

Guest editorial

Improving patient safety in primary care: learning from the secondary sector

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All healthcare providers should strive to ensure that patients receive safe, good-quality care. There is a strong focus today on having effective systems for managing risks, reporting failures and errors, and learning from them. Despite this, things sometimes still go awry. Inspections or assessments against standards will tell us whether care met the standard measured, but only investigation can diagnose the precise causes of failure.

The Healthcare Commission's main purpose is to promote improvement in the safety and quality of healthcare services provided to patients. To fulfil this remit, the commission has explicit powers to conduct investigations into the provision of health care by National Health Service (NHS) bodies. So far, over its first three years, the commission has dealt with over 200 cases of which 13 resulted in a formal investigation. Although they involved larger organisations, a recent review of these enquiries, *Learning from Investigations*, also provides salutary lessons for all of us working in primary care.¹ Failures were characterised by some familiar, recurrent themes:

Leadership

At any level, this is clearly important in setting the direction of an organisation, developing its culture, ensuring delivery and maintaining effective governance. Leaders ensure effective teamwork and create an ambience in which staff feel able to express their concerns.

Continuity of leadership is, for the most part, one of the strengths of general practice. However, many practice managers are subservient to the doctors that employ them. As a result they may be reticent in enforcing adherence to quality systems, for example annual appraisal.

Unsurprisingly, many of the investigations featured serious failures in teamwork, both between managers

and clinicians and between clinical groups. All clinical staff have a responsibility to work together: nurses, doctors, midwives, allied health professionals and those involved in social care.

Management and targets

Targets or outcome measures are an integral feature of a modern 21st century healthcare system, and have resulted in measurable improvements for patients in some important areas. NHS managers have always had to deal with conflicting priorities. The vast majority do it successfully but potential conflicts can compromise quality of care. For example, there is some evidence of relative neglect of conditions that are not incentivised under the Quality and Outcomes Framework (QOF).²

Governance and the use of information

The Healthcare Commission report provided examples of where the information generated was either not sufficiently detailed to identify serious problems, or the information was merely collected on a regular basis and not used to inform decisions. These situations can provide 'false assurance' within the trust, because board members take comfort in the knowledge that data are collected and that no concerns have been raised. This information may also inappropriately reassure the strategic health authority responsible for managing the performance of the trust, and the primary care trust commissioning the service in question. At practice level, QOF data alone may also be falsely reassuring.

The impact of mergers and organisational change

Many of the trust boards investigated were vulnerable to 'being consumed by the business of health care, in the form of mergers, reconfiguration of services, financial deficits, and targets'.¹ Services for patients can often be improved by reorganising the strategic delivery of health services or by merging organisations. However, if not carefully managed, the process of organisational change can divert management away from maintaining service quality. While mergers and other organisational changes will continue to be necessary in some situations, there is clear evidence that they bring with them a high degree of risk, if not handled appropriately by senior leaders.

Primary care trust reorganisations and the formation of practice-based commissioning consortia have provided comparable distractions in primary care. Many practices are seeing substantial financial and managerial resources diverted to tendering processes as they compete with the private sector for provision of services.³ The advent of polyclinics in London and elsewhere will be attended by organisational disruption.⁴

In concluding its report, the commission urged that as a basic requirement:

- senior managers (for which read general practitioners also) need to encourage a culture of openness and actively elicit the views of frontline staff on matters relating to safety
- systems for clinical governance must be 'built in' to the running of trusts, rather than being 'bolted on'. This should apply to practice consortia similarly. Most practices pursue clinical governance activities in vainglorious isolation, but opportunities to work across practice boundaries are increasing
- senior management teams should regularly build in protected time, uncluttered by other priorities, to reflect on whether they are meeting the needs of their most vulnerable patients and how they can be assured that these individuals are safe from harm.

Strengthening leadership for quality, cultural change and transforming the NHS from a 'doing' organisation into a 'learning' organisation are enduring challenges.⁵ One further message goes unstated – to politicians and departmental civil servants – spare us from further unnecessary organisational turbulence.

Moving forward

In relation to service failure, problems often occur at the borders between one organisation or team and

another. The Healthcare Commission has therefore put considerable effort into working jointly with other bodies: sharing information, referring or receiving concerns, and, where appropriate, working in partnership on investigations. For many practices, the most obvious fault lines are to be found at the increasingly blurred interface between primary and secondary care. Yet how many practices regularly review patient-safety issues with their local hospital trust?

NHS regulators have focused more on high-risk services in hospitals, but this is shortly to change. Department of Health proposals, currently out for consultation, envisage that practices will have to register with the new Health and Social Care watchdog and the Care Quality Commission, and be subject to 'spot checks'. To register, they will need to demonstrate compliance with a new set of standards. The new commission will have much greater powers than the organisations it replaces (the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission).

Individual registration by the healthcare professionals' governing body is no longer enough to protect the public as services delivered from primary care become more complex. A professionally led accreditation scheme should lessen the risk of micromanagement by heavy-handed regulators. However, it needs to be demonstrably rigorous. The Royal College of General Practitioners is piloting a scheme within 46 practices across four primary care trusts in England.

Practices are not currently required to report incidents to the National Patient Safety Agency (NPSA) and it is difficult to assess the risk primary medical care poses. In 2006/2007, 2410 episodes were reported to the NPSA from general practice, the most common being medication related (25%), followed by consent/confidentiality/communication issues (13%), then problems of access/transfer/discharge (12%). These figures are artificially low. An impact assessment accompanying the consultation predicts the standards resulting in registration could result in 30 000 fewer emergency admissions saving £78 million.⁶

The new registration system should enforce minimum standards, identifying and, if necessary, eliminating seriously under-performing practices. Whether the proposals – along with stronger primary care trusts' contracting powers and better information on practice performance to underpin patient choice – will raise standards in the majority is more doubtful. The fact remains that the powers granted to primary care trusts, under the general medical services contract, to deal with local practice problems are weak. Their willingness to monitor practices on their patch is variable. Many primary care trusts simply do not have the capacity to undertake rigorous annual visits to practices as part of the Quality and Outcomes Framework. From their vantage point, the work of

the Healthcare Commission has always been unbalanced in its focus on secondary care.

The new Care Quality Commission is likely to take a reactive approach based on surveillance, data, and targeting inspections on the most risky practices. A methodology has been developed for analysing performance that clusters practices according to numbers of partners, local demography and Index of Multiple Deprivation. The idea is to provide a safety net for reassuring the public and providing primary care trusts with back-up as required. A registration scheme that can be applied to all health and social care providers – including those in the independent sector – needs to be robust but not overly bureaucratic. Greater clarity regarding the setting and monitoring of standards in primary care should therefore be welcomed.

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PEER REVIEW

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