Despite the power of modern medicine to cure and ameliorate illness, it is also fraught with the risk of patient harm. Much of the focus on patient safety has been in hospitals and there is a paucity of high-quality evidence about patient safety in primary care, which is where most people get most of their healthcare. There is an increasing awareness that the risks identified in acute care manifest differently in primary care and that there are risks to patient safety that are unique to primary care. Strategies to improve patient safety are an important aspect of healthcare reforms; the US Institute of Medicine considers patient safety ‘indistinguishable from the delivery of quality health care.’

A key report by Sir Liam Donaldson in 2000 set the patient safety agenda in England. However, more than a decade on, patient safety problems are a continuing issue for the National Health Service (NHS). Although there have been successful initiatives around specific procedures or conditions, there have also been a number of organisational and system failures.

One high-profile example of these was the substandard care and subsequent deaths in the Mid-Staffordshire NHS Foundation Trust. The final report into the Mid-Staffordshire public inquiry (known as the Francis Report) was released in February 2013. It focused on how a culture of secrecy and denial, and a unilateral focus in one organisation led to dreadful suffering for its patients, but it highlighted the failures of a whole system. The subsequent Keogh Report on 14 other hospital trusts, released in July 2013, found that none of them was providing consistently high-quality care to patients and 11 are now under special remedial measures for fundamental breaches of care.

More recently, the Berwick Report was produced at the request of Prime Minister David Cameron to distil for the government the implications of these failures in patient safety and quality. The report stated upfront that the NHS should ‘place the quality of patient care, especially patient safety, above all other aims’ and it concludes that ‘the most important single change in the NHS in response to this report would be for it to become more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end’. The report provides recommendations for different groups including NHS organisations, leaders, staff and clinicians.

Although these reports relate to acute care, there are recommendations with implications relevant to general practice. Changes are already being made that will significantly impact general practitioners (GPs), and the alignment of these changes to the recommendations of the three reports is being emphasised (Box 1).

General practice can be proud that it treats over 90% of patient episodes in the NHS and that it has led learning from significant event auditing (SEA). There has, thankfully, not been a Mid-Staffordshire equivalent in general practice. However, the limited research on patient safety issues in general practice and estimates of the incidences of error and rates of patient harm in primary care have been criticised as lacking in consistency and theoretical construct. Indeed, there is evidence to suggest that patient safety could be as much of a problem in general practice as it is in acute care.

Moreover, although Donaldson’s report and similar reports from the United States have engendered considerable activity in quality and safety, there is little evidence to show that health services are becoming safer. A key challenge has been in measurement and monitoring of patient safety. One authority on the subject recently concluded ‘Sadly, when it comes to our national effort to improve patient safety, we do not know whether the glass is half empty or half full’.
It is imperative therefore that GPs act to translate the findings and recommendations of these reports into safer care for their patients, starting with the required changes in process and culture within their practice and among their peers. There are lessons to be gained from the work of Donald Berwick, and other leaders in quality improvement like W. Edwards Deming and Joseph Juran, on how to do this in the context of a busy practice.19

Recognising the enormous strains and competing priorities in general practice, we offer five pragmatic suggestions to help GPs start down this road.

**Start every partnership meeting with a patient safety story**

The Patient Safety First campaign20 provides guidance on the use of patient stories for hospital executive boards. The GP partnership is in essence equivalent to a board. As practicing clinicians, GPs are much more closely connected to patient issues than hospital boards and starting meetings with patient stories provides an engaging method to build collegiality. Patient stories highlight the problems and perspectives of patients and help place them and keep them at the centre of the healthcare system – using their stories in this way means ‘safety becomes a key focus of all we do’.26 General practice serves as a window on the NHS and the narration of stories about safety problems across the interfaces with community services and acute care can provide valuable insights to feed into the commissioning agenda.

**Make every significant event audit achieve its full potential to improve patient safety**

Many general practices were conducting SEAs even before they became part of their pay-for-performance system, the Quality and Outcomes Framework.21 However, there is much variation in the quality of analysis and there is great potential to learn more systematically from SEAs.22 General practice should build on the good work done with SEAs and be bold enough to change systems and processes where needed rather than simply relying on reminders, the recirculation of protocols and requests for vigilance and hard work as the only solutions.

