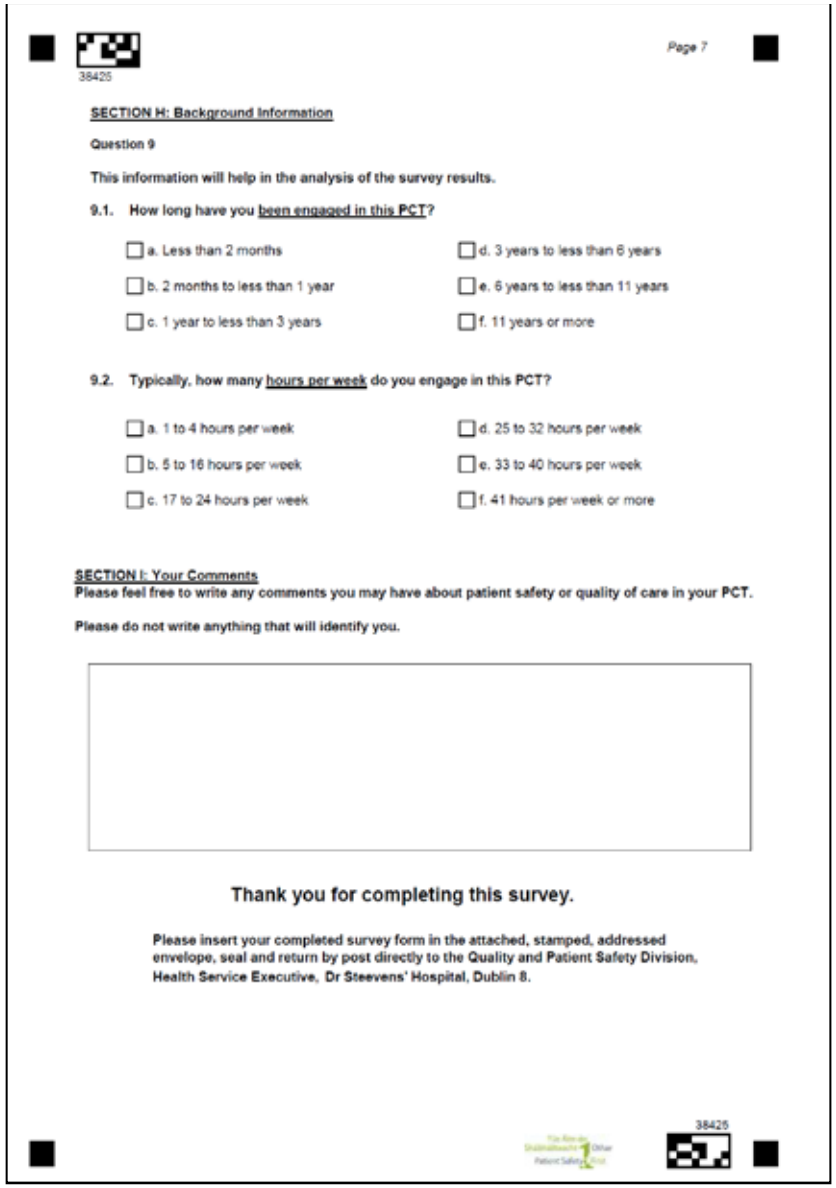
SECTION G: Quality and Safety (Clinical Governance) Development

Question 8

The benefit of clinical governance rests in improved patient experiences and better outcomes in terms of quality and safety.

