The Primary Care Patient Safety Strategy Summary

Why: Primary Care (general practice, community pharmacy, optometry and dental services) delivers 90% of NHS interactions, face to face, by phone or online. 97% of encounters in general practice are safe, but there are between 20,000 and 30,000 incidents of avoidable significant harm identified in general practice in England per year - Incidence, nature and causes of avoidable significant harm in primary care in England. Every one of these incidents has a personal cost to patients, service users, families, carers and staff, as well as a financial cost to the NHS. The top 3 patient safety incident types in the *Avery et al, 2020* retrospective general practice case note review were: diagnosis 61%, medication-related 26% and delayed referral 11%.

How: The strategy has been informed by the patient safety discovery group comprising primary care providers, commissioners and patient safety partners from across all primary care areas and draws together best practice. It is not a contractual requirement on primary care providers, or integrated care boards (ICBs). NHS England will continuously review its effectiveness and how we can best implement the strategy to improve patient safety - Primary care patient safety strategy & The NHS Patient Safety Strategy.

It focuses on:

1. developing a supportive, learning environment and just culture in primary care, with sharing across the system so that the services can continually improve
2. ensuring that the safety and wellbeing of patients and staff is central, and that our approach to managing safety is systematic and based on safety science and systems thinking
3. involving patients in the identification and co-design of primary care patient safety ambitions, opportunities and improvements

The **NHS England Patient Safety Incident Response Framework** was launched in acute, ambulance, mental health and community healthcare providers in 2022. It sets out the approach for responding to patient safety events (or incidents) for the purpose of learning and improving patient safety. This approach is flexible and adapts as organisations learn and improve, so they explore patient safety incidents relevant to their context and the populations they serve - NHS England » Patient safety incident response standards.

It is necessary to recognise that **healthcare staff** operate in complex systems, want to do a good job and should be able to rely on the structure and processes within a practice, the organisational arrangements that surround a practice, the wider interactions with other providers of health and social care and the influence of regulatory bodies, to help them be successful and safe. Focusing on the action or inaction of one person ignores the risks in the system that allowed the incident to occur. Improving safety requires us to improve the safety of systems of work, and not to focus on individuals - From Safety-I to Safety-II white paper.

The **new approach** in patient safety is that when things go wrong in care and when things go right, it is important that patient safety events are recorded so the learning will continually improve patient safety: locally, at place, across systems and nationally. However, we know that the culture of incident recording within primary care is relatively underdeveloped and quite variable compared to secondary care, which means there will be areas of patient safety that we do not yet understand.

Continuity of care in general practice can strengthen and support access by reducing the need for repeated patient contacts so that we can further improve patient safety. It can support development of trust between a patient and their GP and enhances the GP's understanding of their patient's circumstances, thus improving patient safety. For those patients who have more than 4 consultations over 2 years, it could save 5.2% of GP appointments and avoid hospital admission.

Action on patient safety also improves **equality** in healthcare as there is evidence that population groups experience patient safety events unequally. General Practice, has an essential role to play in addressing inclusion health, working in partnership to manage long-term conditions and to prevent ill health, which includes promoting patient safety, amongst socially excluded groups. The COVID-19 pandemic highlighted

gaps in healthcare for people from groups who face inequalities, such as those on low incomes and from minority ethnic backgrounds.

Given the **capacity pressures** in primary care and ICBs, this strategy seeks to continuously improve patient safety through existing processes and structures as much as possible, rather than adding work. The **timeframes** for the implementation of the local commitments are intentionally flexible to allow for the piloting of different approaches, and while this strategy is for all areas of primary care, some improvements will be implemented first in general practice and the successes and learning then used in the rollout to community pharmacy, optometry and dental services - Delivery plan for recovering access to primary care.

In summary:

- The **NHS staff survey** in primary care will provide standardised, comparable, actionable staff experience data that can be used to understand challenges and target these for improvement, with the long term aim for the survey to form part of the annual cycle across the whole of primary care.
- **Safety culture** Safety culture: learning from best practice & Improving patient safety culture – a practical guide.
- **Patient safety culture;** teamwork, communication, just culture, psychological safety, promoting diversity, inclusive behaviours and civility - Improving patient safety culture – a practical guide.
- Complete free **patient safety syllabus training** - NHS Patient Safety Syllabus training - elearning for healthcare.
- ICBs should ensure primary care staff have access to **Freedom to Speak Up (FTSU)** guardians who are independent to the provider practice - ICBs, ICSs and Freedom to Speak Up.
- **Looking after staff** is a key component of providing safe provider care - Practitioner Health.
- Diverse **patient involvement** ensures that the voice of all communities is heard, especially those experiencing health inequalities - Involving patients in patient safety & Action on inclusion health.
- **Insight:** register for and use the new incident recording (**LFPSE**) and incident response (**PSIRF**) systems - Primary care information on the new national learn from patient safety events (LFPSE) service & Learn from patient safety events (LFPSE).
- **Involvement:** identify patient safety leads and lay patient safety partners
- **Improvement:** review and test patient safety improvements in diagnosis, medication, referrals, optometry and dental services - National General Practice Improvement Programme.
- **Medical examiners** provide independent scrutiny of deaths that are not investigated by a coroner, and give bereaved people the chance to ask questions and raise concerns. Based in acute trusts, they have been working with GP practices to help them prepare for all deaths to be review by medical examiners - The national medical examiner system & this podcast explaining how partnership working between GPs and medical examiners improves the experience of bereaved people, and explores the advantages for GPs.

Other key ambitions

We know that **improving the interface between primary and secondary care** is a key part of patient safety. We know that patient safety events are more likely to occur at these points of change and we want to develop a primary care culture with leadership that promotes an enabling and psychologically safe environment that extends across boundaries. The new National Care Records Service (NCRS), which replaced the Summary Care Record application in 2024, helps with this ambition - GPSC Working better together.

We want to promote **a culture of safety event recording in primary care**, together with an **improved learning response**. This is encouraged by moving to a **just culture** that focuses on the role of systems, not individuals, when things go wrong, a systems approach to solutions, compassionate leadership and engaging and involving patients, families and staff following a patient safety incident.