Quality in Primary Care 2013;21:333–7

Editorial

Implementing the Berwick Report in general practice

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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.[1] 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.'[2]

A key report by Sir Liam Donaldson in 2000 set the patient safety agenda in England.[3] 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[4]) 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[5] 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[6] 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.[7] 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).[8]

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).[9] There has, thankfully, not been a Mid-Staffordshire equivalent in general practice. However, the limited research on patient safety issues in general practice[10] 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.[11] 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.[12–14]

Moreover, although Donaldson's report and similar reports from the United States[15,16] have engendered considerable activity in quality and safety, there is little evidence to show that health services are becoming safer.[17] 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'.[18]

Box 1 Implications of the Francis Report for GPs[4]

The report concludes that GPs have an important role in undertaking monitoring on behalf of their patients who receive acute hospital and other specialist services. It highlights that:

- GPs should have a role to check on the quality of service, in particular in relation to an assessment of outcomes
- internal systems are needed to enable GPs to flag any patterns of concern
- GPs have a responsibility to their patients to keep themselves informed of the standards of local services and service providers to inform patient choice
- GPs have an ongoing responsibility for their patients and that responsibility does not end on referral to hospital
- GPs should take advantage of their position as commissioners to ensure patients get safe and effective care.

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 campaign[20] 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'.[6] 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 unforgiveable, 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 Agency[24] or the London Protocol[25] 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.[27] 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'.[28] 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'.[29] 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.[30] The Patient Participation Directed Enhanced Service[31] 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 quality improvement and empowered to work towards a tomorrow where they can identify risks and safety threats and implement small-scale tests of change to identify workable solutions to address these. Education and staff training feature as important dimensions of patient safety culture in culture surveys.[32]

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?'[33] 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'.[6] Patient and carer voices start to be heard 'at every level, even when that voice is a whisper'[6] – 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'[6] 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,[34] 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',[6] with more productive and satisfying working lives for leaders, clinicians and staff and, most importantly, safer patient care.

REFERENCES

1 Pearson A and Aromataris E. *Patient Safety in Primary Healthcare: a review of the literature.* Australian Commission on Safety and Quality in Health Care/The Joanna Briggs Institute: Adelaide, 2009. www.safetyandquality.gov.au/wp-content/uploads/2009/01/Patient-Safety-in-Primary-Health-Care-A-Review-of-the-Literature-2009.pdf (accessed 10/13).

2 Aspden P, Corrigan JM, Wolcott J and Erickson SM (eds). *Patient Safety: achieving a new standard for care.* The National Academies Press: Washington, DC, 2009. www.nap.edu/openbook.php?record_id=10863&page=R1 (accessed 10/13).

3 Donaldson L. *An Organisation with a Memory. Report of an expert group on learning from adverse events in the NHS.* Department of Health: London, 2000.

webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065086.pdf (accessed 10/13).
4 The Mid-Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC. *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry*. 3 vols. Stationery Office: London, 2013. www.midstaffspublicinquiry.com/report (accessed 10/13).
5 Keogh B. *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: overview report*. NHS, London: 2013. www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf (accessed 10/13).
6 Berwick D. *A Promise to Learn – a commitment to act. Improving the safety of patients in England*. National Advisory Group on the Safety of Patients in England, 2013. www.gov.uk/government/publications/berwick-review-into-patient-safety (accessed 10/13).
7 Royal College of General Practitioners. *RCGP Summary: The Francis Report, February 2013*. RCGP: London, 2013. www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Francis-Report-Overview-2013.ashx (accessed 10/13).
8 Gerada C. Viewpoint: Practice federation and continuity of care key after Francis report. *GP* 2013. www.gponline.com/News/article/1170640/Viewpoint-Practice-federation-continuity-care-key-Francis-report (accessed 10/13).
9 Pringle M, Bradley C, Carmichael C *et al*. *Significant Event Auditing*. Occasional Paper 70. Royal College of General Practitioners: London, 1995. www.ncbi.nlm.nih.gov/pmc/articles/PMC1239424 (accessed 10/13).
10 Makeham M, Dovey S, Runciman W and Larizgoitia I. *Methods and Measures used in Primary Care Patient Safety Research. Results of a literature review*. WHO: Geneva, 2008. www.who.int/patientsafety/research/methods_measures/makeham_dovey_full.pdf (accessed 10/13).
11 McKay J, Bradley N, Lough M and Bowie P. A review of significant events analysed in general practice: implications for the quality and safety of patient care. *BMC Family Practice* 2009;10:61. www.biomedcentral.com/1471–2296/10/61 (accessed 10/13).
12 National Patient Safety Agency. *Delayed Diagnosis of Cancer. Thematic review*. NHS: London, 2010. www.nrls.npsa.nhs.uk/resources/?EntryId45=69894 (accessed 10/13).
13 Khoo EM, Lee WK, Sararaks S *et al*. Medical errors in primary care clinics – a cross sectional study. *BMC Family Practice* 2012;13:127. www.biomedcentral.com/1471–2296/13/127 (accessed 10/13).
14 Avery T, Barber N and Ghaleb M. *Investigating the Prevalence and Causes of Prescribing Errors in General Practice: the PRACtICe study*. General Medical Council: London, 2012. www.gmc-uk.org/about/research/12996.asp (accessed 10/13).
15 Kohn LT, Corrigan JM and Donaldson MS. *To Err is Human: building a safer health system*. The National Academies Press: Washington, DC, 2000. www.nap.edu/openbook.php?isbn=0309068371 (accessed 10/13).
16 Institute of Medicine. *Crossing the Quality Chasm. A new health system for the 21st century*. National Academy Press: Washington, DC, 2001. www.nap.edu/openbook.php?isbn=0309072808 (accessed 10/13).
17 James JT. A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety* 2013;9(3):122–8. journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx (accessed 10/13).
18 Pronovost PJ and Wachter RM. Progress in patient safety: a glass fuller than it seems. *American Journal of Medical Quality* 2013; Epub ahead of print. ajm.sagepub.com/content/early/2013/07/31/1062860613495554 (accessed 10/13).
19 The Health Foundation. *Quality Improvement Made Simple. What every board should know about healthcare quality improvement*. The Health Foundation: London, 2013. www.health.org.uk/public/cms/75/76/313/594/Quality_improvement_made_simple.pdf?realName=uDCzzh.pdf (accessed 10/13).
20 Clarke J. *Leadership for Safety, 'How to' guide supplement: using patient stories with boards*. NHS Patient Safety First: London, 2009. www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Patient%20stories%20how%20to%20guide%2020100223.pdf (accessed 10/13).
21 Pringle M. Improving quality: bridging the health sector divide. *International Journal for Quality in Health Care* 2003;15:457–62. intqhc.oxfordjournals.org/content/15/6/457.full (accessed 10/13).
22 National Patient Safety Agency. *Extracting Data and Sharing Learning from Significant Event Audits in General Practice*. NHS: London, 2010. www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=66362& (accessed 10/13).
23 Donaldson L. *Patient Safety Technical Briefing to World Health Assembly*. World Health Organization: Geneva, 2010. www.who.int/patientsafety/news/establishment/en/index.html (accessed 10/13).
24 National Patient Safety Agency. *Seven Steps to Patient Safety. The full reference guide*. NHS: London, 2004. www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=59971& (accessed 10/13).
25 Taylor-Adams S and Vincent C. *Systems Analysis of Clinical Incidents: The London Protocol*. Faculty of Medicine, Imperial College: London, n.d. www1.imperial.ac.uk/medicine/about/institutes/patientsafetyservicequality/cpssq_publications/resources_tools/the_london_protocol (accessed 10/13).
26 Institute for Innovation and Improvement. *NHS Innovation and Improvement Survey: 2009 Report*. London: NHS, 2009. www.institute.nhs.uk/images//stories/Building_Capability/Innovation/UK_NHS_Survey_March10.pdf (accessed 10/13).
27 Reinertsen JL and Johnson KM. Rounding to influence: leadership method helps executives answer the 'hows' in patient safety initiatives. *Healthcare Executive* 2010; 25(5):72–5. www.ihi.org/knowledge/Pages/Publications/RoundingtoInfluence.aspx (accessed 10/13).
28 World Health Organization. *Patients for Patient Safety – statement of case*. WHO: Geneva, 2013. www.who.int/

patientsafety/patients_for_patient/statement/en/index.html (accessed 10/13).
29 World Health Organization. *Exploring Patient Participation in Reducing Health-Care-Related Safety Risks*. WHO: Geneva, 2013. www.euro.who.int/en/what-we-publish/abstracts/exploring-patient-participation-in-reducing-health-care-related-safety-risks (accessed 10/13).
30 The Joint Commission. *Speak Up Initiatives*. n.d. www.jointcommission.org/speakup.aspx (accessed 10/13).
31 Patient Participation Directed Enhanced Service. *Patient Experience*. n.d. www.patientexperience.co.uk/understanding-the-patient-experience/patient-participation-directed-enhanced-service (accessed 10/13).
32 Manchester Patient Safety Framework. *Primary Care*. NHS: London, 2006. www.nrls.npsa.nhs.uk/resources/?entryid45=59796 (accessed 10/13).
33 Stewart B. What would Don Berwick do? Obama's real plan for health care reform. *GeriPal Blog* 2010. www.geripal.org/2010/04/what-would-don-berwick-do-obamas-real.html (accessed 10/13).
34 Limb M. Patient care is being damaged by rising bureaucracy, GPs warn. *BMJ* 2013;347:f5732. careers.bmj.com/careers/advice/view-article.html?id=20014602 (accessed 10/13).

PEER REVIEW

Commissioned; not externally peer reviewed.

CONFLICTS OF INTEREST

None declared.

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Received 6 October 2013
Accepted 7 October 2013