8 part 1. Think about your service...	Yes	No	Don't Know
a. Have you had any clinical governance education or training? (please tick one)	☐1	☐2	☐3
b. To your knowledge, has your Primary Care Service established a clinical governance structure that ensures a partnership between clinicians and management? (please tick one)	☐1	☐2	☐3

8 part 2. Think about your service, read each question and indicate...	A great extent	Some extent	No extent	Don't Know
a. To what extent do you believe that quality and safety is the goal of every clinical initiative in your PCT? (please tick one)	☐1	☐2	☐3	☐4
b. To what extent do you believe that quality and safety is the goal of every management/administrative initiative in your PCT? (please tick one)	☐1	☐2	☐3	☐4
c. To what extent are clinicians in your PCT involved as full active participants in all governance decision making processes? (please tick one)	☐1	☐2	☐3	☐4
d. To what extent are clinicians in your PCT involved in a partnership with management with shared decision making, responsibility and accountability? (please tick one)	☐1	☐2	☐3	☐4
e. To what extent has your Primary Care Service sought to identify clinical leaders? (please tick one)	☐1	☐2	☐3	☐4
f. To what extent has your Primary Care Service sought to give responsibility to your team for clinical service decision making in your clinical area? (please tick one).	☐1	☐2	☐3	☐4
g. To what extent do staff in this PCT involve patients and families in improving quality and patient safety? (please tick one)	☐1	☐2	☐3	☐4



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SECTION H: Background Information

Question 9

This information will help in the analysis of the survey results.

9.1. How long have you been engaged in this PCT?

- ☐ a. Less than 2 months
- ☐ b. 2 months to less than 1 year
- ☐ c. 1 year to less than 3 years
- ☐ d. 3 years to less than 6 years
- ☐ e. 6 years to less than 11 years
- ☐ f. 11 years or more

9.2. Typically, how many hours per week do you engage in this PCT?

- ☐ a. 1 to 4 hours per week
- ☐ b. 5 to 16 hours per week
- ☐ c. 17 to 24 hours per week
- ☐ d. 25 to 32 hours per week
- ☐ e. 33 to 40 hours per week
- ☐ f. 41 hours per week or more

SECTION I: Your Comments

Please feel free to write any comments you may have about patient safety or quality of care in your PCT.

Please do not write anything that will identify you.

Thank you for completing this survey.

Please insert your completed survey form in the attached, stamped, addressed envelope, seal and return by post directly to the Quality and Patient Safety Division, Health Service Executive, Dr Steevens' Hospital, Dublin 8.

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Evaluation of the Primary Care Quality and Safety Project

Introduction
This survey is being undertaken as part of an evaluation of the North Sligo & North Cork Primary Care Quality and Safety Project.

About the Survey
The aim is to gather and share the learning from primary care team members and primary care managers involved in the two primary care quality and safety action projects (undertaken Q4 2013 and Q1,2,3 2014) and to provide you with a measure of your understanding and experience at the end of the project.

The survey results will be shared with the project team and in summary form with members of the national HSE Quality and Patient Safety (QPSD) and Primary Care Divisions.

All information will be treated confidentially. No individuals will be identifiable in any way. The HSE QPSD will provide assistance by analysing the results – all information will be returned to the project team and the survey findings will not be used for any other purpose.

A survey report will be sent to the Project Lead for circulation to the Project Group, PCT members and managers. The data, staff comments and analysis will be returned to the Project Lead. No information will be retained by the QPSD.

Your participation is confidential and voluntary.

SURVEY INSTRUCTIONS
This survey asks for your opinions about the project and the quality and safety resources used. It will take about 5 minutes to complete.

Your contribution to the development of quality and safety initiatives is essential and we value the time you have given to assisting this by completing this survey.
Please return your completed questionnaire in the addressed envelope to:

Maureen Flynn
National lead for Quality and Safety Governance Development
Quality and Patient Safety Division, Health Services Executive
Room 222, Dr. Steevens Hospital, Dublin 8

By: 24th October 2014

Question 1

DIRECTIONS: The statements below are designed to identify your understanding in a number of areas following completion of your Primary Care Quality and Safety Project. Each item has 5 possible responses. The responses range from **1** (Low understanding) through **2, 3, 4** (increasing understanding) to **5** (High understanding). **Please read each statement and think back and rank your understanding before the commencement of the project (left side of the table). Next think about now and rank your understanding as a result of the project (right side of the table). If the statement is not applicable, please leave it blank**

