Shared learning and better incident reporting can help primary care organisations to improve patient safety.

Improving patient safety in primary care

In this article...
- The drive to improve patient safety in primary care
- How a national campaign is promoting shared learning
- How a new electric form helps with incident reporting

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A national drive to improve patient safety is extending to all healthcare settings, including primary care. General practice does not have the same infrastructure to support governance and safety arrangements as large acute trusts, and there has not been the same level of national learning. However, a new system of professional regulation requires nurses in all settings to show how they promote a safety culture. This article shows how joining the Sign up to Safety campaign allows primary care organisations and individuals to access a network of support and shared learning to make improvements in their places of work. Better reporting of patient safety incidents using a new national e-form will also help to develop and spread best practice.

Patient safety is a fundamental principle of high-quality healthcare; only safe healthcare services are truly efficient, effective and able to offer the best experience for staff and patients. While much attention has been paid to improving patient safety and reducing patient harm in the NHS over the last decade, until recently this work has mainly focused on acute settings, resulting in greater clarity about what works in these settings. With safety issues attracting the attention of regulators, commissioners and the public, the drive for improvements is now extended to all settings, including community and mental health.

Changing professional and regulatory standards
Promoting patient safety, and learning from and speaking up when things go wrong are all enshrined in the Nursing and Midwifery Council’s (2015) code. From next year, all nurses and midwives will be required to show how they are promoting this safety culture as part of the NMC’s new professional revalidation process.

The code includes a duty of candour, requiring nurses and midwives to be open and honest with colleagues, patients and healthcare regulators when things go wrong; it states nurses and midwives should immediately raise concerns if they are aware of a threat to patient safety or public protection (NMC, 2015).

A similar duty of candour is being extended to other health professionals, allowing the NMC and other professional bodies to take action against staff who are not candid about errors with their patients (Department of Health, 2015). The government has also placed a new legal duty on healthcare organisations to ensures when something goes wrong, they tell patients and relatives about it promptly (DH, 2015).

Patient safety in general practice
Nationally, it is recognised that general practice does not have the same infrastructure and resources to support governance and safety arrangements as large hospital trusts. While patient safety is a key concern for primary care clinicians, it has to compete for attention in the busy lives of general practice staff. In addition, national learning from patient safety incidents is given less attention than in the acute sector, and is often limited to significant event audits. However, the need to improve

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patient safety in all care settings is leading to new systems and initiatives being introduced in primary care.

One way primary care organisations and nurses can access shared support and learning to meet patient safety requirements is by joining up to the Sign up to Safety campaign (www.england.nhs.uk/signuptosafety). This national initiative enables NHS organisations to share experiences and learning on interventions that reduce harm, and support each other to make improvements.

**Sign up to Safety campaign**

Sign up to Safety is a three-year national campaign to:

- Help the NHS in England create the conditions that support a safer NHS;
- Address the problem of unsafe care and avoidable harm.

It is about motivating people to take action, build local ownership, capture knowledge and share learning and ideas that make care safer.

Launched in 2014, the campaign is one of a series of national patient safety initiatives that, together, are aiming to halve incidents of avoidable harm and save 6,000 lives as a result. It offers support and guidance through its network of participants, who share helpful tools, stories and resources. To date, more than 230 organisations and individuals have joined.

The campaign encourages bottom-up, locally owned change and is for everyone in the NHS, no matter where they work. Most organisations that have signed up are acute trusts but all types of organisations are encouraged to participate, including those in general practice (Fig 1). The campaign aims to align the whole system to achieve a shared ambition of keeping patients safe.

On joining, individuals and organisations are asked to sign up to five safety pledges (Box 1) but there are no mandatory interventions, targets or “performance management” from the centre - the energy, ideas and expertise are found inside the NHS and within each organisation, harnessing the commitment of staff across the NHS in England to make patient care safer.

### Benefits of signing up

Joining the campaign is a chance for individuals and organisations to share their passion for, knowledge and experience in patient safety with others, creating broad-based learning and a network connecting people and organisations across the NHS in England. It also helps people access the many interventions shown to improve safety in the NHS and worldwide. It:

- Helps engage and motivate staff;
- Offers safety briefings and de-briefings;
- Gives methods for investigating patient safety incidents;
- Improves patient communication skills;
- Helps with ways to design safe care using tools and techniques from other industries, including useful checklists.

**‘Listen, learn, act’**

The campaign’s mantra is “Listen, learn, act”:

- **Listen** to patients, carers and staff;
- **Learn** from what they say when things go wrong;
- **Act** to improve patients’ safety and ensure harm-free care.

The campaign supports the patient safety recommendations in the Berwick review, and is designed to help realise the ambition to make the NHS the world’s safest healthcare system by creating one devoted to continuous learning and improvement (National Advisory Group on the Safety of Patients in England, 2013).

This ambition is bigger than any individual or organisation and requires all to unite behind the common aim. Patients need to be confident the NHS is doing all it can to ensure the care they receive is safe and effective at all times.

### Engaging patients

A key aspect of the campaign is the role patients can play in their own safety, and how to help them stay informed and safe. Organisations are encouraged to seek the views of patients, their families and carers about their perceptions of safety and where they think improvements can and should be made.

Patients’ opinions can be powerful influencers and a true force for change, but they need to be heard and acted on. This might be through a patient suggestion scheme or inviting patient representatives to sit on committees or forums. Many general practices already have patient engagement groups and these are a valuable resource. Another way to empower patients is to inform them about safety and quality issues using videos or messages in waiting areas. Sign up to Safety is about sharing learning experiences in these and other areas, to encourage broad-based learning across the whole country.