Donaldson said ‘to err is human, to cover up is unforgivable, and to fail to learn is inexcusable’.23 The objective of learning from a significant event is to understand the root causes and then to address these to prevent an adverse event or events recurring. Utilising a systematic, non-threatening approach such as those described by the National Patient Safety Agency24 or the London Protocol25 facilitates identification of root causes. Equally important is for those staff and clinicians involved in the event to be supported. Any changes made on the basis of an SEA should be tested and monitored to ensure that they have indeed improved safety.

**Conduct a ‘round to influence’**

The 2009 NHS Institute for Innovation and Improvement survey of general practice staff showed that, in most practices, there was limited discussion with staff about safety culture, and not all relevant staff were involved in discussing safety incidents.26 Leadership is required to raise the importance of patient safety among staff. A specific focus should be
on asking staff questions about the task in hand – for example, in order to improve the level and quality of event reporting, a leader should ask staff if they know what significant events are and how to report a safety event, and asks them to demonstrate how they report an event. This ‘rounding to influence’ approach is an evidence-based leadership technique that can help close the gap between discussion and front-line realities and embed the importance of these issues in the minds of staff. This also means that practice leaders can learn directly from and remain connected with the staff whose actions they are responsible for.

**Patient safety is everyone’s business – empower patients**

The one constant in any episode of care is the patient (or their carer). Patients and caregivers see things that busy healthcare workers often do not and safety can be improved if patients are included as full partners in reform initiatives, and learning can be used to inform systemic quality and safety improvements. Patient centredness is a central theme in the Francis, Keogh and Berwick reports: patients may be involved in a number of ways and increasingly legislation and health organisations ‘promote and emphasize the role of patients to improve quality and safety of health care’. There are an increasing number of practical examples of how to do this, such as The Joint Commission’s ‘Speak Up’ campaign in the USA. The Patient Participation Directed Enhanced Service offers an opportunity to start a dialogue with patients and their carers about their involvement in patient safety.

**Patient safety is everyone’s business – empower staff**

Making care safer requires everyone’s commitment and engagement. General practice owners and leaders should strive to help their staff to help them provide safer care. This requires capability building with patient safety being one of the key issues which should be discussed at staff induction. Staff should be trained in what significant events are and how to report a safety event, and asks them to demonstrate how they report an event. Education and staff training feature as important dimensions of patient safety culture in culture surveys.

**Conclusion**

These are just five pragmatic suggestions that can start the journey to safer care. Berwick is often quoted as saying ‘What can you do by next Tuesday?’ It should be easy to pick one of these approaches and try it by next Tuesday. The learning comes from doing, subsequent reflection, making changes as required, and then repeating the cycle.

These simple pragmatic actions, when done as iterative learning cycles, are consistent with many of Berwick’s recommendations. For example, they ‘continually and forever will help reduce patient harm by embracing wholeheartedly an ethic of learning’. Patient and carer voices start to be heard ‘at every level, even when that voice is a whisper’ – and patient and carer involvement in their care is increased. The actions also allow staff to start developing a ‘mastery of quality and patient safety sciences and a general practice will then start to use these techniques, become a learning organisation and build trust and capability.

Some will no doubt say this is a step too far or too idealistic, some will say they have no capacity to undertake more with the many competing priorities placed on practices, but hopefully some will embrace it and lead the way for others. In the current climate of cost cutting, reforms, low morale and high stress, delivering quality care and ensuring patient safety can be the road to a united profession. It offers a sense of purpose, a sense that aligns with the caring professions, it offers guiding principles against which to manage the competing priorities of a busy practice, and it gives GPs authority to speak up where cuts genuinely pose a threat to patient safety. If general practice can create the culture outlined in Berwick’s vision, then the NHS will be a service infused with ‘pride and joy in work’, with more productive and satisfying working lives for leaders, clinicians and staff and, most importantly, safer patient care.

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PEER REVIEW
Commissioned; not externally peer reviewed.

CONFLICTS OF INTEREST
None declared.

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Received 6 October 2013
Accepted 7 October 2013