	UNDERSTANDING *Circle the appropriate numbers where you saw yourself prior to commencing the project and where you see yourself now as a result of the Primary Care Quality and Safety Project. 1 = low understanding through to 5 = high understanding*									
	Before the Quality & Safety Project					**After** the Quality & Safety Project				
	Before Sept 2013					**Now (After) Sept 2014**				
My understanding of…	Low 1	2	3	4	High 5	Low 1	2	3	4	High 5
1. the term clinical governance (governance for quality and safety)*	1	2	3	4	5	1	2	3	4	5
2. the ten principles for quality and safety*	1	2	3	4	5	1	2	3	4	5
3. the structures for quality and safety*	1	2	3	4	5	1	2	3	4	5
4. the eight processes for quality and safety (risk management, audit etc)*	1	2	3	4	5	1	2	3	4	5
5. accountability and responsibility for quality and safety of patient care within primary care	1	2	3	4	5	1	2	3	4	5
6. how to undertake actions to improve quality and safety of primary care services	1	2	3	4	5	1	2	3	4	5
7. how to obtain feedback from service users/public on their experiences of primary care services	1	2	3	4	5	1	2	3	4	5
8. how to address quality and safety issues within my PCT	1	2	3	4	5	1	2	3	4	5

Note: * described in the Quality and Patient Safety Clinical Governance Development Leaflet provided at the workshops see details at www.hse.ie/gpclinicalgovernance

Question 2

DIRECTIONS: The statements below are designed to obtain your opinion on the resources used in the Primary Care Quality and Safety Projects. Each item has 5 possible responses. The responses range from **1** (Strongly Disagree) through **3** (No Opinion) to **5** (Strongly Agree). Please read each statement. ***Circle the one response that most clearly represents your degree of agreement or disagreement with that statement.*** If the statement is not relevant to you please circle the N/A response. **Please respond to all of the statements.**

	Strongly disagree	Disagree	No Opinion	Agree	Strongly agree	Not applicable
1. The *Quality and Safety Clinical Governance Information Leaflet* provided me with an understanding of clinical governance*	1	2	3	4	5	N/A
2. The *Quality and Safety Multidisciplinary Prompts* (used at the PCT workshop) were applicable to our primary care team*	1	2	3	4	5	N/A
3. The *Quality and Safety Multidisciplinary Prompts* (used at the PCT workshop) helped our primary care team identify actions for improvement*	1	2	3	4	5	N/A
4. The *Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers* (used at the PC managers workshop) was useful in assessing the primary care structures and processes for quality and safety*	1	2	3	4	5	N/A
5. The *Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers* (used at the PC managers workshop) helped our primary care managers identify actions for improvement*	1	2	3	4	5	N/A
6. The actions undertaken during the project have resulted in improvements for service users	1	2	3	4	5	N/A
7. The actions undertaken during the project have resulted in improvements for primary care personnel	1	2	3	4	5	N/A
8. The *Safety Pause Information Sheet* (one page) shared at the workshop is useful for PC*	1	2	3	4	5	N/A
9. I would recommend the use of *Quality and Safety Multidisciplinary Prompts* by other primary care teams / managers	1	2	3	4	5	N/A
10. I would recommend the use of *Quality and Safety Clinical Governance Development Assurance Check for Health Service Providers* by other primary managers	1	2	3	4	5	N/A

Note: *copies of documents supplied at the workshops available at www.hse.ie/go/clin/calgovernance

Question 3

Please describe three things that made this project work well

1.

2.

3.

Question 4

Please describe three things that would have improved the project?

1.

2.

3.

Question 5

Please describe three actions to improve quality and safety of services that your primary care team implemented

1.

2.

3.