### Engaging the primary care team

Many general practices have staff responsible for areas such as risk management, health and safety and complaints; this work can be combined under the banner of Sign up to Safety. This involves setting up a small safety team of people who can work

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**Box 1. The Five Safety Pledges**

- **Put safety first**: commit to reducing avoidable harm in the NHS by half and make public the goals and plans developed locally.
- **Continually learn**: be more resilient to risks as an organisation, by acting on patient feedback and constantly measuring and monitoring how safe services are.
- **Be honest**: be transparent with people about progress to tackle patient safety issues, and support staff to be candid with patients and their families if something goes wrong.
- **Collaborate**: take a leading role in supporting local collaborative learning so improvements are made across all the services patients use.
- **Be supportive**: help people to understand why things go wrong and how to put them right; give staff time and support to improve, and celebrate progress.

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**FIG 1. Organisations Signed Up to the Campaign**

<table>
<thead>
<tr>
<th>Organisation type</th>
<th>Number of organisations signed up</th>
<th>Percentage of total organisations signed up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute incl. children’s acute</td>
<td>134</td>
<td>2%</td>
</tr>
<tr>
<td>Mental health</td>
<td>30</td>
<td>6%</td>
</tr>
<tr>
<td>Clinical commissioning group</td>
<td>28</td>
<td>10%</td>
</tr>
<tr>
<td>Community provider incl. community pharmacy</td>
<td>24</td>
<td>12%</td>
</tr>
<tr>
<td>Ambulance trusts</td>
<td>5</td>
<td>13%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>15</td>
<td>57%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>236</td>
<td>100%</td>
</tr>
</tbody>
</table>

Data correct to 20 February 2015.

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together to share learning and reduce avoidable harm. Ideally, the team should be multidisciplinary and, where appropriate, should include patient representatives. Administrative staff have a vital role to play in identifying systems and processes that can be improved to prevent errors, for example in areas such as repeat prescribing.

A good way to engage staff and gather ideas is to ask the wider team: what top five things keep you awake at night? Use this to help develop an action plan. If staff feel the plan adds value to their everyday work, they are more likely to support it.

Incident reporting
Better incident reporting is another way primary care organisations can improve the safety of the care they provide. With an estimated 360 million consultations each year, most healthcare takes place in primary care settings (NHS England, 2015). Human error means some mistakes are inevitable but, despite many GPs committing to improving patient safety, the number of incidents reported to the National Reporting and Learning System in general practice is comparatively low (NHS England, 2015).

The everyday “glitches” experienced in general practice can be just as important as the dramatic failures more usually associated with secondary care, and it is only by reporting such errors that the service can learn and make improvements. Reports of harm or near misses to the NRLS provide important insights on how to improve patient safety both locally and nationally. This enables risks to be identified and action taken – such as cascading patient safety alerts, developing learning resources and holding workshops – to help NHS staff prevent future incidents.

Reporting made easier
NHS England launched a new e-form in February that allows general practice staff to quickly and easily report patient safety incidents to the NRLS (bit.ly/NRLSGPForm). The e-form, developed in consultation with general practice staff, can be used to report all patient safety incidents and near misses, whether or not they resulted in harm (NHS England, 2015). These are used to spot any emerging patterns or areas of concern, raise awareness of the risks, and share learning with health providers nationwide to keep patients safe and prevent problems occurring elsewhere.

Practices can include their practice code or submit a report anonymously; patient-identifiable information is not required. When submitting reports, there is an option to request a significant event audit template, which can be used for continuing professional development, appraisal and revalidation. This can also provide evidence of patient safety activity during Care Quality Commission inspections.

What to report
Organisations should report all patient safety incidents, clinical and non-clinical, where a patient was harmed or might have been harmed. This includes near misses and incidents with a beneficial outcome, for example, where appropriate barriers and defences prevent an incident from occurring. These incidents could relate to systems, communications, knowledge or human errors (Fig 2). Reporting them helps identify what works in practice, which can be shared locally and nationally to help develop and spread best practice. There is clear evidence that a culture of learning, particularly from mistakes, is critical to improving patient safety (DH, 2015). Experience in other industries, such as aviation, shows staff are more likely to report incidents as the reporting culture matures. This means an increase in incident reporting should not be taken as an indication of worsening patient safety but a sign that awareness of safety issues is increasing and the culture is becoming more open and transparent (NHS England, 2015).

Conclusion
The national drive to improve patient safety has been extended to all healthcare settings, including primary care. From next year nurses will have to show how they promote a safety culture as part of the NMC’s new professional revalidation process. Joining the Sign up to Safety campaign, and improving incident reporting using a new electronic national reporting form, can help primary care nurses and organisations meet these aims through shared support and learning.

References

For more on this topic go online...
- Clinical supervision in a community setting
- Bit.ly/NTCommSupervision

BOX 2. EXAMPLES OF REPORTABLE INCIDENTS

- Wrong bottles used for blood tests causing false readings and irregular results
- Prescribing errors such as an inappropriate dose of a drug, which the community pharmacist notices when dispensing the prescription
- A patient slips and falls on ice on pavement outside the practice
- Continuing treatment with warfarin without monitoring clotting levels that results in an overdose and bleeding problems requiring close monitoring and follow-up
- A home visit is missed, resulting in a patient continuing to be in pain until medication can be altered
- Test results filed in a patient’s notes without being reviewed by GP
- Vaccine cold chain storage broken