

Monitoring patient safety in general practice:

the increasing role of GPs

PATIENT SAFETY

Patient safety has been defined¹ as 'a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimises the incidence and impact of, and maximises recovery from, adverse events'.

GPs play a key role in health care in the UK: more so than in most other developed countries. From birth virtually the entire population is registered with their own general practice (often keeping to their own GP) and their medical notes travel with them 'from cradle to the grave' when they change practices. GPs refer non-emergency patients to hospital and receive discharge letters about their patients from hospitals so that, in theory, a record of much of a patient's lifetime medical history resides in their general practice medical notes.

Following the introduction of fundholding in 1991, then primary care trusts in 1998, and now, as a result of the Health and Social Care Act 2012, clinical commissioning groups (CCGs), GPs are responsible for commissioning about 60% of all NHS resources, which are allocated, using a formula developed for the Advisory Committee on Resource Allocation, to CCGs. The allocation is to practices, aggregated to CCG level. With this increased financial power comes increased responsibility, outlined in the NHS England CCG Assurance Framework 2013/2014 which states that:

'The framework is designed to give assurance that CCGs are delivering quality and outcomes for patients, both locally and as part of the national standards, as well as being the basis for assessing that they are continuously improving from the start point of authorisation. Of necessity, it therefore looks at both the organisation's performance and its health'.

Hence, GPs are not only accountable for the quality of care provided in their practices but also, as members of CCGs, for quality and outcomes of their CCGs.

THE FRANCIS REPORT ON THE MID STAFFORDSHIRE PUBLIC INQUIRY

In February 2013 Robert Francis, QC,

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drew attention in his report of the Mid Staffordshire Public Inquiry to poor care at the Mid Staffordshire NHS Foundation Trust. He wrote:

*'... the system as a whole failed in its most essential duty — to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital ... Large numbers of patients were left unprotected, exposed to risk, and subjected to quite unacceptable risks of harm and indignity over a period of years'.*²

Although a few individual GPs tried to raise concerns at Stafford, Francis commented²: 'The local GPs only expressed substantive concern about the quality of care at the Trust after the announcement of the HCC [Healthcare Commission] investigation, when it had become obvious there were issues and when they were specifically asked'. In an interview Francis stated:

*'It's vital that GPs remember that their responsibility to their patient doesn't end when they go into hospital. They need to be more systematic about how they gather information because, after all, they are meant to advise patients on where is the best place to go for their treatment. The old fashioned way of phoning up their friend the consultant and having a word is just not good enough'.*³

The National Reporting and Learning System, part of the NHS Commissioning Board since June 2012, is the main mechanism for the collection of information on patient-safety incidents in England and Wales. However, only 0.4% of reported patient safety incidents are from general practice and yet they may, for example, have been concerned about the out-of-hours cover provided for their patients by the '111' service.^{4,5} A national online incident reporting system for primary care, reporting patient safety incidents as part

of the Quality and Outcomes Framework, and in-practice adverse event and mortality reviews are possible ways for GPs to adopt a 'more formal approach to patient safety' (A Reeves, personal communication 2013).

There is a considerable volume of 'metrics' available concerning patient safety. The Bristol Royal Infirmary Inquiry⁶ used information from inspections, case note reviews, and adjusted death rates, the last having the advantage that deaths must, by law, be notified, and even poor providers, who tend to be less vigilant, would be likely to record deaths. Adjusted death rates are available at CCG level and can be broken down in great detail. In general practice there is information on death rates at practice level (and Shipman could probably have been picked up earlier if allowance was made for GPs working in care homes) but it has not been routinely used.⁷

All this is far from the days when Sir James Spence, a paediatrician, (1892–1954) said:

*'The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts'.*⁸

Or the description of general practice portrayed in John Berger's book *A Fortunate Man: The Story of a Country Doctor*.⁹ There is now an emphasis on integrating primary-community and secondary care, and GPs are under pressure from all directions, including that of commissioning secondary health care for their patients and making sure that the providers are 'delivering quality'.

CAN GPs COPE?

There have been several changes in the structure of general practice in England over the past decade. From December 2004, GPs have been able to transfer their out-of-hours responsibilities to an 'accredited organised provider of out-of-hours services' and 90% have opted to

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do so. One of the consequences is that GPs are no longer seen by their patients as providing 24-hour primary care coverage. This may have had an effect on the current A&E crisis, although several other factors are likely to be operative, including the increase of admissions for alcoholism. In 2011/2012, there were an estimated 1 220 300 admissions related to alcohol consumption where an alcohol-related disease, injury, or condition was the primary reason for hospital admission or a secondary diagnosis (a broad measure). This is more than twice as many as in 2002/2003.¹⁰

From 2003 to 2012 the number of GPs, as a proportion of GPs plus hospital doctors, has reduced from 34% to 30%, yet there is 'a broad consensus that care must shift from hospital to community'.

On 5 July 2013, Clare Gerada, Chair of the RCGP, stated, in an email to members, 'We're worried that, as public attention continues to be diverted onto secondary care and A&E, the very real crisis in general practice is being overlooked'. Sir Bruce Keogh, Medical Director, NHS England, stated in 2013 'I think the NHS is the

most fragile it's ever been'.¹¹ Lord Darzi stated that 'there is a vacuum of strategic leadership, and I don't think there is the resilience in the system to deal with the tsunami that is about to hit us'.¹¹

GPs are now involved in the patient safety goal of 'achieving a trustworthy system of healthcare delivery' for their patients both within their practices and also, as members of CCGs responsible for commissioning secondary care, of assuring 'that CCGs are delivering quality and outcomes for patients'. I hope that GPs will be able to cope with the additional workload; they work in the front line of health care and the problems at Mid Staffordshire might have been picked up in 2001, not 2007, had the prescient report of Stafford Primary Care Group been acted on.¹²

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Provenance

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