Question 6

	Strongly disagree	Disagree	No Opinion	Agree	Strongly agree	Not applicable
Overall I was satisfied with the outcomes from our primary care quality and safety project	1	2	3	4	5	N/A

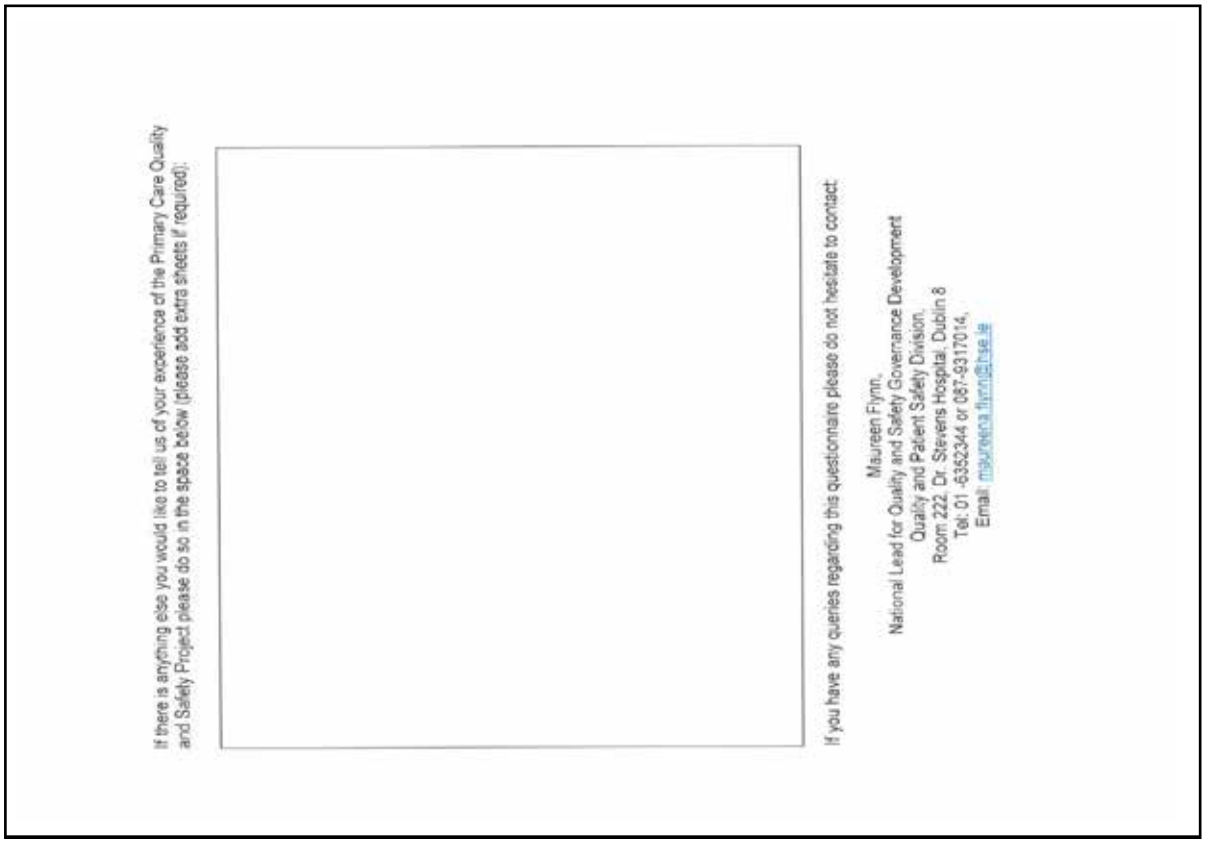
Question 7

I participated in the primary care quality and safety action project as a (tick all that apply):

- Primary Care Team Member ☐
- Primary Care Service Manager ☐
- Project Team Member ☐

Thank you for taking the time to complete this questionnaire.

Your assistance in providing this information is very much appreciated.



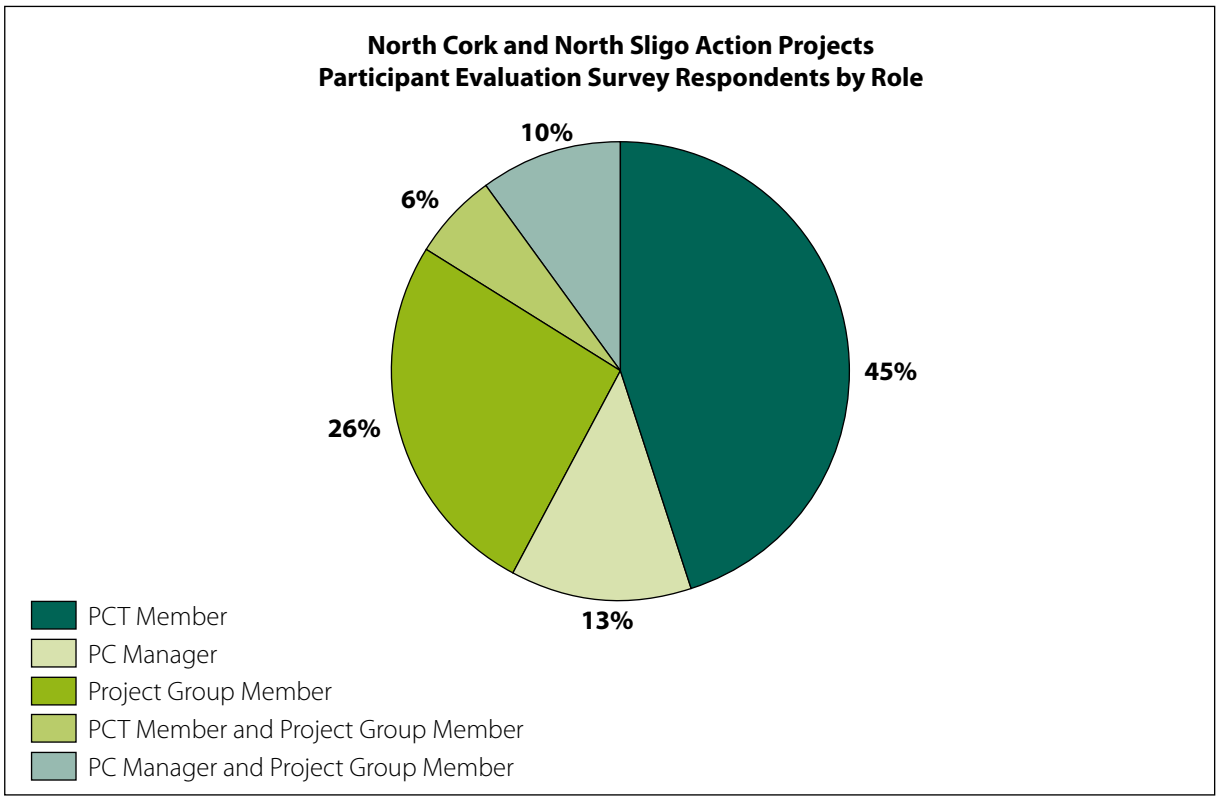
If there is anything else you would like to tell us of your experience of the Primary Care Quality and Safety Project please do so in the space below (please add extra sheets if required):

If you have any queries regarding this questionnaire please do not hesitate to contact:

Maureen Flynn,
National Lead for Quality and Safety Governance Development
Quality and Patient Safety Division,
Room 222 Dr. Steevens Hospital, Dublin 8
Tel: 01 -6352344 or 087-9317014,
Email: maureenn.flynn@hse.ie

Summary of Findings

Figure: Profile of Participant Evaluation Survey Respondents by Role



Question 1: Change in understanding

This question set out to measure the change in the participants understating of eight different aspects systems before and after the projects. The findings are detailed in the Table below.

Table: Participant evaluation survey: Question 1: Change in understanding. Improved Understanding Proportions (i.e. proportions with a higher ranking after the Project)

Question		Total Valid* Paired Responses N	Improved Understanding N	Improved Understanding %	P**
Q1.1	Clinical Governance Term	32	25	78.1	<0.0001
Q1.2	Ten Principles	31	28	90.3	<0.0001
Q1.3	Structures	30	22	73.3	<0.0001
Q1.4	Eight Processes	31	25	80.6	<0.0001
Q1.5	Accountability & Responsibility	31	22	71.0	<0.0001
Q1.6	How to Undertake Actions	31	21	67.7	<0.0001
Q1.7	How to Obtain Feedback	31	21	67.7	<0.0001
Q1.8	How to Address Issues	29	21	72.4	<0.0001

* excludes missing values
** Statistically significant differences between paired responses for each item were identified using Wilcoxon signed-rank tests

Question 2: Feedback on the resources used and actions taken

This question sought the respondents opinion on the resources used in the Primary Care Action Projects. Findings are detailed in Table below.

Table: Participant evaluation survey: Question 2: Feedback on the resources used and actions taken change in understanding positive response proportions (i.e. proportions with a 'Strongly Agree' or 'Agree' Response)

Question		Total Valid* Responses N	Positive Responses N	Positive Responses %
Q2.1	Leaflet provided an understanding of clinical governance	32	27	84.4
Q2.2	Prompts were applicable to our PCT	27	20	74.1
Q2.3	Prompts helped our PCT identify actions for improvement	28	24	85.7
Q2.4	Assurance Check was useful in assessing structures and processes	24	14	58.3
Q2.5	Assurance Check helped identify actions for improvement	24	17	70.8
Q2.6	Project Actions resulted in improvements for service users	31	12	38.7
Q2.7	Project Actions resulted in improvements for primary care personnel	31	16	51.6
Q2.8	Information Sheet is useful for PC	26	13	50.0
Q2.9	Prompts recommended for use by other primary care teams/managers	30	19	63.3
Q2.10	Assurance Check recommended for use by other primary managers	30	17	56.7

* excludes 'Not Applicable' and missing values

Question 6: Participants overall assessment

At the end of the survey respondents were invited to provide an overall assessment of their satisfaction with the outcomes of the Primary Care Quality and Safety Action Projects. Responses are detailed on the next Table.

Table : Participant evaluation survey: Question 6: Participants overall assessment
Overall I was satisfied with the outcomes from our primary care quality and safety project

Opinion	N	%
Strongly Disagree	3	10.0
Disagree	3	10.0
No Opinion	6	20.0
Agree	15	50.0
Strongly Agree	3	10.0
TOTAL	30	100.0
Not applicable	1	
Missing Value	1	
GRAND TOTAL	**32**	

Appendix 7 Agenda for Joint Learning Event

Primary Care Quality and Safety Action Projects Learning Event

Date: 26th November 2014
Time: 10.15-15.30 (Light Lunch provided from 13.00)
Venue: The Library Room, the Royal College of Physicians of Ireland, No 6 Kildare Street, Dublin 2.

Aim:

To gather and share the learning from the two Primary Care Quality and Safety Action Projects.

Objectives:

1. Explore what worked for the two different Primary Care Teams (PCTs) and associated managers
2. Gain specific learning from identified Quality Improvement Plans(QIPs)
3. Explore how the learning can be used to support the assessment and implementation process for the National Standards for Safer Better Healthcare (2012)
4. Identify how the learning can be disseminated and used.

Outline Agenda

10.15 Registration – Tea / Coffee

10.45 **Welcome and Introduction**
Angela Alder, National Lead for Quality and Patient Safety, Primary Care Division

10.50 **Presentations**
Primary Care Quality and Safety Action Projects (30 minutes each)
- North Sligo based on QIPs identified by the North Cork team
- North Cork based on QIPs identified by the North Sligo team

11.50 **Findings of Participant Survey**
Thora Burgess, Project Manager, Clinical Governance Development

12.15 **Thematic Analysis of Evaluation Points**
Maureen Flynn, National Lead for Quality and Safety Governance Development

13.00 **Lunch**

13.30 **Thematic Discussion on Collective Learning**
All Participants (facilitated round table, mix of attendees from both projects).

14.45 **Feedback from Discussion Groups**

15.15 **Summary of Key Learning**
Maureen Flynn, National Lead for Quality and Safety Governance Development

15.30 **Completion of Meeting Evaluation Form and Close of Learning Event**

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